

CONSCIENCE AND COMPETING LIBERTY CLAIMS

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Abstract

Some treatment requests from gay patients seriously conflict with the religious or moral beliefs of their respective medical providers. Not all legal solutions to these disputes serve the common good. Therefore, this article proposes that state healthcare conscience protection statutes provide the most effective way to resolve these liberty conflicts and to serve the medical needs of all patients. Part one of this manuscript showcases four clinical scenarios that illustrate how a clash of liberty claims between homosexual patients and their respective clinicians could play out within today's healthcare setting. Part two describes the centrifugal legal forces that are shaping judicial opinion to favor sexual liberty interests over religious conscience concerns. Part three argues for a tri-phasic political solution. We encourage healthcare providers: (1) to present their state legislators with a conscience primer—reasons why, as legislative guardians of the common good, they need to care about conscience protection for healthcare professionals; (2) to prevail upon their legislators to sponsor and enact robust state healthcare conscience protections; and (3) to dialogue with the gay community and their advocates, making the case that, first, diversity of the marketplace is the most effective way to match the diverse needs of all patients and, second, a dialogical, rather than a coercive, method of accessing care is the best way to serve the good of all.

Introduction

This discussion investigates emerging conflicts in what could become a second cycle of healthcare conscientious objection. The first round, following *Roe v. Wade*, continues to involve religious healthcare providers in conscientious objection to abortion, contraception, and sterilization, and is directed toward the protection of the basic human goods of life and procreation. The second round follows both the legalization of sodomistic sex¹ and same-sex civil unions² and the introduction of sexual orientation nondiscrimination statutes that apply to public accommodations³. This new legal landscape will impel these same healthcare professionals to defend the basic goods of marriage and family as they conscientiously decline services that directly facilitate patients' same-sex relations or homosexual parenting.

Part One: Clinical Cases

In states with sexual orientation public accommodation laws, homosexual patients are given unfettered access to all public services, including healthcare. Against this legislative backdrop, the following clinical scenarios realistically illustrate how conflict between the sexual liberty claims of homosexual patients and the religious liberty concerns of their respective medical professionals could arise.

Case #1⁴:

A woman in a homosexual relationship seeks treatment from a gynecologist for endometriosis and polycystic ovaries. Once these pathologies are successfully resolved, the patient returns to the gynecologist and requests Clomid to stimulate her ovaries. The clinician insists that, although she has no moral reservations about improving the woman's health and wellbeing by treating her gyn-abnormalities, she does have a moral objection to providing Clomid. The physician explains that, since the only goal of giving Clomid would be to help the patient conceive a child, doing so would make her morally complicit in facilitating a pregnancy outside a heterosexual marriage and in depriving the child of the complimentary parenting of a mother and a father. Since providing the drug contradicts her religious convictions about the meaning of marriage and family, the physician advises the patient to seek the help of another gynecologist.

Case #2⁵:

A male patient seeks help from his internist for problems related to erectile dysfunction. Since the patient is no longer able to have satisfying sex with his male partner, he requests that the doctor write a prescription for medication that will address this problem. The physician explains that, although she is willing to treat the underlying health conditions that may be contributing to his erectile dysfunction, she cannot in good conscience write a prescription for a drug that would directly facilitate sex outside a heterosexual marriage. For this reason, she suggests the patient find another physician to help him meet his objective.

Case #3⁶:

A male client seeks psychological counseling for emotional issues pertaining to his sexual relationship with his male partner. The clinical psychologist explains to the client that she has no issue with helping him improve his psychological health, including resolution of emotional conflicts. She considers it a matter of professional and moral responsibility to provide sound counseling services irrespective of the client's sexual orientation. Nonetheless, the psychologist carefully delineates that to which she *would* object: providing counseling services with the direct goal of affirming the man's sexual relationship with his male partner. Since such affirmation fails to comport with her deeply held beliefs and moral values, the clinician informs the client she cannot effectively counsel him. When the client takes exception to her reservation, the counselor advises the man to seek the services of another clinical psychologist who may be better equipped to help him with these problems.

Case #4⁷:

A gravely ill patient arrives in the ICU suffering from liver failure. Knowing that death is near, he asks the attending physician to facilitate his marriage to his life-long same sex partner. The patient requests that the physician apply for a civil union license at the county clerk's office and then proxy-sign the license on the dying patient's behalf. The physician explains that, although she is willing to provide quality care in the ICU, she cannot conscientiously comply with the patient's extra-medical request, as her proxy signature would directly facilitate a same-sex union. The attending physician asks to be relieved of the case.

Although the four clinical scenarios involve different facts, they share some common characteristics. The patient in each scenario requests non-emergent assistance to achieve a result that is permitted by law. The professional is arguably competent to provide the services and presumably offers them willingly to other patients. However, she chooses not to offer treatment to the homosexual patient in order to avoid direct cooperation in actions that violate her conscientious beliefs regarding marriage and family. The professional accurately presents the medical options available to the patient, honestly and clearly discussing the basis for her refusal to provide the service.⁸

It is assumed that each clinician's counseling approach and decision not to provide treatment is consistent with the ethical obligations imposed by the applicable state licensing board, as well as any other board or organization to which the medical professional may belong.⁹ But, will such refusal subject her to civil claims because she is allegedly discriminating against the patient based on his/her sexual orientation?

The answer to the civil liability question depends on where the treatment refusal takes place. If these cases were to occur in California, a decision of the California Supreme Court¹⁰ allows us to reasonably predict that a patient-initiated lawsuit would likely favor the homosexual plaintiff against the conscientiously objecting healthcare professional. Although claims from homosexual patients in other jurisdictions with sexual orientation public accommodation laws (including Connecticut, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington, Wisconsin, and Washington, D.C.)¹¹ have not yet been similarly adjudicated, conscientious healthcare professionals have reason to be concerned.

Part Two: Why Healthcare Rights of Conscience (HCROC) Are an Endangered Species.

The Constitution Cannot Fully Protect HCROC.

Our nation has a long history of crafting legislative solutions for conflicts between laws of general application and the conscientious religious beliefs of minorities who are affected by them.¹² While utilitarian considerations played a role, our Constitutional tradition of religious liberty—and its foundational doctrine that there is a higher authority than that of the State—most fully explain our history of legislative protections for conscience.¹³

Nevertheless, a healthcare provider has limited constitutional protections. It is true that the First Amendment expressly constrains the government from enacting laws that infringe upon the free exercise of religion.¹⁴ However, as the Supreme Court's decision in *Smith* indicates, state laws that impinge upon religious liberty may nevertheless be valid.

In *Employment Division v. Smith*,¹⁵ the Supreme Court considered a conflict between state law and the religious freedom of Native Americans. The claimants ingested peyote for sacramental purposes at a religious ceremony of their Native American Church. Their employer dismissed them for illicit drug use. After being denied the unemployment compensation for which they applied, the claimants sued the state. In their decision, the Court noted that “the ‘exercise of religion’ often involves not

only belief and profession but the performance of (or abstention from) physical acts.”¹⁶ If a state law bans acts or abstentions only for the religious belief they display—such as casting an idol or refusing to bow in worship—then such a law would violate the First Amendment.¹⁷ Yet, First Amendment protections are less robust when the law prohibits conduct that the state is otherwise free to regulate—such as the use of an illegal drug. As the Court argued, “We have never held that an individual’s religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the state is free to regulate.”¹⁸

The Court opined that “the right of free exercise does not relieve an individual of the obligation to comply with a ‘valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes).’”¹⁹ Although the counsel for the plaintiffs argued that this law should be evaluated under a balancing test set forth in *Sherbert v. Verner*,²⁰ the Court rejected this more rigorous standard.²¹

The government’s ability to enforce generally applicable prohibitions of socially harmful conduct, like its ability to carry out other aspects of public policy, “cannot depend on measuring the effects of a governmental action on a religious objector’s spiritual development.” To make an individual’s obligation to obey such a law contingent upon the law’s coincidence with his religious beliefs, except where the State’s interest is “compelling”—permitting him, by virtue of his beliefs, “to become a law unto himself,” —contradicts both constitutional tradition and common sense.²²

Referencing the fact that some states had already enacted religious conscience protections, the Court advised that state legislatures were the appropriate source for these protections.²³ Nevertheless, the Court was quick to point out that once you assign conscience protections to the care of legislators, you risk the possibility that the religious beliefs of minorities will be trumped by the resolve of the majority. This, the court declared, is the price we pay for democracy:

It may fairly be said that leaving accommodation to the political process will place at a relative disadvantage those religious practices that are not widely engaged in; but that unavoidable consequence of democratic government must be preferred to a system in which each conscience is a law unto itself or in which judges weigh the social importance of all laws against the centrality of all religious beliefs.²⁴

The decision in *Smith*, then, does not necessarily support the religious liberty of conscientiously objecting healthcare professionals against claims based on state sexual orientation public accommodations law. Without an exemption for moral or religious conscience, the legislative preference for sexual liberty interests of homosexual patients would likely trump the providers’ religious claims of conscience.²⁵

Congress Cannot Fully Protect HCROC.

In 1993, Congress reacted to the implications of *Smith* by enacting, in bipartisan fashion, the Religious Freedom Restoration Act (RFRA).²⁶ The Act begins with the following Congressional findings:

- (1) the framers of the Constitution, recognizing free exercise of religion as an unalienable right, secured its protection in the First Amendment to the Constitution;
- (2) laws “neutral” toward religion may burden religious exercise as surely as laws intended to interfere with religious exercise;
- (3) governments should not substantially burden religious exercise without compelling justification;
- (4) in *Employment Division v. Smith*, 494 U.S. 872 (1990) the Supreme Court virtually eliminated the requirement that the government justify burdens on religious exercise imposed by laws neutral toward religion; and
- (5) the compelling interest test as set forth in prior Federal court rulings is a workable test for striking sensible balances between religious liberty and competing prior governmental interests.²⁷

Accordingly, the Act provides, in part, that:

Government may substantially burden a person’s exercise of religion only if it demonstrates that application of the burden to the person—

- (1) is in furtherance of a compelling governmental interest; and
- (2) is the least restrictive means of furthering that compelling governmental interest.²⁸

This restriction on government authority applies “even if the burden results from a rule of general applicability.”²⁹

However, in *City of Boerne v. Flores*,³⁰ the Supreme Court declared that RFRA was an unconstitutional exercise of Congressional power.³¹ RFRA remains applicable to the Federal Government, but it does not apply to the states.³² Therefore, to expand protections for free exercise of religion, some states enacted their own version of RFRA.³³ Most, however, did not. This means that the courts of forty states will be applying the jurisprudence of *Smith* to determine constitutional protections for citizens (like the healthcare providers featured in our cases) who are affected by statutes that otherwise qualify as “neutral laws of general application.”

Congress might enact additional legislation to address conscience protections for healthcare services that are funded by payments from the Federal government.³⁴ For example, Congress is currently considering conscience protections for healthcare workers, employers, and insurers in connection with proposed amendments to the Patient Protection and Affordable Care Act.³⁵ While such provisions may be helpful, they provide limited protections grounded only in federal law. Moreover, these safeguards do not necessarily preempt state public accommodation claims, such as those raised by the homosexual patients in the cases under consideration.

Sexual Liberty Protections Threaten HCROC.

As the demographics of religious belief have changed, the idea of protections for conscience has expanded to defend other deeply held personal beliefs and decisions that are not strictly religious in character. The Due Process Clause of the Fourteenth Amendment has become a significant constitutional vehicle for defining a “substantive

sphere of liberty”³⁶ that extends to a broad range of other decisions including prevention of pregnancy, sexual relationships, and abortion.³⁷ As the Supreme Court has observed:

These matters, involving the most intimate and personal choices a person may make in a lifetime, *choices central to personal dignity and autonomy*, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. *Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.*³⁸

Although the judicial approach in *Smith* allowed state laws to prevail over competing religious liberty interests, the emerging judicial approach for sexual liberty claims would strike down conflicting state laws with increasing frequency. The liberal ideal of personal autonomy and radical individualism animates these outcomes. Consistent with the tenets of secular humanism, the Supreme Court expanded sexual liberty or “privacy” interests by striking down state laws that restricted access to contraception³⁹ and abortion.⁴⁰ The Court also removed legal proscriptions against private homosexual conduct between consenting adults,⁴¹ thereby expanding the range of choices for citizens in matters of sexual expression. Despite Justice Scalia’s admonition in *Smith* that legislatures, not courts, should weigh the social value of laws against the value of other beliefs and religious practices,⁴² the Supreme Court chose to become actively engaged in this balancing enterprise anyway.⁴³

It should be noted that the Court is not alone in expanding sexual liberty. State legislatures have also been instrumental in removing barriers to sexual freedom. For example, before the Court effectively struck down the remaining state sodomy statutes in *Lawrence v. Texas*, a substantial majority of states had already removed criminal sanctions for such conduct.⁴⁴ State courts and legislatures have also enacted statutes that legalize various forms of relationships between same-sex couples, extending the “approval” of the state toward such liaisons.⁴⁵

State Sexual Orientation Public Accommodation Laws Threaten HCROC.

A recent California case ruled in favor of a lesbian patient who claimed sexual orientation discrimination because two physicians refused to provide intrauterine insemination to facilitate her pregnancy. In *North Coast Women’s Care Medical Group, Inc. v. San Diego County Superior Court*,⁴⁶ the Supreme Court of California ruled that, under the Unruh Civil Rights Act, religious liberty did not protect the conscientiously objecting physicians from patient claims.⁴⁷

All persons within the jurisdiction of this state are free and equal, and no matter what their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, or sexual orientation are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever.⁴⁸

On the basis of *Smith*, the California Supreme Court rejected the physicians’ Free Exercise claims.

The opinion in *North Coast*, then, suggests that health care professionals in California are not free to follow their consciences when refusing treatment in cases similar to those under discussion. California has enacted conscience protections in matters involving abortion,⁴⁹ but it has not protected other conscientious treatment refusals in the context of patient claims based on sexual orientation public accommodation laws.

We advise vigilance on the part of healthcare providers since, one by one, states and local governments have been enacting sexual orientation protections. As of January 2012, twenty-one states and the District of Columbia have enacted statutes of some kind addressing discrimination based on sexual orientation.⁵⁰ While not all of these laws necessarily provide a basis for patient claims against clinicians,⁵¹ a trend toward expanding sexual orientation protections to the sphere of public accommodations will likely lead to increased threats against health care rights of conscience.

Part III: The Political Solution

State Conscience Protection Laws Can Safeguard the Religious Liberty Interests of Healthcare Professionals.

Phase One: *Educate your state lawmakers.* Let them know your concerns about escalating threats to the conscientious practice of medicine. Present your state legislators with a “conscience primer:” a clear delineation of the serious harms to the provider, the profession, and the polity when the state fails to protect the legitimate exercise of conscience rights within healthcare.

A Conscience Primer:

Coercing the conscience of healthcare providers produces:

Personal harms:

- To coerce healthcare providers’ conscience is to threaten them with the Scylla of professional undoing, should they stand their ground, or the Charybdis of moral corruption, should they capitulate.⁵²
- To require healthcare workers to act in a way contrary to their conscience is to strike at the heart of who they are, violating their very person—someone who, by nature, tends to the true and the good and is only fulfilled by doing good and avoiding evil.⁵³ Doing so deforms their inner moral self (character) with the vicious effects of bad choices, interrupting all the stages of their ability to act humanly (including the capacity to understand the moral principles of human nature, to reason from these principles, to judge according to them, and to choose and carry out these conscientious judgments in concrete acts). In compromising the freedom for excellence that follows from their natural openness to truth, goodness, and happiness, you deny them the right to freely exercise their prudent conscience, an inalienable requirement of human dignity.
- In summation, to coerce religious healthcare providers into acting against their conscience or to prevent them from following their religious convictions so radically defaces their dignity,⁵⁴ freedom, and moral

integrity as to imperil their quest for integral human happiness and a life of grace—and even endanger the realization of their final beatitude, the eternal vision of God.

Professional harms:

- To succumb to cooperation in the provision of a treatment they have judged to be immoral means healthcare providers both confirm the patient in his wrongdoing and violate the premier norm of medicine: do no harm.
- Coercion of conscience discourages the affected professionals and their like-minded conscientious objectors from remaining in the medical profession, and new healthcare recruits from entering the field. Elimination of conscientious objectors, “morally serious persons”⁵⁵ who are “unwilling to just follow orders,”⁵⁶ not only stunts moral diversity within the healthcare field, but also smothers rich moral debate—an oft-cited means toward maintaining the purity of personal and professional integrity in the healing profession.
- Attempts to contravene conscience suppress personal autonomy, forcing the providers to bracket their religious convictions and park their moral beliefs outside their clinic.⁵⁷ Suppression of moral autonomy, in turn, causes ethical distress and anxiety in the practitioners as they wrestle with their situation: ‘Is protecting my professional standing worth forfeiting my moral integrity?’ ‘Is keeping my job worth sacrificing conscientious care as the hallmark of my personal and professional identity?’ Obviously, anxious clinicians are also distracted ones, spending more time worrying about their own affairs and less time focused on the needs of their patients.⁵⁸
- To practice within an anti-conscience milieu slowly but inexorably breeds callousness within the providers, replacing their wholesome empathy toward patients’ vulnerabilities with an insalubrious attitude that “patients do not deserve caring responses from their physicians.”⁵⁹
- To ask healthcare providers to contravene their conscientious judgments has a boomerang effect: it provokes clinicians to take a similarly restrictive attitude toward the moral view of their patients, extinguishing, thereby, a key element of provider-patient respect and trust.
- To prohibit healthcare rights of conscience, to constrict healthcare providers’ fidelity to core personal beliefs, is to encourage moral laxity toward other general professional responsibilities.

Political harms:

- Denying healthcare rights of conscience violates what national and international human rights proclamations recognize as the basic civil right of every human being.⁶⁰ “the right to freedom of thought, conscience and religion,” including the freedom to “manifest his religion or belief in teaching, practice, worship and observance.”⁶¹

- Coercion of conscience generates intolerance toward objectors and their system of objective morality.⁶² Such intolerance vitiates civic peace and harmony⁶³ and can even lead to a tyranny of relativism, where every citizen's pursuit of the true and the good is held hostage by relativist and individualist tendencies to a "sly selectiveness" that indirectly suppresses any ideas outside the mainstream of "popular opinion" or elitist political ideology.⁶⁴
- To the extent that laws of the state fail to give primacy of place to free exercise of the conscientious judgments of its citizens, to such an extent has the state overreached its authority, arrogating to itself the right to decide what is good and evil, and failing to secure the fundamental rights of individuals against unjust encroachment by government and the majoritarian view.
- Promoting an anemic sense of conscience and conscientious objection in healthcare (and in other professions) could help to derail even the most liberally enlightened state and push it towards a destructive authoritarianism.⁶⁵
- To coerce healthcare providers' conscience robs the polity, on the one side, of a clear voice for the meaning of sexuality,⁶⁶ marriage,⁶⁷ and family⁶⁸ and imposes on all Americans, on the other, an LGBT "ethic" and legal system.
- Anesthetizing the conscience of healthcare providers means that they and all those in the culture who agree with their moral assessment of homosexual sex and same-sex marriage experience anguish over two things: the fact that the immoral behavior is going on in society, weakening its moral fiber, and the fact that the state appears to have a greater interest in facilitating the amoral behavior than in inhibiting it.⁶⁹

Phase Two: *Convince sympathetic state lawmakers to sponsor appropriate legislation to protect health care rights of conscience.* One option would be to carve out religious freedom and conscientious objection exemptions within: (a) same-sex civil union or same-sex marriage statutes and/or (b) new state civil rights statutes protecting gender, sexual orientation, or marital status *while* the respective laws are being debated. The ideal is to create conscience protection statutes that broaden the right to religious objection beyond abortion and sterilization issues to any sort of medical service that abrogates moral convictions.

A second option would be to draft a stand-alone conscience protection statute. Illinois' Healthcare Right of Conscience Act includes safeguards for a wide range of persons involved in the healthcare delivery system as well as robust protections against liability:

No physician or health care personnel shall be civilly or criminally liable to any person, estate, public or private entity or public official by reason of his or her refusal to perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care service which is contrary to the conscience of such physician or health care personnel.⁷⁰

The Act also prevents individuals, public or private institutions, or public officials from discriminating against persons who exercise conscience rights.⁷¹

Broad conscience protections like these send a strong message of support not only to religious individuals but also to institutional providers of healthcare.⁷² These comprehensive safeguards make good legal sense. Healthcare institutions—no less than individual providers—need conscience safeguards that guarantee a participation in healthcare delivery that reflects their moral/religious values. Furthermore, since small or moderately sized healthcare organizations tend more readily to mirror the religious convictions of their proprietors, carving out exemptions for them provides a stage upon which owners and employees alike can integrate their religious beliefs into everyday professional practice.

Phase Three: *Dialogue with members of the gay community, aiming for a win-win resolution to liberty conflicts between homosexual patients and religious providers.* Emphasize that a liberal, tolerant society should not embrace coercion when other means are available.⁷³ Coercing conscience does not merely harm the healthcare provider. It also harms the patient, encouraging rancor and distrust between two private citizens (the provider and the patient). Dialogue, rather than coercion, is the only path capable of generating progress without inflicting serious harms.⁷⁴

If patient-provider liberty conflicts were to occur in states with robust sexual liberty protections, it is safe to predict the following. The legal risks of noncompliance with sexual orientation public accommodation laws would effectively drive conscientious professionals from the marketplace. And, since gay patients would be spared the embarrassment of treatment refusal and the inconvenience of having to seek out another provider, gay rights activists would probably welcome the departure of conscientious clinicians.⁷⁵ Furthermore, the LGBT community would view a reduction in religious healthcare providers as only a short-term inconvenience: compliant providers would simply take the place of those who conscientiously refused to perform treatment.⁷⁶ However, such prognostications would ignore other marketplace dynamics that adversely affect all patients.

Homogenization of medical professionals would disenfranchise religious patients who only want to receive medical care from providers who share their moral convictions about life, family and sexuality. Unlike their homosexual counterparts, these religious patients would have few, if any, clinician alternatives. If a state enacts robust healthcare conscience protections, it will guarantee that the diversity of clinicians matches the diversity of the patient population, providing everyone with the care they want from a provider they appreciate.

Private ordering could also reduce any residual “friction” between homosexual patients and religious healthcare providers. For example, the Internet enables patients to research not only their treatment options, but also their provider alternatives and, most importantly, the particular philosophy of medicine that grounds these prospective clinicians. The sharing of information among patients, coupled with the emergence of networks of like-minded physicians, will facilitate citizens’ access to healthcare services that meet their moral/medical needs. In sum, markets can fulfill desires of the entire community without incurring the harms brought on by coercive laws.

