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Conscience Clauses and Oral Contraceptives:
Conscientious Objection or Calculated Obstruction?

Mary K. Collins, CNM, MN

I. INTRODUCTION

A busy mother of two runs by her neighborhood pharmacy to refill her
birth control pills, a routine chore she has engaged in monthly for the past
year. The pharmacist tells her, "I personally don’t believe in birth control
and therefore I’m not going to fill your prescription." Increasing numbers
of pharmacists and physicians are refusing to dispense or prescribe these
forms of pregnancy prevention, citing moral objections to hormonal
contraceptives like the Pill. The objections are based on the belief that
hormonal methods of contraception are abortifacients; that is, that the use of
these methods will result in the destruction of a fertilized egg. While the
conflict between religious or personal conviction and modern health care
has been ongoing in regard to abortion, sterilization, and the "morning after
pill," the expansion of the conflict to include oral contraceptive use is new
and growing. Health care providers, with pharmacists leading the charge,
are lobbying throughout the nation for "conscience or refusal clause" laws.
These statutes protect an individual from the potential consequences of
refusing to prescribe or dispense medications based on ethical, moral, or
religious objections.

2. Id.
4. Kara Lewentheil, Refused at the Counter, CHOICE! MAGAZINE (Oct. 20, 2004),
ean-041020-pharmacist.xml.
Most states have already passed some version of conscience clauses. However, the majority of these clauses relate expressly to abortion, often the surgical type. Opponents of conscience clause legislation highlight the potentially devastating effect these clauses may have on women's reproductive health, the disproportionate effects on women in rural or underserved populations, and the individual right to appropriate health care. In contrast, proponents of these laws stress the fundamental right to express personal, religious, and moral convictions and to live in accordance with these beliefs. The problems for women seeking health care begin when these opposing ideologies collide.

In particular, Catholicism teaches that life begins at conception and forbids most family planning methods. This creates a dilemma in the United States because "Catholic hospitals constitute the largest not-for-profit provider of American health care." Many other religions and sects share beliefs similar to Catholicism concerning family planning.

This article explores the current dilemma of conscience clause legislation as it relates to prescribing and dispensing oral contraceptives. Part II traces the scientific and religious bases of the current conflict and the development of these statutes. Part III reviews the rights of the health care provider and the health care consumer in light of legal trends in employment and health law. Part IV outlines areas for compromise and reconciliation of competing views where possible. Finally, Part V reviews the opposing arguments and the possibility of reasonable compromise.

II. DISTINGUISHING MYTH FROM REALITY

A. The Science

Understanding the concepts underlying contraceptive use and religious teachings requires a working knowledge of the scientific basis underlying the arguments. The following are very simplistic explanations of the complex biochemical processes that are the human menstrual cycle, fertilization, implantation, and the physiology of hormonal contraception.

6. Id. at 97-98.
7. See id. at 77.
1. Ovulation

The human female reproductive system is a complex, interactive system. It starts in the brain, ends in the uterus, and is mediated by a number of hormones. Gonadotropin-releasing hormone (GnRH), produced in the brain by the hypothalamus, acts on the anterior pituitary gland to stimulate the production of follicle-stimulating hormone (FSH) and luteinizing hormone (LH). These hormones, in turn, act on the ovary. The ovary may contain hundreds of thousands of follicles, depending on the woman’s age. The follicles contain the ova or “eggs.”

The chosen follicle for a cycle grows in response to FSH secreted by the pituitary gland. Meanwhile, the ovary produces estrogen, which stimulates many changes throughout the body, including thickening of the endometrium (lining of the uterus). High levels of estradiol in the bloodstream, produced by the secretion of FSH, signal the pituitary gland to produce a “surge” of LH and FSH which stimulates the follicle to prepare for the release of the ovum. Prostaglandins and other chemicals work on the follicle walls to cause rupture of the follicle and release of the mature ovum.

The remnant of the follicle becomes the corpus luteum, which produces progesterone, thereby readying the endometrium for implantation of a fertilized ovum. If fertilization does not take place, the hormone levels fall and blood flow to the endometrium is interrupted, resulting in the sloughing that is known as menstruation.

2. Fertilization

Fertilization begins with gametogenesis, the process by which the primitive germ cells (oogonia in females and spermatogonia in males), containing forty-six chromosomes, reduce and divide in order to produce mature ova and spermatids with twenty-three chromosomes each. Forty-six chromosomes (twenty-two pairs of autosomal chromosomes and one pair of sex chromosomes) comprise the full complement necessary to carry

10. Id.
12. HATCHER ET AL., supra note 9, at 70.
13. Id. at 70-71.
14. Id. at 73.
15. Id.
16. PRITCHARD ET AL., supra note 11, at 916.
17. HATCHER, ET AL., supra note 9, at 73.
18. Id.
19. PRITCHARD ET AL., supra note 11, at 907.
all the genetic information needed to create a human being. It is necessary to diminish that number by half in order for the female egg and the male sperm to unite, combine their DNA, and begin the process toward development of another human being. This process is called "fertilization."

Fertilization occurs when the sperm invades the ovum ("egg"), a process known as capitation. Capitation happens when many sperm produce enzymes that weaken the membrane surrounding the ovum, allowing one sperm to enter. Once a sperm enters the ovum, the fertilized ovum with its full complement of chromosomes, now called a zygote, begins to divide into multiple cells, or blastomeres. When the zygote divides into about 16 blastomeres, it becomes a morula. This stage ends when there are fifty to sixty cells present and the zygote is ready for implantation. At this stage, the group of cells is called a "blastocyst."

