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HARVARD LAW REVIEW

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Dov Fox

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MEDICAL DISOBEDIENCE

Dov Fox*

America's medical conscience regime is broken. Doctors or nurses who conscientiously deny care get shielded from being sued, fired, or prosecuted — even if they don't tell patients what their options are. Yet there's no solicitude for clinicians who have equally moral reasons to deliver services their hospital or state restricts. This asymmetry selectively burdens providers and drives patients underground. Contested practices run the gamut: from abortion to aid-in-dying, from puberty blockers to conversion therapy, from opioids to ivermectin. Some the law permits; others it forbids. Some are safer, or cheaper. Others fall within the medical norm, rather than push its boundaries. These particulars matter. So does the fact that conscientious provision honors patients' wishes, while conscientious refusal overrides them. A principled system would protect refusers less and providers more, with carve-outs for both tailored to distinct levels of authority: the employer and the government. Conscience exemptions from workplace policies demand clear disclosures and meaningful offsets: both to shore up patient access and to distance institutions from services they oppose. For civil or criminal violations, conscience should excuse partially at most. So no blanket immunity for malpractice or abandonment. A limited defense, for providers too, would mitigate punishments for supplying clinically reasonable care. The long-simmering tension between law and medicine has reached a boiling point. Relief requires equipping a diverse society and dynamic profession to navigate the controversies of our time and adapt to change from within.

INTRODUCTION

Days after Texas banned most abortions, the *Washington Post* ran an op-ed called “Why I Violated Texas’s Extreme Abortion Ban.”¹ Dr. Alan Braid recounted that as a junior resident before *Roe v. Wade*²:

* Herzog Research Professor, University of San Diego School of Law. I owe many debts of gratitude. To my family above all. And to dazzling librarians: Melissa Abernathy, Bee Bornheimer, Jane Larrington, Sasha Nuñez, Julianne Odin, and especially Liz Parker. Erin Hudak, Connor Hume, Meena Kaypour, and Hector Lozada provided rich research assistance. Conversations with Reva Siegel in the wake of *Dobbs* were bracing and priceless. The project profited from the generosity of colleagues like Don Dripps, Miranda Perry Fleischer, and Mila Sohoni. I’ve been fortunate for criticisms and recommendations from fellow travelers: Kate Bloch, Jeff Blustein, Bob Bohrer, Jeff Botkin, Abe Brummett, Mara Buchbinder, Naomi Cahn, June Carbone, Nathan Chapman, Ellen Clayton, David Cohen, Glenn Cohen, Carl Coleman, Nico Cornell, Chris Cowley, Bernard Dickens, Greer Donley, Jen Drobac, Sara Dubow, Brian Earp, Jason Eberle, Paul Enriquez, Kyle Ferguson, Holly Fernandez Lynch, Gill Frank, Lori Freedman, Kyle Fritz, Kathleen Frydl, Sara Gerke, Sherif Girgis, Alberto Giubilini, Imogen Goold, Leslie Griffin, Lewis Grossman, Lisa Harris, Claudia Haupt, