Coercing Conscience

The Effort to Mandate Abortion as a Standard of Care

Maureen Kramlich

There is no duty in either law or medical ethics for health-care providers to participate in abortion. But pro-abortion organizations are actively working to change this state of affairs through enactment of legislative mandates to compel provider participation. Such mandates would force medicine to reverse course on its approach to abortion. Medical professionals, including most who favor keeping abortion legal, are unwilling to perform the procedure themselves, but if abortion activists succeed in passing laws requiring participation, abortion will become a part of standard medical care. Once such laws make abortion a part of routine medicine, the new legal regime will marginalize pro-life providers, and the law will impose new forms of medical liability.

Laws Protecting Conscience Rights

Fortunately, the law on both the federal and state levels protects health-care professionals who object to participation in abortion. Federal constitutional law provides ample precedent for Congress and the states to enact laws prohibiting discrimination against health-care providers with conscientious objections to abortion. In Roe v. Wade1 the United States Supreme Court created a negative right to abortion, i.e., a right of the individual seeking abortion to be free from governmental interference. The

Court did not create a right of access to abortion, i.e., an entitlement requiring the
government to compel providers to effect exercise of the abortion “right.”

In subsequent decisions, the Court affirmed this principle. In Webster v. Reproductive Health Services, the Court upheld a Missouri law’s prohibition on the use of public employees and facilities for abortion. In Harris v. McRae the Court concluded that the Hyde Amendment’s ban on the use of federal funds for supposedly “medically necessary” abortions did not violate Roe. Moreover, in Roe’s companion case, Doe v. Bolton, the Court left intact a conscience clause in the state of Georgia’s abortion statute while striking down other provisions of the law. As a matter of constitutional law, therefore, the federal government and the states have been free to enact laws protecting the conscience rights of health-care providers who object to participation in abortion.

To date, the federal government and forty-six states have enacted such laws. These laws vary in the scope of protection provided. Some states do not limit protections to objections to abortion but include other controversial procedures, for

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3Harris v. McRae, 448 U.S. 297 (1980).

5See 42 U.S.C. § 300a-7(b) (prohibiting public discrimination against individuals and entities that object to performing abortions on the basis of religious beliefs or moral convictions); 42 U.S.C. § 300a-7(c) (prohibiting entities from discriminating against physicians and health-care personnel who object to performing abortions on the basis of religious beliefs or moral convictions); 42 U.S.C. § 300a-7(e) (prohibiting entities from discriminating against applicants who object to participating in abortions on the basis of religious beliefs or moral convictions); 42 U.S.C. § 238n (prohibiting discrimination against individuals and entities that refuse to perform abortions or train in their performance); 20 U.S.C. § 1688 (ensuring that federal sex discrimination standards do not require educational institutions to provide or pay for abortions or abortion benefits).

example, euthanasia (California\textsuperscript{7} and South Dakota\textsuperscript{8}), sterilization (Kansas,\textsuperscript{9} Massachusetts,\textsuperscript{10} New Jersey,\textsuperscript{11} Pennsylvania\textsuperscript{12}), artificial insemination (Maryland\textsuperscript{13}), abortifacient drugs (South Dakota\textsuperscript{14}) and contraception (Massachusetts).\textsuperscript{15} The state of Illinois has enacted a comprehensive right of conscience law, under which the protection of physicians and other health-care personnel extends to any procedure “which is contrary to the conscience of such physician or health-care personnel.”\textsuperscript{16} The state of Washington provides comprehensive conscience protection to individual health-care providers and to religiously affiliated health-care plans and facilities.\textsuperscript{17} Federal law protects objections to a range of activities, including contraception,\textsuperscript{18} executions,\textsuperscript{19} and certain forms of HIV prevention,\textsuperscript{20} as well as conscientious objection to some or all wars.\textsuperscript{21}

Conscience laws are also narrow in some respects. Some federal laws limit the protections to specific funding programs. Some state laws do not cover the full range of health-care professionals. Others are unclear about whether the protections extend to all forms of objectionable participation (e.g., referrals). Most do not provide appropriate remedies.\textsuperscript{22} Nonetheless, the law recognizes the principle that health-care professionals ought not to be compelled to participate in procedures to which they object. The law specifically identifies abortion as the kind of procedure in which providers should not be forced to participate.