3. Implantation

The process of implantation, although poorly understood, occurs when the blastocyst burrows into the lining of the uterus and begins to differentiate into cells that will form the placenta and supporting structures, as well as the embryo. Advances in the treatment of infertility have opened a window into this fascinating process. Infertility specialists, using in vitro fertilization (IVF) techniques, have found that the rate of implantation of fertilized ova, while varied, is generally low. The implantation rate is calculated by dividing the total number of embryos that implant in the uterus by the total number of embryos placed into the uterus. Different in vitro fertilization (IVF) centers report varying implantation rates and the statistical methods used are not always consistent. However, in 2000, the Centers for Disease Control and Prevention (CDC) reported that of the 99,639 IVF cycles carried out in the
United States, only about 25,228 resulted in a successful pregnancy (a little over 25%).\textsuperscript{32} This translates into a preembryo wastage factor as high as 74% in the infertile population.

Problems with implantation occur more often than many realize.\textsuperscript{33} In an optimally fertile population, preembryo loss is calculated at approximately 25%, with half occurring through failure of the fertilized ovum to implant and the other half lost after implantation but prior to clinical pregnancy.\textsuperscript{34} Factors affecting implantation may include normality of the sperm fertilizing the ovum,\textsuperscript{35} presence or absence of leptin,\textsuperscript{36} blood-flow to the endometrium,\textsuperscript{37} genetic expression within the endometrium,\textsuperscript{38} prostacyclin production,\textsuperscript{39} and endometrial thickness.\textsuperscript{40} These are just a few of the more recently studied factors associated with success or failure of implantation.\textsuperscript{41} Because the complexity of this biological process is poorly understood, no one can state with complete surety whether alterations in the endometrium alone necessarily cause preembryo loss or that preembryonic wastage during oral contraceptive use is proximally caused by the oral contraceptive. If oral contraceptives add to the already significant natural rate of preembryo loss, it logically follows that research would show evidence of an even higher rate than that seen in nature. However, that is not the case.

\textsuperscript{32} Id.
\textsuperscript{33} Id.
\textsuperscript{34} 
PRITCHARD, ET AL., supra note 11, at 896.
\textsuperscript{37} Ernest Hung Yu Ng et al., Comparison of endometrial and sub endometrial blood flow measured by three-dimensional power Doppler ultrasound between stimulated and natural cycles in the same patients, 19 HUM. REPROD. 2385, 2385 (2004).
\textsuperscript{39} J. C. Huang et al., Prostacyclin Enhances the Implantation and Live Birth Potentials of Mouse Embryos, 19 HUM. REPRO. 1856, 1856-57 (2004); J. C. Huang et al., Prostacyclin Enhances Embryo Hatching but not Sperm Motility, 18 HUM. REPROD. 2582, 2588 (2003).
\textsuperscript{40} P. Kovacs et al., The Effect of Endometrial Thickness on IVF/ICSI Outcome, 18 HUM. REPROD. 2337, 2340 (2003). However, endometrial thickness alone was not of value in predicting implantation rates or pregnancy outcome. Id.
\textsuperscript{41} A complete discussion of the process of implantation is beyond the scope of this paper.
4. Hormonal Contraception

Hormonal contraceptives include all birth control methods that use one or both of the hormones—estrogen and progesterone—to prevent conception. Besides oral combined contraceptives (the “Pill”), there are progestin-only contraceptives, which include the “mini-pill,” the progestin-containing intrauterine devices (IUD), the injectable progesterone, Depo-Provera, and the subdermal implant, Norplant.

Combined contraceptives, whether delivered by pill, skin patch, or vaginal ring, consist of an estrogen (ethinyl estradiol) and a synthetic progestin. These hormones work together to interrupt the brain-ovary feedback system, thereby decreasing the amount of GnRH produced, which suppresses FSH/LH production and prevents ovulation. The progestin also thickens cervical mucus, which can prevent or slow sperm transport into the uterus. Mechanisms of action, which are theoretically possible but unconfirmed, include alterations of the endometrium, which might discourage implantation, and changes in the motility of the fallopian tubes, which might interfere with the transportation of either sperm or the fertilized ovum. The theoretical possibility that a fertilized ovum might not implant in the uterus leads some to label the oral contraceptive as an abortifacient. However, this argument compares apples to oranges in that it ignores the fact that if ovulation occurs while on the Pill, the endometrium is going to be altered from the hormonal effect of that ovulation. The endometrium influenced by blocked ovulation on oral contraceptives is most likely different from the endometrium of an ovulatory cycle on the Pill. Until the research is done to compare these two conditions, arguments on both sides lack certainty.

42. For purposes of this paper, references to the Pill include combination oral contraceptives, as well as the contraceptive “patch” and vaginal “ring,” which are just new delivery systems for the same hormone prescription of estrogen and progesterone together.

43. See generally HATCHER ET AL., supra note 9, at 406 (listing and defining these contraceptives).

44. Id.

45. See supra Part II A(1).


47. Id.

48. Id.

49. Am. Ass’n of Pro Life Obstetricians and Gynecologists, Hormone Contraceptive Controversies and Clarifications, http://www.aaplog.org/decook.htm (Apr. 1999). The AAPLOG website has a thorough and in depth analysis of the scientific evidence underlying this issue. While there is no conclusion regarding the issue of oral contraceptives as abortifacients, the scientific literature analysis reinforces the lack of any evidence that the Pill results in fertilized eggs that fail to implant. Id.

50. Id.

51. Id.
Some believe the argument is stronger for the contention that progestin-only post-coital (so-called "emergency") contraceptives work by preventing implantation of the fertilized ovum, mainly because emergency contraception is taken after intercourse. However, a review of research into the mechanism of action for emergency contraception and post-coital use of mifepristone (RU-486 or the "abortion pill") reveals that use of either in a post-coital dose result in delay or prevention of ovulation with no effect on endometrial receptivity or implantation. If these "emergency" methods do not function through loss of a fertilized ovum, it is even less likely that the Pill functions in such a manner.