Conclusion

Protections for healthcare rights of conscience have not kept pace with expanding sexual liberty interests. Unfortunately, some laws skew the competition between religious and sexual liberty as a zero-sum game. Indeed, when states adopt coercive antidiscrimination laws that favor the interests of homosexual patients at the expense of conscientious providers, one side definitely wins; the other side definitely loses. In contrast, when states enact robust safeguards for healthcare rights of conscience, both sides win. Protecting diversity in the provider community—rather than forcing conscientious providers out of medicine—will maximize liberty and healthcare options for all.

References

1. *Lawrence v. Texas*, 539 U.S. 558 (2003), overruling *Bowers v. Hardwick*, 479 U.S. 186 (1986).
2. As of March 2012, Connecticut, District of Columbia, Iowa, Maryland, Massachusetts, New Hampshire, New York, Vermont, and Washington have enacted same-sex marriage laws; Delaware, Hawaii, Illinois, Maine, New Jersey, and Rhode Island have legalized same-sex civil unions; California, Nevada, New Jersey, Oregon, and Wisconsin (appeal pending) recognize same-sex domestic partnerships and Colorado has legalized “reciprocal beneficiary” same-sex relationships.
3. California, Connecticut, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington, Wisconsin, and Washington, D.C. prohibit discrimination on the basis of sexual orientation in public accommodations. See, e.g., Cal. Civ. Code § 51b: “all persons within the jurisdiction of this state are free and equal, and no matter what their sex, race, color, religion, ancestry, national origin, disability, medical condition, marital status, or sexual orientation are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever.”
4. This clinical scenario resembles circumstances in *North Coast Women’s Care Medical Group v. San Diego County Superior Court*, 189 P.3d 959 (Cal. 2008).
5. A physician presented this clinical scenario to the Center for NaProEthics with the goal of discerning the moral dimensions of a treatment refusal.
6. This case resembles the facts of a suit brought by a student who was expelled from her graduate counseling program because of her conscientious beliefs. See *Ward v. Polite*, 667 F.3d 727 (6th Cir. 2012).
7. This case mirrors the situation described in the Delaware statute legalizing same-sex civil unions [13 Del. Code § 207(a)]: “In the case of critical illness of one of the parties desiring to enter into a civil union, the physician attending such party may appear for the ill party and make an application for a civil union license for such party, if such physician first makes an affidavit and delivers it to the issuing officer stating that in the opinion of said physician the party for whom said physician is acting is at the point of death and that this person may lawfully enter into a civil union. The application for the civil union license shall be altered in such case to show that said physician acted as proxy and the affidavit of the physician shall be filed with the application.” Although assistance on the part of the attending is discretionary, it is possible that a refusal, allegedly based on sexual orientation, could run awry of a sexual orientation public accommodations statute.
8. Requests for reproductive services from unmarried heterosexual patients may also result in treatment refusals from conscientious providers. It should be noted, however, that in some states marital status is a protected category for antidiscrimination laws. In these states, then, refusing a reproductive treatment to an unmarried patient could present a similar legal liability for the religious medical professional.
9. Ethical licensing and accreditation standards may also present difficulties for these professionals. (See Jill Morrison & Nicole Allekotte, “Duty First: Toward Patient-Centered Care and

Limitations on the Right to Refuse for Moral, Religious, or Ethical Reasons,” *Ave Maria L. Rev* 9(2010):167-70.) Nonetheless, the impact of such standards on healthcare rights of conscience is beyond the scope of this discussion.

10. *North Coast Women's Care Medical Group v. San Diego County Superior Court*, 189 P.3d 959 (Cal. 2008).
11. Cf. note 3 *supra*.
12. Proposed legislation that enacts federal protections for conscience rights in connection with the Patient Protection and Affordable Care Act includes a finding of fact that “[conscience protections] are deeply embedded in the history and traditions of our Nation and codified in numerous State and Federal laws, including laws on health care.” H.R. 1179, § 2 (March 17, 2011); S. 1467, § 2 (August 2, 2011). See also *Gillette v. United States*, 401 U.S. 437, 453 (1971) (“[I]t is hardly impermissible for Congress to attempt to accommodate free exercise values, in line with ‘our happy tradition’ of ‘avoiding unnecessary clashes with the dictates of conscience’”) (Citations omitted).
13. See *id.* at 445 (“It is true that the legislative materials reveal a deep concern for the situation of conscientious objectors to war, who absent special status would be put to a hard choice between contravening imperatives of religion and conscience or suffering penalties. Moreover, there are clear indications that congressional reluctance to impose such a choice stems from a recognition of the value of conscientious action to the democratic community at large, and from respect for the general proposition that fundamental principles of conscience and religious duty may sometimes override the demands of the secular state.”).
14. See U.S. Const. amend. I (“Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.”) Both the Free Exercise Clause and the Free Speech Clause may provide a basis for conscience safeguards. The Due Process Clause of the Fourteenth Amendment (“nor shall any State, deprive any person of life, liberty, or property, without due process of law”) as well as the Equal Protection Clause of the Fourteenth Amendment (“nor [shall any state] deny to any person within its jurisdiction the equal protection of the laws”) likewise provide a basis for conscience protections from the states. See U.S. Constitution amend XIV, § 1. The Supreme Court has interpreted the Fourteenth Amendment to include First Amendment protections against the states. See, e.g., *Cantwell v. Connecticut*, 310 U.S. 296 (1940).
15. 494 U.S. 872 (1990).
16. *Id.* at 877.
17. See *id.*
18. *Id.* at 879. The Court cited *Reynolds v. United States*, 98 U.S. 145 (1878) in which it rejected a claim that criminal laws against polygamy were unconstitutional when the practice of polygamy was required by religious beliefs: “To permit this would be to make the professed doctrines of religious belief superior to the law of the land, and in effect to permit every citizen to become a law unto himself.” (*Reynolds*, *supra*, 98 U.S. at 166-67). An interesting question: Would a challenge based on more recent cases involving sexual liberty sustain the same result?
19. *Id.* (citation omitted).
20. 374 U.S. 398 (1963).
21. *Smith*, *supra*, 494 U.S. at 883-84.
22. *Id.* at 885 (Citations omitted).
23. *Id.* at 890.
24. *Id.*
25. In some cases, pharmacists (and pharmacy owners) have been able to mount successful challenges to state statutes based on facts showing animus against religious providers. See, e.g., *Stormans, Inc. v. Selecky*, ___ F.Supp. 2d, 2012 WL 566775 (W.D. Wash. Feb. 22, 2012) (holding dispensing regulations invalid under strict scrutiny); *Morr-Fitz, Inc. v. Blagojevich*, 2011 WL 1338081 (Trial order) (Circuit Court of Illinois, Seventh Judicial Circuit, April 5, 2011) (invalidating Illinois dispensing rules under strict scrutiny). *Morr-Fitz* illustrates the value of conscience protective statutes, as other Illinois laws, including its state version of RFRA and its