\textsuperscript{7}CAL. PROB. CODE § 4734.
\textsuperscript{8}S.D. CODIFIED LAWS § 36-11-70 (3).
\textsuperscript{9}KAN. STAT. ANN. § 65-446.
\textsuperscript{10}MASS. GEN. LAWS ANN. CH. 112, § 12I AND MASS. GEN. LAWS ANN. CH. 272, § 21B.
\textsuperscript{12}PA. CONS. STAT. ANN. tit. 43, § 955.
\textsuperscript{13}MD CODE ANN., HEALTH-GEN. I § 20-214.
\textsuperscript{14}S.D. CODIFIED LAWS § 36-11-70 (2).
\textsuperscript{15}MASS. GEN. LAWS ANN. ch. 272, § 21B.
\textsuperscript{16}745 ILL. COMP. STAT. 70/4.
\textsuperscript{17}See Wash. Rev. Code §§ 48.43.065 and 70.47.160.
\textsuperscript{18}Sec. 635(c) of Title VI of Division J (Treasury and General Government Appropriations) of the Consolidated Appropriations Resolution, 2003, Pub. L. No. 108-7, 117 Stat. 11, 472.
\textsuperscript{19}18 U.S.C. § 3597(b).
\textsuperscript{22}For a thorough analysis of the inadequacies of some of these laws, see Lynn D. Wardle, “Protecting the Rights of Conscience of Health Care Providers,” Journal of Legal Medicine 14 (1993): 177.
The Policies of Major Medical Organizations

Medical ethics also recognizes this principle. The American Medical Association (AMA), in its abortion policy, offers support for broad conscience rights. The policy states: “Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles.”23 Similarly, the American Pharmacists Association “recognizes the individual pharmacist’s right to exercise conscientious refusal and supports the establishment of systems to ensure patient access to legally prescribed therapy without compromising the pharmacist’s right of conscientious refusal.”24 The American Nurses Association has stated: “Where a particular treatment, intervention, activity, or practice is morally objectionable to the nurse, whether intrinsically so or because it is inappropriate for the specific patient, or where it may jeopardize both patients and nursing practice, the nurse is justified in refusing to participate on moral grounds.”25

Nevertheless, pro-abortion groups have been actively trying to abolish conscience laws and to change the policies of medical organizations. For example, in June of 2000, the AMA considered a resolution offered by its California affiliate to support legislation requiring hospitals to provide “a full range of reproductive services.”26 The delegates did not approve this resolution but instead reaffirmed the organization’s existing conscience policy.

Challenges to the Policies of Particular Hospitals

Abortion activists have also developed a strategy to challenge the policies of particular hospitals, especially in the context of mergers and other affiliations. This is done mostly through the use of judicial and administrative interventions to effectively override existing conscience protections. Pro-abortion groups have developed at least four kinds of interventions: charitable trust law, antitrust law, constitutional litigation, and certificate-of-need proceedings.

The charitable-trust-law strategy involves first insisting that a hospital attempting to merge be treated as a trust, and then arguing that the proposed (or resulting) merger is a departure from the trust’s charitable purpose. Essentially, the argument is that if a hospital, in the course of a business transaction such as a purchase or a merger, ceases performing abortions, that hospital has abandoned its charitable purpose. Under the antitrust theory, abortion activists argue that the entity resulting

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from a merger, by gaining too large a share of the health-care market, engages in anticompetitive conduct. In constitutional litigation, activists argue that hospitals are essentially state actors and as such violate the establishment clause of the First Amendment when they agree to follow a pro-life policy, for example, as expressed in the U.S. bishops’ *Ethical & Religious Directives for Catholic Health Care Services*. Finally, pro-abortion groups have intervened in administrative proceedings, such as certificate-of-need proceedings, to harass and pressure hospitals that need these certificates to operate—or to defeat the certificates altogether.

Pro-abortion organizations have had some success with these strategies. They have resulted in

- Forcing a private community hospital to open its doors for late abortions;  
- Denying a certificate of need to an outpatient surgical center that declined involvement in abortion, after an abortion-rights coalition intervened in the proceedings;  
- Forcing a private nonsectarian hospital to leave a cost-saving consortium because the consortium abided by a pro-life policy in its member hospitals;  
- Dismantling a hospital merger after abortion advocates approached a state attorney general to challenge the merger; and  
- Pressuring a hospital to place two million dollars in trust for abortions and sterilizations before allowing the hospital to consolidate.

These strategies have effectively circumvented the conscience laws protecting the rights of the hospitals, forcing particular hospitals to choose between a pro-life policy and institutional survival.

This approach binds only particular hospitals in particular circumstances at particular times: litigation binds only the parties involved. By contrast, legislation has far-reaching consequences, binding all health-care providers. Pro-abortion groups have, therefore, developed a calculated strategy to abolish conscience rights through legislative mandates.