For years, the IUD was believed to work by creating a hostile environment within the uterus, thereby resulting in loss of the preembryo. Research has now shown that the IUD prevents ovulation and fertilization as its chief mode of action. In one study, investigators examined the ova found in the fallopian tubes of women who were using an IUD and of those who were not. Significantly fewer ova were found in the tubes of women using IUDs and, of the ova found, none were fertilized. In comparison, about one half of the ova from women not on contraception were fertilized.

Studies almost universally show that contraceptives primarily, and possibly exclusively, work by preventing fertilization. The possibility that hormonal contraception can work by preventing a fertilized ovum from embedding in the uterus remains just a theoretical possibility. There is no direct proof that preembryos that would otherwise have developed into fetuses are lost through use of the Pill. Conversely, although there is substantial proof that the Pill prevents fertilization, there is no direct proof that preembryos are never lost. In reality, implantation is an extremely complex process that the medical community does not yet fully understand.

54. *Id.*
55. *Id.*
56. *Id.*
57. *Id.* at 4 (citing F. Alvarez et al., *New Insights on the Mode of Action of Intrauterine Contraceptive Devices in Women*, 49 Fertility & Sterility 768, 770 (1988)).
58. Bollinger, supra note 1.
59. *Id.*
60. E. Levitas et al., *Blastocyst Stage Embryo Transfer in Patients Who Failed to Conceive in Three or More Day 2-3 Embryo Transfer Cycles: a Prospective, Randomized
related to how the placenta develops, which in turn is related to pregnancy loss, growth of the fetus, and the health of the mother during the pregnancy. It is logical to assume that if hormonal contraception creates such an abnormal endometrium that it interferes with implantation, it also increases pregnancy complications associated with poor placentation. However, there is no evidence that oral contraceptive use at the time of conception and through early pregnancy causes any of these complications.

B. The Religion

The religious and moral opposition to oral contraception originates on two fronts: a general opposition to the prevention of pregnancy and the belief that the Pill, in particular, is an abortifacient.

1. Religious Objection to the Prevention of Pregnancy

The Catholic Church promotes its belief that "the act of sex between married partners has a two-fold purpose that cannot be separated: it brings the couple together in an act of love symbolizing their depth of feelings for one another (unitive purpose) and it provides an opportunity to bear children (procreative purpose)." The Church bans alienation of the two purposes through the use of contraception.

The Catholic Church is not the only religious institution to ban or restrict contraception. Protestant religious leaders in the United States have a rich history opposing the use of artificial means to prevent pregnancy. Sylvester Graham, a Presbyterian minister, and Anthony Comstock, an early American anti-obscenity activist, crusaded throughout the 1800s to stop the sin of contraception. Comstock later helped draft a federal law passed in 1873 banning the mailing of contraceptive information or devices, as well as other lewd publications. Although Judaism teaches that procreation is a "mitzvah," Orthodox Jewish thought "permits the use of the Pill, as it does

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61. PRITCHARD ET AL., supra note 11, at 40-41.
62. HATCHER ET AL., supra note 9, at 426.
64. Id.
65. HAROLD SPEERT, OBSTETRICS AND GYNECOLOGY IN AMERICA, A HISTORY 159 (1980). Comstock seemed to equate information regarding family planning with obscene literature. See id.
66. Id.
67. Mitzvot (plural of mitzvah) are commandments from God. Performance of these commandments by the faithful Jew helps to renew the covenant between him and God. LEO
not interfere with the natural process of insemination." Judaism forbids surgical methods of pregnancy prevention.

2. Oral Contraception as an Abortifacient

Today in the United States, the Catholic Church is synonymous with the beliefs that human life begins at conception and that abortion is murder. It might surprise many to know that the Church has not always held these beliefs. St. Augustine believed abortion was wrong but that it did not constitute homicide because the early fetus was not yet a person. During the Middle Ages, abortion was not considered murder, as the fetus was not considered a human being. However, the reason for the abortion was relevant to the issue of punishment; abortions to conceal "sexual sins" or as contraception were punished with penance or excommunication. The Church continued to promote the belief that a fetus was not a human being until 1869 when Pope Pius IX first implied that the church believed life began immediately at conception.

In 1869, Pope Pius IX held that abortion at anytime during the pregnancy was punishable by excommunication. Since then, the Church has consistently held that "[f]rom the moment of conception, the life of every human being is to be respected in an absolute way.

The Catholic Church is not the only religious organization teaching that human life begins at conception. There are many pro-life websites supported by faith-based organizations of every possible denomination. Although Judaism opposes abortion as a means of contraception, abortion when the mother’s life is at risk is encouraged. The fetus is considered a mere potentiality to which the mother’s life takes precedence. Ancient and modern Jewish theological scholars disagree over when the fetus becomes a human being. Some believe the fetus is not a human until birth,

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68. Id. at 291.
69. Id.

71. Id.
72. See id.
73. See id.
74. Id.
76. TREPP, supra note 67, at 292-3.
77. Id.
others believe human life begins at conception, and still others believe life begins at some time during pregnancy. Many Islamic religious leaders also view the embryo as potential, rather than actual, life: “[M]any scholars indicate that ensoulment of the fetus does not occur until the end of the fourth month of pregnancy (120 days).”

The history of mainstream religious belief concerning this question in the United States mimics that of the Catholic Church. This country has always been a religious and ethnic melting pot. Indeed, many of the early immigrants came to avoid religious persecution. As a result, the United States boasts a myriad of religious denominations. Interestingly, during the first half of American history when religion was deeply ingrained in the fabric of daily life, abortion (until the time the fetus first moved) was legal and common. Between 1828 and the turn of the century, anti-abortion statutes were passed nationwide and, for the first time since the birth of the nation, abortion at any time during the pregnancy became illegal.