- Health Care Right of Conscience Act, also provided a legal basis for protecting the conscience rights of pharmacists and pharmacy owners in that case.
26. Pub. L. No 103-141, 107 Stat 1488 (1993), codified at 42 U.S.C.A. §§ 2000bb-2000bb-4.
 27. 42 U.S.C.A. § 2000bb.
 28. 42 U.S.C.A. § 2000bb-1(b).
 29. 42 U.S.C.A. § 2000bb-1(a).
 30. 521 U.S. 507 (1997).
 31. RFRA, in the Court's view, went beyond the proper scope of Congressional remedial powers under the Fourteenth Amendment. The Court argued that Congress effectively attempted a substantive change in Free Exercise safeguards, rather than merely enforcing existing constitutional protections. See *id.* at 532-35. Among other things, this was thought to entail "considerable congressional intrusion into the States' traditional prerogatives and general authority to regulate for the health and welfare of their citizens." *Id.* at 535.
 32. See *Gonzales v. O Centro Espirita Beneficente Unia do Vegetal*, 546 U.S. 418 (2006).
 33. One author counts ten states that have passed their own version of RFRA: Arizona, Connecticut, Florida, Idaho, Illinois, New Mexico, Oklahoma, Rhode Island, South Carolina and Texas. See Patricia Kelleen Forlizzi, "State Religious Freedom Restoration Acts as a Solution to the Free Exercise Problem of Religiously Based Refusals to Administer Health Care," *New England L. Rev* 44(2010): 400. However, a state RFRA may not provide protections as robust as other legislative approaches to conscience rights, especially since the substantiality of a burden and the "compelling" nature of the government's interest are indeterminate and not always productive of the desired protection. "Equal access to health care may be deemed a compelling state interest, but the imposition of a State RFRA and its strict scrutiny mandate will not always result in a victory for equal protection." See *id.* at 418. For example, in *North Coast*, the California Supreme Court concluded that the antidiscrimination goals of the Unruh Act were sufficiently compelling to withstand even this strict scrutiny requirement. See *North Coast, supra*, 189 P.3d at 968.
 34. For example, the Religious Land Use and Institutionalized Persons Act (RLUIPA), 42 U.S.C. § 2000cc-1 et seq., was enacted in 2000 to protect religious freedom in the context of incarcerated persons and zoning restrictions. Although this law constrains state and local laws, it was held to be a valid exercise of Congressional power under Article 1 due to its limited application to circumstances involving federal funds. See, e.g., *Cutter v. Wilkinson*, 544 U.S. 709 (2005) (upholding RLUIPA application to state prisoners where federal funds were involved).
 35. See, e.g., H.R.1179, Respect for Rights of Conscience Act of 2011 (March 17, 2011); S. 1467, Respect for Rights of Conscience Act of 2011 (August 2, 2011).
 36. See e.g., *Planned Parenthood v. Casey*, 505 U.S. 833, 848 (1992).
 37. *Id.* at 852.
 38. *Id.* at 851 (emphasis added).
 39. *Griswold v. Connecticut*, 381 U.S. 479 (1965).
 40. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973).
 41. See, e.g., *Lawrence v. Texas*, 539 U.S. 558 (2003) (unconstitutionality of a Texas criminal statute applied to adult males in the privacy of their home) overruling *Bowers v. Hardwick*, 478 U.S. 186 (1986) (upholding a similar statute against constitutional challenge).
 42. See note 23, *supra*.
 43. See also *Washington v. Glucksberg*, 521 U.S. 702, 788-89 (Breyer, J., concurring) (suggesting that legislatures are superior decision makers about emerging issues when future implications are potentially significant but unknown).
 44. In 1961, all fifty states had outlawed sodomy, but by 2003 only thirteen states had retained such laws, and only four states enforced them, and then only against homosexual conduct. See *id.* at 572. The Court also noted that the European Court of Human Rights had long ago ruled in *Dudgeon v. United Kingdom*, 45 Eur. Ct. H.R. (1981) that a Northern Ireland Law proscribing consensual homosexual conduct was invalid under the European Convention on Human Rights. See *id.*