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27 See *Valley Hospital Ass’n v. Mat-Su Coalition for Choice*, 948 P.2d 963 (Alaska 1997).

28 See State of Connecticut Office of Health Care Access Final Decision in Roy Bebe, M.D., Hartford Hospital, John Dempsey Hospital, New Britain General Hospital, Saint Francis Hospital and Medical Center, and ASC Network Corporation d/b/a Avon Surgery Center for a Certificate of Need, Docket No. 96-547 (Sep. 29, 1997).

29 See Wes Allison, “City, Bayfront Settle Suit,” *St. Petersburg (Florida) Times*, April 11, 2001, 1A.


A Legislative Strategy

The legislative strategy has four aspects. First and foremost, the strategy seeks to mandate new standards of care in order to require the profession to do what it has resisted. Second, it involves an incremental approach with respect to the procedures required, beginning with contraception. Third, it attempts to blur the line between contraception and abortion. Fourth, when mandates have to include some protection for conscience rights to be politically feasible, pro-abortion groups have demanded a very narrow category of permissible objections.

New Standards of Care

Although the AMA refers to abortion as a “medical procedure,” the medical profession has largely rejected it as a part of the practice of medicine. In its most recent survey of abortion providers, the Alan Guttmacher Institute—a research organization affiliated with Planned Parenthood—reported that the number of facilities performing abortions, including hospitals, clinics, and physicians’ offices, was just 1,819.\footnote{Stanley K. Henshaw and Lawrence B. Finer, “The Accessibility of Abortion Services in the United States, 2001,” \textit{Perspectives on Sexual and Reproductive Health} 35.1 (January/February 2003): 17.} Even physicians who identify themselves as “pro-choice” stigmatize their colleagues who perform abortions. The executive director of the American College of Obstetricians and Gynecologists, an adamantly pro-abortion organization, once remarked, “it’s not pleasant being an abortion doctor. By and large, they are zealots who are strongly committed and who believe, in most instances correctly, that if they don’t provide the service, no one will.”\footnote{Gina Kolata, “Under Pressures and Stigma, More Doctors Shun Abortion,” \textit{New York Times}, January 8, 1990, A1.} And the founder of Medical Students for Choice, Jody Steinauer, M.D., has acknowledged, “there’s sort of an idea of someone who provides abortion as isolated from mainstream medicine.”\footnote{Jody Steinauer, M.D., interview by Lynn Neary, \textit{All Things Considered}, National Public Radio, January 21, 2003.}

Also dividing physicians, though to a lesser extent, is “emergency contraception” (EC), which has abortifacient properties. And it divides them even though most physicians do not describe its mode of action as “abortifacient.” Depending on when it is administered in a woman’s cycle, the regimen may interfere with the implantation of the newly conceived embryo. But because of a politically motivated change in the definition of conception, the Food and Drug Administration (FDA) and most secular medical groups classify the drugs as contraceptives rather than abortifacients. Nevertheless, the AMA has not taken a position that offering the drugs is a standard of care even for rape victims. The AMA House of Delegates policy calls for greater access to EC and states that \textit{information} about the drugs “is a part of the comprehensive information to be provided” to rape victims.\footnote{American Medical Association, House of Delegates, policy, H-75.985, “Access to Emergency Contraception,” http://www.ama-assn.org/ama/pub/upload/mm/19/womenpolicy.pdf.} The
AMA has not, however, suggested that comprehensive treatment includes offering the drugs.

Because medical professionals have rejected abortion as a part of their medical practices, the abortion lobby is seeking to impose abortion on the profession by legislating new standards of care. An American Civil Liberties Union (ACLU) attorney, Margaret Crosby, has explained the purpose behind such efforts: "No one has the right to commit malpractice.... If we can establish that a standard of care is being violated, the public interest in patient health will clearly outweigh the sectarian hospitals’ or insurers’ right to limit care." This quotation was contained in the executive summary of a national meeting of groups organizing to abolish conscience rights. The executive summary continued:

Activists and lawyers, said Crosby, need to argue that the denied services are a fundamental part of health care. They need to educate judges about the burden faced by women who are denied these services. They need to focus in the legislative arena on enacting laws requiring institutions to provide more comprehensive care.

In traditional medical malpractice, courts set standards of care by referring to internal professional standards, requiring doctors to “have and use the knowledge, skill, and care ordinarily possessed and employed by members of the profession in good standing.” Courts do not measure physicians by standards the profession itself does not accept, because, according to Prosser and Keeton, courts have a “healthy respect... for the learning of a fellow profession” and want to avoid “overburden[ing] it with liability based on uneducated judgment.”