The debate on the point at which human life begins continues today. Reasonable persons will always differ on this question. The medical community, while not equipped to determine when personhood occurs, agrees that a pregnancy does not begin until implantation. The American College of Obstetricians and Gynecologists’ Committee on Ethics believes that during the first fourteen days after fertilization, the embryo lacks the “biologic individuality necessary for a concrete potentiality to become a human person, even though it does possess a unique human genotype. The preembryo can thus be considered valuable but not at the same level as a human person.” The Committee based its conclusions on the ability of the preembryo to undergo twinning, lose cells and still develop, and the tremendous percentage of preembryos lost through common malfunctions in the process. Theologians also use scientific principles to debate the issue of hominization. As one theologian notes, “only about 45% of eggs that are fertilized actually come to term. The other 55% miscarry for a variety of reasons...[s]uch vast embryonic loss intuitively argues against the creation of a principle of immaterial individuality at conception.”

78. Id.
80. SPEERT, supra note 65, at 166.
81. Id. at 167.
82. AM. COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS COMMITTEE ON ETHICS, PREEMBRYONIC RESEARCH: HISTORY, SCIENTIFIC BACKGROUND, AND ETHICAL CONSIDERATIONS 1, (No. 136, Apr. 1994).
83. Id. at 5.
84. Id. at 5-6.
85. Thomas A. Shannon & Allan B. Wolter, Reflections on the Moral Status of the Pre-
For those who believe life begins at conception, anything that disrupts the fertilized ovum from its growth and development becomes an abortifacient. However, "[t]his claim [that oral contraceptives may work by preventing implantation], made by contraceptive manufacturers for decades, has never been proven...[e]ven the American Association of Pro-Life Obstetricians and Gynecologists agrees that it is just speculation." On the other hand, there is no definitive proof that oral contraceptives never interfere with the process of implantation. This lack of absolute certainty motivates the opposition to Pill use.

III. CONSCIENCE CLAUSES: LEGISLATIVE PROTECTION FOR THE CONSCIENTIOUS OBJECTOR

Health care institutions face numerous and often difficult ethical decisions every day. Individuals working within these settings have the same personal beliefs, biases, and convictions as other persons. However, health care workers are more likely to face a situation that may be at variance with their personal convictions as they try to meet the needs of patients. People involved in the giving or receiving of medical care may confront such complex issues as infertility, terminal disease, coma, or disability. Rapid changes in technology overwhelm society's ability to reconcile new capabilities with old ethical standards. Religious doctrines struggle to make sense of novel scientific discovery. Conscience clauses are one mechanism used to protect the individual provider or institution from being forced into action contrary to deeply held religious belief. The person who refuses to provide health services may be protected by these statutes from retaliatory action or civil liability.87

When the Supreme Court upheld a woman's right to privacy in decisions about whether to carry a pregnancy,88 a flood of legislation aimed at protecting the individuals and entities that refused to participate in abortions ensued.89 The federal government responded first. The Church Amendment prohibits courts, public officials, or public authorities from requiring the recipients of certain federal monies to provide abortions or sterilizations.90 President Bush expanded this concept when he signed the

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86. Bollinger, supra note 1 (quoting the author's interview with David Grimes, MD., clinical professor of obstetrics and gynecology, University of North Carolina School of Medicine).
89. Davis, supra note 87, at 859–60.
90. 42 U.S.C.A § 300a-7 (West 2005).
Consolidated Appropriations Act of 2005, which included the Hyde-Weldon Conscience Protection Amendment. The amendment expands the right of conscience protection by including health maintenance organizations and health insurance plans in the class of entities protected and by prohibiting the federal government from denying funding to any of these entities based on their refusal to provide abortion.

The states quickly followed. Forty-six states have enacted legislation allowing at least some health services providers to refuse to provide or participate in abortions. Laws of this type continue to evolve. Today, federal and state conscience or refusal laws vary as to whom and what they protect and how the objector is protected. The statutes also differ on requirements for the conscientious objector to receive statutory protection for refusal to provide health services.

A. Who is Protected?

The Church Amendment protects both individual providers and institutions that receive grants, contracts, loans, or loan guarantees under the Public Health Service Act or the Developmental Disabilities Services and Facilities Construction Act. The amendment prohibits institutions that obtain grants or contracts for research under all programs administered by the Secretary of Health and Human Services (HHS) from employment discrimination against individuals who refuse to provide abortion services.

The protection of individuals is greater than that of institutions. Institutions that receive money under these acts escape state requirements to provide the facilities or personnel for abortions or sterilizations. However, the federal statute protects individuals employed by the institutions from employment discrimination, discrimination regarding staff privileges, or discrimination against those applying for or accepted to

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93. ALAN GUTTMACHER INST., STATE POLICIES IN BRIEF: REFUSING TO PROVIDE HEALTH SERVICES (Aug. 1, 2005) [hereinafter STATE POLICIES], http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf. The four states with no policy on refusal to provide abortion are Alabama, West Virginia, New Hampshire, and Vermont. Id. Some states require the objection to be in writing. See e.g., ARK. CODE ANN. § 36-2151 (2005)(Ark.); COLO. REV. STAT. ANN. § 18-6-104 (2005).
95. 42 U.S.C, § 6000 (repealed 2000).
training or study programs. Mirroring the federal legislation, many state laws also extend more immunity to the individual than to the institution.

Of the states with policies shielding the conscientious abortion objector, all forty-six offer protection for individual providers, but only Mississippi expressly includes pharmacists. Depending on the state, the unwilling worker may be protected from forced participation, retaliation by an employer, or civil liability as a consequence of refusing to provide abortion- or sterilization-related health care. Just which individuals are sheltered depends on the specific language of the particular statute. Many of the laws shelter only individuals who perform or participate in the actual procedure. California specifically delineates which health care workers may refuse to participate, naming physicians, nurses or "any other person employed or with staff privileges." The statute also limits immunity from employer retaliation to those asked to "directly participate in the induction or performance of an abortion." The identity of those protected may depend on the interpretation of "performance" or "participation."