45. Marriage is often seen as an important status symbol. Hence, the goal of making it equally possible for both homosexuals and heterosexuals to achieve this “status” has prompted state courts, based on equal protections considerations, to strike down opposite-sex restrictions. See, e.g., *Kerrigan v. Commissioner*, 957 A2d 407 (Conn. 2008) (noting that “consigning same-sex couples to civil unions [] has relegated them to an inferior status, in essence, declaring them to be unworthy of the institution of marriage”); *Lewis v. Harris*, 908 A. 2d 196 (2006) (noting that “[u]ltimately, the message is that what same-sex couples have is not as important or as significant as ‘real’ marriage”). Cf note 3 *supra*.
46. 189 P.3d 959 (Cal. 2008).
47. See Cal. Civ. Code § 51(b).
48. Cal Civ. Code § 51(b). It should be noted that during the years at issue in *North Coast*, neither sexual orientation nor marital status were included in the statute. Nevertheless, the California Supreme Court ruled that sexual orientation was a protected category based on other California cases.
49. See Cal. Health & Safety § 123420 (protects a “moral, ethical, or religious” refusal to participate in abortion, including a liability limitation from suits for failure to provide or refusal to participate, and makes it a misdemeanor criminal offense). Note, however, that this law does not apply to “medical emergency situations and spontaneous abortions.” *Id.*, § 123420(d).
50. See National Gay and Lesbian Task Force, State Nondiscrimination Laws in the U.S. (January 20, 2012, at www.theTaskForce.org (last accessed 3/6/12).
51. For example, nondiscrimination laws affecting employment or housing would not impact patient care.
52. Blessed John Paul II argued that, when faced with the dilemma either of abandoning the medical profession or of compromising one’s convictions, healthcare providers should take the “middle path” of conscientious objection which must be “respected by all, especially legislators” [Address of John Paul II On the Occasion of the International Congress of Catholic Obstetricians and Gynaecologists, 18 June 2001; *Evangelium vitae*, 72-74].
53. Cf. *Ibid.*, 74.
54. Douglas B. White and Baruch Brody, “Would Accommodating Some Conscientious Objections by Physicians Promote Quality in Medical Care?” *JAMA* 305(2011):1804.
55. A morally serious healthcare worker certainly qualifies as “a man of conscience” and, as such, can take as his models Blessed John Henry Cardinal Newman, St. Thomas More, and St. Thomas Becket who, within their professional lives, paid unequivocal “obedience to that truth which must rank higher than every social authority and every kind of personal taste” [Ratzinger, *Values*, 87].
56. White, “Accommodating,” 1805.
57. Leon Kass warns that when the ends of medicine are not clearly defined or agreed upon, the practitioner is at risk of becoming a mere “technician and engineer of the body, a scalpel for hire, selling his services upon demand” [*Toward a More Natural Science: Biology and Human Affairs* (The Free Press: New York, NY, 1985) 158]. Benedict XVI encourages healthcare workers to never lose sight of the fact that biomedical sciences are at the service of the human being and counsels them that anesthetizing their conscience will only reduce healthcare services to “a cold and inhuman character” [Address of His Holiness Benedict XVI to Members of the International Congress of Catholic Pharmacists, 29 October 2007]. Margaret Somerville argues that denial of conscience in the healthcare setting does a great disservice not only to the individual medical professional but to the medical profession in general, where maintaining respect in the human encounter between healthcare worker and patient is of paramount importance. [MercatorNet, 17 October 2008 (www.mercatornet.com, last accessed 11/20/11).]
58. John Paul II underscores the psychophysical scope of patients’ needs and their correlative requisites that healthcare professionals practice not only biomedicine but the “spiritual medicine” of compassionate human contact imitative of the gospel image of the Good Samaritan: the willingness even at great personal sacrifice to help those in need of healing, all the while witnessing “to those higher values which have their firmest foundation in faith” [Address to a Congress of Catholic Doctors, 7 July 2000].
59. White, “Accommodating,” 1805.

60. Ratzinger argues that when conscience and authority seem to be “locked in struggle with each other,” human freedom is rescued in an appeal “to the classical principle of moral tradition that conscience is the *highest norm* which man is to follow even in opposition to authority” [“Conscience and Truth,” 8]. Cf. *Dignitatis humanae* #3 and *Gaudium et spes* #79.
61. *Universal Declaration of Human Rights* #18.
62. Loyalty to conscience on the part of Christian believers not only puts them in solidarity with the same quest on the part of their non-Christian fellow-citizens, but also, to the extent that an upright conscience prevails, facilitates just resolutions to societal problems, resolutions that follow from objective truths rather than “blind choice” [*Gaudium et spes* #16].
63. John Paul II fuses societal respect for conscience with “a force for peace.” Citizens’ right to follow conscience, to judge and to act in accordance with truth, promotes “unity rather than division; reconciliation rather than hatred and intolerance.” Seeking the truth together, “with respect for the conscience of others,” enables all people “to go forward along the paths of freedom which lead to peace, in accordance with the will of God” [*If You Want Peace, Respect the Conscience of Every Person*, 1 January 1991, XXIV World Day of Peace].
64. Aleksandr I. Solzhenitsin, *A World Split Apart* (New York: Harper & Row Publishers, 1978) 30. NYU law professor Jeremy Waldron’s observation that it “infuriates” his fellow liberals that some intellectuals continue “to actually argue on matters that many secular liberals think should be beyond argument, matters that we think should be determined by shared sentiment or conviction” and “to refuse to take the liberal position for granted” is a good example of “sly selectivity.” [“Secularism and the Limits of Community,” *New York University School of Law: Public Law & Legal Theory Research Paper Series, Working Paper no. 10-88, December, 2010, 16-17.*]
65. Ratzinger points out that the source of concern over the blunting of moral sensitivity so rampant under Marxist regimes was “that those who lived in a system of deceit had lost much of their powers of perception. Society had lost the ability to feel compassion, and human emotions had withered away. An entire generation had become impervious to the good and was incapable of human deeds. . . . When conscience falls silent and we do nothing to resist it, the consequence is the dehumanization of the world and a deadly danger” [*Values*, 83].
66. Chai Feldblum, lesbian activist, is unequivocally committed to using government, through the power of its laws, to shape public opinion toward agreement that heterosexuality and homosexuality are equivalent moral goods. She claims that nothing short of this sort of moral equivalency will bring full equality to LGBT people. [“Gay is Good: The Case for Marriage Equality and More,” *Yale JL & Feminism* 17(2005):139, 140.]
67. The Congregation for the Doctrine of Faith calls Christians to give witness to the moral truth regarding marriage by avoiding approval of homosexual acts and homosexual unions and by participating in the following discreet and prudent actions: “unmasking the way” that state tolerance, but not explicit legal recognition, of homosexual unions “might be exploited or used in the service of ideology; stating clearly the immoral nature of these unions; reminding the government of the need to contain the phenomenon within certain limits so as to safeguard public morality, and above all, to avoid exposing young people to erroneous ideas about sexuality and marriage that would deprive them of their necessary defenses and contribute to the spread of the phenomenon” [“Considerations Regarding Proposals to Give Legal Recognition to Unions Between Homosexual Persons,” Part II].
68. In their evaluation of forty-nine empirical studies on same-sex or homosexual parenting, Robert Lerner and Althea Nagai categorize the surveys’ claim—viz., it makes “no difference” whether a child has two heterosexual parents or two homosexual parents (two moms or two dads)—as inconclusive. Quantitative analysis experts Lerner and Nagai, having identified at least one fatal flaw in each of the studies, concluded, for that reason, that the papers: (1) yield no reliable generalizations and (2) “are no basis for good science or good public policy” [*No Basis: What the Studies Don’t Tell us About Same-Sex Parenting* (Washington, DC: Marriage Law Project, 2001) 3].
69. Robert H. Bork uses this argument in reference to the Supreme Court’s decision in *Griswold v. Connecticut*. Even though, in 1965, the Court admitted “the majority finds the use of contraception immoral,” it made no effort to inhibit the practice, despite the fact that the ruling