But some state legislatures, at the urging of the pro-abortion movement, are not as reluctant and have imposed duties on medical professionals that the profession has not adopted itself. These statutory duties create new avenues for liability, because while courts consult professional standards, they may also refer to statutory standards of care. In such cases, the fact that a relevant statute has been violated may be evidence in fact of negligence (negligence per se) or at least presumptive evidence of negligence, depending upon the law of the jurisdiction.

Once the statute is determined to be applicable—which is to say, once it is interpreted as designed to protect the class of persons, in which the plaintiff is included, against the risk of the type of harm which has in fact occurred as a result of its violation—and once its breach has been established, probably a majority of the courts will hold that the issue of negligence is thereupon conclusively determined, in the absence of sufficient excuse, and that the court must so


37 Ibid.


39 Ibid., 189.
direct the jury. The standard of conduct is taken over by the court from that fixed by the legislature.\textsuperscript{40}

Subsequently, having failed to convince the medical profession that emergency contraception and abortion are basic health care, abortion activists have imposed or are seeking to impose those procedures as customary medical practice through the enactment of legislation.

\textit{An Incremental Approach}

At the time of this writing, twenty states\textsuperscript{41} have enacted contraceptive mandates. A twenty-first state has adopted a mandate by administrative regulation.\textsuperscript{42} According to Planned Parenthood, bills are currently pending in twelve states. The mandates require that employee health benefit plans that include prescription drug coverage must also include FDA-approved contraceptive drugs and devices, as well as contraceptive services. Thus the mandates apply to ordinary birth control pills, intrauterine devices, Depo-Provera, Norplant, diaphragm fittings, and “emergency contraception.” One state, North Carolina, specifically excludes emergency contraception.

Planned Parenthood has promoted the mandates as necessary to ensure that women receive “basic health care.”\textsuperscript{43} The abortion lobby is aiming to enact into law the principle that contraception is a part of basic health care, and then to build upon that principle by enacting into law mandates for other procedures. Evidence of this aim is found on the website of the Pro-Choice Resource Center, an organization dedicated to mobilizing pro-abortion activists. One of its stated goals is to “defeat or repeal public and private policies that restrict access to EC.”\textsuperscript{44} As a part of its efforts to defeat these policies, it advocates “[s]upport[ing] the passage of contraceptive equity legislation, which requires insurance companies to cover emergency contraception if they provide coverage of other prescription drugs.”\textsuperscript{45} So, contraceptive mandates are efforts to require not only contraception in health plans but also abortifacient drugs in the form of “emergency contraception” mandates.

\textsuperscript{40}Ibid., 230.


\textsuperscript{42}W.A.C. 284-43-822.


\textsuperscript{45}Ibid.
Several states are considering or have considered specific mandates for emergency contraception which are designed to override the conscience rights of Catholic hospitals and others. Catholic hospitals observe ethical directives which allow provision of emergency contraception to rape victims when its mode of action would be contraceptive, i.e., preventing ovulation or fertilization, but not when conception has occurred and the mode of action would be abortifacient. Although only a few state legislatures are considering such measures, the Abortion Access Project, operating in twenty-one states, is organizing an effort to garner support for them. It is quite clear from the project’s materials, including fact sheets and resources on its website, that it has targeted Catholic hospitals. Mandating these abortifacient drugs is an incremental means to require hospitals to perform abortions generally. In fact, the group’s materials on emergency contraception are included in a kit titled: “Designing A Campaign to Increase Hospital-Based Abortion Services.” Here the effort targeting Catholic hospitals on “emergency contraception” is listed among the “sample approaches” for “Mobilizing to Pressure Hospitals” to perform abortions.

Such mandates are not simply directed at Catholic providers. In Maryland, a bill mandating emergency contraception for rape victims also carved out exceptions to the state’s existing conscience law. The bill was offered as an amendment to a law protecting institutional and individual health-care providers who decline involvement in artificial insemination, sterilization, or abortion.

The next step in the anti-conscience agenda is legislative mandates requiring abortion in all health plans, and this has proved to be the case. The New York State legislature is considering a bill to require all private health insurance plans that provide maternity coverage to include abortion coverage, as if abortion were a basic part of maternal health.

Obscuring the Line Between Contraception and Abortion

Pro-abortion researchers are also conducting a scientific study that has the effect of obscuring the line between abortion and contraception. The World Health Organization (WHO) Research Group on Post-Ovulatory Methods of Fertility Regulation, which includes the United Nations Population Fund, is conducting research into the use of Mifepristone (RU-486, the “abortion pill”) as EC. Mifepristone is also being tested as an ordinary contraceptive.