In Spellacy v. Tri-County Hospital, a Pennsylvania superior court found that the state conscience statute shielded those who "perform, participate or cooperate in" abortion or sterilization procedures from liability for refusing to perform their duties. The plaintiff was an admissions clerk who would not process the paperwork of patients receiving terminations of pregnancies. The court found that the plaintiff's responsibilities did not place her in the class of persons protected under the conscience law. Alternatively, the court also held that the hospital had attempted repeatedly to accommodate the plaintiff's needs and

98. 42 U.S.C. §300a-7(c) (2004).
99. STATE POLICIES, supra note 93. (See also MISS. CODE ANN. § 41-107-5 (2004). The inclusion of pharmacists has become an issue with the advent of medical terminations of pregnancy that are accomplished by prescription of the "abortion pill," RU-486.
100. See STATE POLICIES, supra note 93.
102. CAL. HEALTH & SAFETY CODE § 123420 (West 1996).
103. Id.
104. Id.
106. Id. at *3-4. The court held that the state statute in question "establishes parameters on a hospital's duty to accommodate employees' religious...objections to abortions and sterilization procedures. [It] limits the duty...owe[d] to...those who 'perform, participate, or cooperate in abortion[s]...Thus, all other hospital employees are excluded from the scope of the Act's protection and the employer owes to them no duty to accommodate." Id. at *4.
107. Id. at *1-2.
108. Id. at *4.
that under *Trans World Airlines, Inc. v. Hardison*, nothing further was required.

Title VII of the Civil Rights Act prohibits employers from discriminating against employees based on religion. This creates a duty of accommodation for the employer regarding the religious practices of the employee. However, the employer is required to incur no more than a *de minimis* cost when allowing for the employee's religious practice. The hospital in *Spellacy* had provided a leave of absence and offered four other positions to the admissions clerk. This analysis of state conscience legislation as consistent with employment discrimination secondary to religion under Title VII of the Civil Rights Act has been used by other courts to evaluate claims of protection under state conscience statutes.

In a Florida case of first impression, Title VII was used as the standard for the employer's conduct under the state conscience law. The hospital failed to prove that accommodation of the plaintiff's religious objections to participation in abortions resulted in an undue hardship and the trial court was directed to order reinstatement. While some believe this analytic basis ignores the plain language of the statute, other jurisdictions may possibly find that federal employment law supplies the balanced template needed to measure conflicting rights. However, at least one court refused to limit a health care provider's right to refuse accommodation if it caused an undue burden on the employer. The decision was based on a plain language reading of the statute. The statute read "[all] persons have the

112. *Id.*
114. *Id.* at 84.
116. 42 U.S.C. § 2000e. The federal law creates a private cause of action for employment discrimination based on religion. The employer must "reasonably accommodate" the employee unless such accommodation results in "undue hardship." *Id.*
118. *Id.* at 1264 (comparing the federal law to Fla. Stat. § 458.22(5) (West 2001) (repealed 1979)).
119. *Id.* at 1267.
120. *See Davis, supra* note 87, at 864.
121. *See, e.g.* Swanson v. St. John’s Lutheran Hosp., 597 P.2d 702 (Mont. 1979) (holding a nurse anesthetist was wrongfully discharged for refusing to participate in a tubal ligation under the state conscience law and that the right to refuse was unqualified by previous participation in such procedures).
122. *Id.*
right to refuse...'[therefore] it applies to 'all persons' irrespective of... the
discomfitures that might result from the exercise of the statutory right.]'\textsuperscript{123}

The right of refusal, however, would not be unlimited under the statute in a
possible instance of untimely refusal.\textsuperscript{124}

Forty-three states protect institutions as well as individuals under
conscience laws, although some specify only private or religious
institutions.\textsuperscript{125} However, public and "quasi-public" entities may not refuse
to permit elective first trimester abortions.\textsuperscript{126} One court evaluated the
hospital's refusal to permit elective abortions under the state's conscience
statute, which provided that no hospital should be required to provide
terminations and protected them from the liability associated with such a
refusal.\textsuperscript{127} "For the state to frustrate [the personal privacy right to abortion]
by its action would be violative of the constitutional guarantee."\textsuperscript{128}
Therefore, the court declined to apply the statute to "non-sectarian non-
profit hospitals."\textsuperscript{129} Individuals, and possibly sectarian hospitals, may
experience greater immunity from these statutes.

Illinois has the most comprehensive state policy governing these laws.
The state's Health Care Right of Conscience Act\textsuperscript{130} protects:

the right of conscience of all persons who refuse to obtain, receive or
accept, or who are engaged in, the delivery of, arrangement for, or
payment of health services and medical care whether acting individually,
corporately, or in association with other persons; and to prohibit all forms
of discrimination, disqualification, coercion, disability or imposition of
liability upon such persons or entities by reason of their refusing to act
contrary to their conscience or conscientious convictions in refusing to
obtain, receive, accept, deliver, pay for, or arrange for the payment of

\textsuperscript{123.} \textit{Id.} at 710 (quoting MONT. CODE ANN. § 50-5-502 (1978)).
\textsuperscript{124.} \textit{Id.} at 711.
\textsuperscript{125.} \textit{STATE POLICIES, supra} note 93.
\textsuperscript{126.} \textit{See} Valley Hosp. Ass'n v. Mat-Su Coalition for Choice, 948 P.2d 963, 972 (Alaska
1997) (holding that Alaska conscience statute gave hospital only statutory right which could
not balance against woman's personal privacy right to termination under Constitution); Doe
v. Hale Hosp., 500 F.2d 144, 147 (1st Cir. 1974) (holding public hospital could not forbid
elective first trimester terminations as long as it offered similar medical procedure).
Univ. of Med. & Dentistry of N.J., 223 F.3d 220, 229 (3rd Cir. 1976) (finding nurse's claim
of protection under the New Jersey Conscience Statute not before the court for failure to
plead the issue before the district court but intimating that the statute might not apply in light
of Bridgeton).
\textsuperscript{128.} \textit{Bridgeton}, 366 A.2d at 647.
\textsuperscript{129.} \textit{Id.}
\textsuperscript{130.} 740 ILL. COMP. STAT. ANN. 70/1 (West 2002).
health care services and medical care.\textsuperscript{131}

Not only does this statute create immunity for all individuals, it expands coverage to all institutions, including payers of health care services.\textsuperscript{132} The potential for conflict between these protections and individual patient needs and rights is mind-boggling.