caused “the majority anguish” and impaired their gratifications. [“Neutral Principles and Some First Amendment Problems,” excerpt taken from Bork’s *A Time to Speak: Selected Writings and Arguments* (Wilmington, DE: ISI Books, 2008) available at: <http://www.firstprinciplesjournal.com/print.aspx?article=1190&bc=b&type=cbtp> (last accessed 6/13/11).]

70. 745 Ill. Comp. Stat. 70/4. Liability protections are also extended to owners, operators, supervisors, and managers, as well as the health care provider. Id. § 70/9. It should be noted, however, that the Act requires that clinicians have a duty to provide emergency medical care. See id. §§ 70/6; 70/9.
71. See id. § 70/5. Those rights allowed a pharmacist to sue his employer who placed the pharmacist on unpaid leave because he refused to dispense contraception on grounds that it violated his conscientious beliefs. See *Vandersand v. Wal-Mart Stores, Inc.*, 525 F.Supp. 2d 1052 (C.D. Ill. 2007) (denying Wal-Mart’s motion to dismiss the pharmacist’s claims). See also 745 Ill. Comp. Stat. § 70/7 (prohibiting discrimination by employers and institutions); id. §§ 70/10-11 (prohibiting discrimination and denial of aid or benefits to facilities that exercise conscience rights). Payers are likewise protected by provisions tailored to their conscientious convictions. See id. §§ 70/11.1-4.
72. This avoids the potential problem generated by the Washington conscience law (Wash. Rev. Code § 43.065(2)(a)) which extends protections only to individuals and not their employers. See *Stormans, Inc. v. Selecky*, ___ F.Supp. 2d, 2012 WL 566775 (W.D. Wash. Feb. 22, 2012).
73. History shows that coercive endeavors do not necessarily have good endings. See, e.g., *West Virginia State Board of Education v. Barnette* 319 U.S. 624, 640-641 (1943), where the Court observed:
- "Struggles to coerce uniformity of sentiment in support of some end thought essential to their time and country have been waged by many good as well as by evil men. Nationalism is a relatively recent phenomenon but at other times and places the ends have been racial or territorial security, support of a dynasty or regime, and particular plans for saving souls. As first and moderate methods to attain unity have failed, those bent on its accomplishment must resort to an ever-increasing severity. As governmental pressure toward unity becomes greater, so strife becomes more bitter as to whose unity it shall be. Ultimate futility of such attempts to compel coherence is the lesson of every such effort from the Roman drive to stamp out Christianity as a disturber of its pagan unity, . . . the Siberian exiles as a means to Russian unity, down to the fast failing efforts of our present totalitarian enemies. Those who begin coercive elimination of dissent soon find themselves exterminating dissenters. Compulsory unification of opinion achieves only the unanimity of the graveyard."
- Modern examples of coercion to achieve conformity regarding sexual liberty can be found in other Western nations. See Jeffery J. Ventrella, “Square Circles!?: Restoring Rationality to the Same-Sex ‘Marriage’ Debate,” *Hast. L. Q.* 32(2004-05):713-14 (citing examples of religious persecution in Canada, England, Spain, and Sweden involving dissenting views on homosexuality).
74. As one commentator suggests: you just can’t hurry love. (See Andrew Koppelman, “You Can’t Hurry Love,” *Brook L Rev* 72(2006):146.)
75. For example, in *Stormans, Inc. v. Selecky*, 2012 WL 566775 (W.D. Wash. Feb. 22, 2012) (No. C0705374RBL), the Washington Board of Pharmacy promulgated rules that required pharmacies to deliver all lawfully prescribed drugs, including “Plan B.” Since many religious pharmacists refuse to dispense abortifacient drugs, smaller pharmacies owned by persons with these conscientious objections had no choice but to close. The Board admitted it was “well aware of this result when it designed the rule.”
76. See id. at n. 6 (“the [State Pharmacy] Board contemplated its rules would result in pharmacies run by religious-objectors being replaced by non-objectors.”) See also *Morr-Fitz v. Blagojevich*, 901 N.E.2d 373 (IL 2008) that involved a challenge to an Illinois administrative rule requiring pharmacists to dispense “Plan B” regardless of religious objections. The court noted that then-Governor Rod Blagojevich opined: “pharmacists with moral objections [to dispensing Plan B contraceptives] should find another profession.” Id. at 390.

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