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These scientific studies are not mere academic exercises, without political ramifications. The United Nations Committee on the Elimination of Discrimination Against Women (CEDAW) has recommended that Mexico liberalize its abortion laws first by introducing RU-486 as a “contraceptive.”

Although pro-abortion organizations appear not to have undertaken similar efforts domestically, as yet, pro-life advocates ought to be aware of the potential application of mifepristone in contraceptive mandates.

Narrowing the Class of Permissible Objections

Legislative mandates have been very deliberately designed to disallow conscientious objections. Laws mandating the provision of EC to rape victims have not allowed any conscientious objections. Contraceptive mandates have included some conscience protections, but only when in the legislative process it appeared the mandate could not be enacted without some kind of conscience clause. Typically, the legislatures adopt boilerplate language provided by the American Civil Liberties Union (ACLU). The ACLU model language provides:

For purposes of this section, a “religious employer” is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

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52Pak Chung Ho, Ernest Hung Yu Ng, and Oi Shan Tang, “Mifepristone: Contraceptive and Non-Contraceptive Uses,” Current Opinion in Obstetrics & Gynecology 14.3 (June 2002): 325.

53United Nations Committee on the Elimination of Discrimination Against Women, Adoption of the Report of the Committee on the Elimination of Discrimination Against Women, 18th Sess. CEDAW/C/1998/I/L. 1/Add. 7 (February 3, 1998), n. 58. The Committee said that it “recommends that the [Mexican] Government consider the advisability of revising the legislation criminalizing abortion and suggests that it weigh the possibility of authorizing the use of the RU486 contraceptive, which is cheap and easy to use, as soon as it becomes available.”


55This is the language of the conscience clause in the California contraceptive mandate, Cal. Health & Safety Code § 1367.25 (b)(1). Catholic Charities of Sacramento is currently challenging the narrowness of this law. That lawsuit, Catholic Charities of Sacramento v. California, No. S099822 (Cal.), is pending before the California Supreme Court.
Virtually all the contraceptive mandates enacted to date provide either no conscience protection or the totally inadequate ACLU “protection,” which transforms religious organizations such as Catholic Charities and Catholic grade schools into “secular” groups with no conscience rights. Litigation brought on behalf of religious social ministries challenging these narrow “conscience clauses” is pending in New York and California.56

A Modest Proposal to Protect Conscience Rights

The trend towards abolition of conscientious rights of objection is a disturbing development in the law. Support for broad conscience rights in the area of abortion has a thirty-year-old tradition, protecting objectors from acting against religious convictions and moral beliefs. In some instances, the law protects those who object to abortion on any grounds whatsoever. For almost forty years, the law has extended conscience protections to objectors who do not hold specifically religious convictions but sincerely held beliefs.57 At the root of this legal tradition is the principle that no one should be forced to kill for any reason.

Pro-abortion organizations are undermining this tradition through novel litigation and calculated legislative strategies. Abortion activists are eroding the conscience rights of health-care providers hospital by hospital, legislature by legislature. In order to counteract these strategies, the pro-life movement and others concerned with protecting conscience rights ought to challenge these mandates and bolster existing conscience protections. At a minimum, state laws that protect objections to abortion and sterilization should extend those protections to contraception and emergency contraception.

On the federal level, at least one author has proposed a global conscience protection law.58 Currently, Congress is considering a more modest proposal. That bill, the Abortion Non-Discrimination Act,59 introduced by Judd Gregg in the Senate and Michael Bilirakis in the House, amends an existing federal conscience protection law.60 That law prohibits state, local, and federal governments from discriminating against health-care entities that decline to perform, train in, or refer for abortions. In the law, “health-care entity” is defined to include individuals and training programs. The definition was explicit because Congress was responding to a threat made by the Accreditation Council for Graduate Medical Education to mandate abortion training in all obstetrics and gynecology residency programs. However, because the definition of “health-care entity” explicitly “includes” residency programs and residents, it has been interpreted by some to exclude other health-

60 42 U.S.C. §238n.
care entities, such as hospitals. Nevertheless, the language of the law, however, is clear enough. The use of the word “includes” signifies the kinds of things that are illustrative of health-care entities, rather than providing an exhaustive list.

The Abortion Non-Discrimination Act clarifies what is already implicit in the law, by specifying the kinds of institutions that are commonly thought of as health-care entities: “a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health-care facility, organization, or plan.” The bill also changes the scope of the law’s protected activities because it provides protection for health-care entities that decline to pay for or provide coverage for abortion.

In light of the campaign to force providers to participate in abortions, passage of this federal bill and additional state protections are urgently needed.