\textbf{B. What Health Services Are Protected?}

Beyond abortion, seventeen states include sterilization procedures, although two states shelter only the individual provider refusing to participate in these procedures.\textsuperscript{133} There has been increasing pressure in the last few years to expand the scope of health services subject to this type of protection due to the rapid development of new technologies such as fertility treatments\textsuperscript{134} combined with the increasing influence of the "Christian Right" in American society.

Much of the new momentum comes from the advent of technologies and medical practices that some Americans find objectionable. Examples include in vitro fertilization and other assisted reproductive technologies; medical research involving human embryos or fetuses, or embryonic stem cells; and end-of-life practices such as assisted suicide or even adherence to living wills.\textsuperscript{135}

The press toward expansion of the protection of refusal clauses raises the question: when does the right to objection based on moral or religious ground impermissibly impinge on the individual right to lawful health care?\textsuperscript{136}

As the scope of conscience or refusal legislation increases, this question may have been answered. Thirteen states now permit the individual, an institution, or both to refuse to provide contraceptive services.\textsuperscript{137} Four states expressly allow pharmacists to refuse to fill prescriptions for the Pill.\textsuperscript{138} Florida's "Comprehensive Family Planning Act"\textsuperscript{139} reads, "this

\textsuperscript{131} Id. at § 70/2.

\textsuperscript{132} Id.

\textsuperscript{133} STATE POLICIES, supra note 93.

\textsuperscript{134} Adam Sonfield, New Refusal Clauses Shatter Balance Between Provider 'Conscience,' Patient Needs, 7 THE GUTTMACHER REPORT 1, (2004).

\textsuperscript{135} Id.

\textsuperscript{136} This question will be discussed in more depth in Part IV.


\textsuperscript{138} STATE POLICIES, supra note 93. Those states are Arkansas, Georgia, Mississippi, and South Dakota. The exemptions in Georgia and South Dakota apply only to pharmacists. Id.
section shall not be interpreted so as to prevent a physician or other person from refusing to furnish any contraceptive or family planning service, supplies, or information for medical or religious reasons; and the physician or other person shall not be held liable for such refusal.\textsuperscript{140} Thus, the statute could be interpreted as shielding anyone connected with the delivery of care or information from liability from the consequences of their refusal to provide the care or information.

Mississippi’s statute is even more far reaching. This law expands protection to payers of health care, allows refusal of any service objected to for religious, moral, or ethical reasons, gives immunity from liability, and includes research in the definition of services.\textsuperscript{141} This is similar to Illinois’ comprehensive policy of immunity for the conscientious objector within the health care field.

\textbf{C. How Are Refusals Protected?}

Depending on the requirements of the individual statute, the person or entity refusing to provide health care may be required to submit the refusal in writing to activate the protection afforded under the law.\textsuperscript{142} The state may require that objections be based on religious, moral, or ethical beliefs.\textsuperscript{143} On the other hand, Mississippi and Illinois include few limitations.\textsuperscript{144} Some of the conscience laws protect the conscientious objector from civil liability arising from the exercise of the right of refusal statute.\textsuperscript{145} When a state fails to recognize a cause of action for the tort of wrongful discharge, the court may decline to recognize a private cause of action within a conscience law.\textsuperscript{146} Health law attorneys must be familiar with the forum state conscience laws when representing employees or institutions involved in this type of litigation.

\textbf{IV. CONSCIENCE LEGISLATION IN ACTION: WHEN PERSONAL FREEDOMS CONFLICT}

Proponents of expanded conscience clause laws believe that current legislation inadequately shields the health care worker who objects to

\begin{itemize}
\item 139. \textit{FLA. STAT. ANN.} § 381.0051 (West 2002).
\item 140. \textit{Id.} § 381.0051(6) (West 2002).
\item 141. Sonfield, \textit{supra} note 134, at 2; \textit{MISS. CODE ANN.} § 41-107 (2005).
\item 142. \textit{See, e.g., ARIZ. REV. STAT. ANN.} § 36-2151 (West 2003).
\item 143. \textit{See, e.g., TENN. CODE ANN.} § 68-34-104 (2001).
\item 144. \textit{Supra} Part III.B.
\item 145. \textit{See, e.g., ARK. CODE ANN.} § 20-16-304 (West 2000) (refusal of family planning services will not result in liability for institution, employee, agent or physician).
\end{itemize}
providing services that conflict with a religious belief.\textsuperscript{147} However, traditionally, the medical profession is primarily dedicated to the needs of the patient. Of the nine principles of medical ethics published by the American Medical Association (AMA), eight focus on responsibilities to the individual patient and the community, while only one speaks to the physician's freedom of choice in providing care.\textsuperscript{148} In reality, there is a growing tension between the right of the provider to a faith-based practice of health care and the rights of the individual patient to receive all that technology might offer. However, complex new technologies are not at the current center of this dilemma, but rather the fifty-year-old bulwark of women's health care, the oral contraceptive.

Many theoretical frameworks address ethical problems in clinical medicine such as "virtue-based ethics, care ethics, feminist ethics, communitarian ethics, and case-based reasoning."\textsuperscript{149} Because this discussion involves women's health, it is appropriate to use the framework adopted by the American College of Obstetricians and Gynecologists. This framework focuses on principle-based ethics,\textsuperscript{150} which utilizes four principles to objectively analyze a given clinical situation: respect for patient autonomy, beneficence, nonmaleficence, and justice.\textsuperscript{151} While no single theoretical approach can resolve every issue raised in health care today, "[a] principle-based approach is a reasonable basis for ethical decision making provided it incorporates the valuable contributions and insights of alternative approaches to ethical problems."\textsuperscript{152}

The first principle, respect for patient autonomy, is particularly important within modern society. Americans have a strong belief in the right of self-determination. This notion forms the basis for much of our social policy. A patient's right to make decisions regarding health care underlies concepts such as informed consent.\textsuperscript{153} The second principle, beneficence, requires a health care provider to work for the good of the patient. While beneficence demonstrates the affirmative direction, the third principle, nonmaleficence, reflects the passive maxim, "first, do no harm."\textsuperscript{154} The fourth principle, justice, reflects the ethical obligations to give care as is due the patient and


\textsuperscript{149} AM. COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, ETHICS IN OBSTETRICS AND GYNECOLOGY 3, (2004) [hereinafter ETHICS IN OB/GYN].

\textsuperscript{150} Id.

\textsuperscript{151} Id.

\textsuperscript{152} Id. at 4.

\textsuperscript{153} Id.

\textsuperscript{154} Id. at 4.
to treat patients equally.155

A. Rights of the Health Care Provider

When analyzing an ethical problem or health care issue, the principles are applied individually and analyzed as a whole in relation to the risk/benefit ratio of a proposed action. When considering the personal autonomy of the individual refusing to provide the Pill, the right to self-determine religious and moral beliefs is universally respected in American society. The health care professional refusing to provide oral contraceptives runs into difficulty when applying the principle of patient autonomy. When a woman requests oral contraceptives, an outright refusal to render this service runs directly counter to the patient’s right of autonomy. At best, the health care provider may share the privately held belief that oral contraceptives may occasionally result in failure of a fertilized ovum to implant with the patient, so that the woman may make an informed decision. However, in the interest of fairness, the patient deserves the knowledge that the majority of experts in women’s health care do not believe oral contraceptives are abortifacients and that pregnancy does not begin until the ovum has implanted. Once the person providing health services imparts this information, if the patient still chooses the Pill, then there is an obligation to at least refer her to someone who will implement that choice.156

For the person who believes that oral contraceptives are abortifacients, beneficence may prohibit prescribing or dispensing the Pill for fear of harm to the fertilized ovum. However, this prohibition must be weighed against the patient’s need for the Pill. Oral contraception is prescribed for a wide variety of female health problems unrelated to contraception. For example, the Pill may be indicated for treatment of irregular menses, endometriosis, fibroids, ovarian cysts, or even acne.157 Furthermore, use of the hormonal agents found in the Pill has been associated with a considerable reduction in the risk for ovarian cancer.158 The Pill is also effective in preventing unwanted pregnancies, which in turn reduces the need for abortion, as well as the number high-risk pregnancies that may endanger the mothers’ health.159 In short, the advantages of the Pill are substantial. Similar to the

155. ETHICS IN OB/GYN, supra note 149, at 4-5.
157. Bollinger, supra note 1, at 1.
158. A discussion of the health, economic, and social advantages of an effective family planning method is beyond the scope of this paper.
159. Adding It Up: The Medical Benefits of Investing in Sexual and Reproductive Health
concept of beneficence, nonmaleficence would obligate a health care professional to avoid providing oral contraceptives for fear of harming the preembryo. The countervailing potential harms to the patient from failure to receive appropriate care must be measured against this risk.

Justice requires due respect for the sincerely held moral and religious convictions of the practitioner, as well as for the needs of the patient. Coupled with the right of religious expression, the principles of beneficence, nonmaleficence, and justice create a compelling interest in the rights of conscience of the health care provider. But is this interest more compelling than the individual rights of the patient?

B. Rights of the Patient

The principle of patient autonomy is pervasive within medicine. Patients have the right to make decisions free from intrusive influences. While one can certainly argue that the patient should receive knowledge covering both sides of the "oral contraception as an abortifacient" debate, the reality is that the Pill is a foundation of women's health care today. Many women, given both sides of this issue, will still choose the safety, efficacy, and convenience of oral contraceptives. Almost all women in the United States have used a family planning method at some point; about 30% have taken oral contraceptives. Refusing to provide women with oral contraceptives may be analogous with refusing to provide acetaminophen to children. Both drugs are used consistently and commonly in modern society, although for different reasons.

Beneficence requires the health care provider to affirmatively promote the patient's well-being. Considering the tremendous utility of Pill use, as well as the economic and social benefits of effective contraception, beneficence undoubtedly creates a compelling interest in the patient's right to access oral contraception. Nonmaleficence also supports the interest in the patient's right to oral contraception. Refusing a medication that is helpful to many may cause significant harm when denied to the patient who requires its use to maintain health, avoid complications, or prevent an


161. Id. at 1042.

unwanted pregnancy. There is a special irony that in refusing to provide the Pill in order to protect the life of a theoretical fertilized ovum, the conscientious objector might create a situation where the woman becomes pregnant because she cannot get her pills and then is forced to choose an abortion for an unwanted pregnancy.

Application of the principle of justice commands a balance between the patient’s compelling right to self-determined access to a beneficial medication versus the health care worker’s interest in avoiding the unproven, theoretical violation of a strong moral imperative not to participate in an abortion. No one discipline can offer a definitive answer to this test. Nonetheless, when interests are equally compelling, justice must weigh on the side of the patient’s right simply because of the unequal positions of the two sides. The patient depends on health care providers to act in her best interest. The professional is in the position to control his or her exposure to morally troubling situations by virtue of the choice of employment situations. It is disingenuous to espouse moral and religious objections to modern family planning methods and then to take a job in a gynecologist’s office. Because the practitioner has more control over the issues presented to her, her interests are less compelling than those of the patient who depends on that care. At the very least, women are due advance notice of providers who will refuse such a commonly used medication so they may avoid the inconvenience or injury that delayed access may cause. If advance notice is not possible, then the patient has a right of referral to another provider who does not share those religious or moral objections.

V. CONCLUSION: WHERE DO WE GO FROM HERE?

Should the health care provider’s right of conscience be protected when the health service provided is the oral contraceptive? Perhaps yes, but with limitations and safeguards. Our society does not relish forcing individuals to participate in actions objectionable to them. However, modern society requires compromise and balance. While many sincerely believe that the Pill is an abortifacient, this belief is unproven by science and unrecognized by the law. The Seventh Circuit said it best in Charles v. Carey:163 “the use of the term ‘abortifacient’ in describing certain birth control methods forces the physician to act as the mouthpiece for the State’s theory of life.”164 At best, this concept is a remote theoretical possibility. At worst, it

163. 627 F.2d 772 (7th Cir. 1980).
164. Id. at 789. See also City of Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 444 (holding that the state may not establish the theory that life begins at fertilization); Margaret S. v. Edwards, 488 F. Supp. 181, 191 (E.D. La. 1980) (clarifying that definition of
is a gross misapplication of scientific principle. However, the First Amendment does not require evidence of the veracity of a religious ideal. "[Men] may not be put to proof of their religious doctrines or beliefs."\(^{165}\) Although the principles of ethical decision making weigh on the side of promoting the patient’s right to access beneficial health care, this must be balanced with respect for the sincerely held beliefs of the objecting professional.

Most health care providers make a concerted effort to cooperate with their employers and patients in an effort to ensure the consequences of the conscientious objection are kept to a minimum. Unfortunately, there is the tremendous potential that refusal of care due to faith-based practice will result in the purposeful obstruction of legal, beneficial health care. The problem arises with the zealot whose ideology shows little respect for the patient’s rights. In one case, employees objected to participation in a procedure to remove a dead fetus because they opposed abortion.\(^{166}\) If the quandary is a reluctance to participate in the process because it terminates a human life, it borders on the ridiculous to refuse to help in a procedure that will relieve a woman from walking around with a dead fetus inside her, a condition that endangers the woman’s life. This is an example of obstruction for the sake of obstruction. Karen Bauer, President of Pharmacists for Life, disagrees with the position of her professional organization, the American Pharmacists Association, which maintains that patients have a right to a referral to obtain their medications.\(^{167}\) Bauer was quoted as saying, "[f]orced referral is stupid... [i]f we’re not going to kill a human being, we’re not going to help the customer go do it somewhere else."\(^{168}\) This reflects a sense of entitlement to impose personal beliefs on others.

However, recent developments underscore a commitment to ensuring women’s access to oral contraceptives. In April of 2005, Illinois Governor Rod Blagojevich issued an emergency rule requiring pharmacies to provide contraceptives without delay upon receipt of a valid prescription.\(^{169}\) This

\(168\). Id. See also Shelton v. Univ. of Med. & Dentistry of N.J., 223 F.3d 220, 223 (3rd Cir. 1976) (Nurse refused to care for patient whose water was broken or to help with a cesarean section of a patient bleeding out because these procedures would end a pregnancy. Her refusal would not have saved either baby but did endanger the mothers’ lives).
may be the type of action needed to prevent conscientious objection from hindering the right to care. The burden will rest on employers to accommodate both the employee and the public. This may be achieved through altered staffing patterns, notice, referral or any combination of these.

Current conscience statutes must be tested in courts across the nation in order to evaluate the scope of protections available to health care providers when patients injured by such decisions seek to test the constitutionality of valuing religious convictions over women's health. Under *Eisenstadt v. Baird*, decisions regarding family planning are a fundamental liberty right.170 As courts have declined to apply conscience statutes to public hospitals that refuse to allow abortions (citing a woman's constitutional right to terminate a pregnancy)171, judges in the future may estop state actors from refusing to provide oral contraception for the same reason. The Supreme Court of California recently held that the federal free exercise law did not excuse Catholic employers from compliance with a state statute requiring employee health plans to cover oral contraceptives if they covered other prescription medications.172

The ideal conscience statutes will balance the interests on both sides. Conscientious objectors should be free to practice in accordance with their beliefs, but should have to give employers and patients reasonably advanced notice that they may not be reliable in certain situations.173 The individual objector should avoid knowingly entering into employment situations guaranteed to create conflict. While health care providers have a duty to ensure informed decision making, women seeking unbiased clinical care should not be subjected to lectures on personally held views of morality. Places of worship are a more appropriate arena for proselytizing. Institutional and individual objectors should develop appropriate accommodations through referral and notice to avoid inconvenience, delay, and possible injury to the patients who depend on them.

The world will only become more complex. Health care providers must follow "the standard of 'due care' for nonmaleficence, which requires that a goal must justify the risks that will be imposed to achieve it."174 Objection for the purpose of obstruction is unacceptable in a health care system dedicated to meeting patient needs and honoring the right of personal autonomy. The health professional should not be required to actively

171. See, e.g., Bridgeton Hosp., 366 A.2d at 647.
173. Harvey at al., *supra* note 156.
participate in actions that violate personal morals. However, this is not a license to impose personal beliefs on others seeking health care. Conscientious objection should be just that: conscious of its moral basis, conscious of the problems created, and dedicated to minimizing the effect on others.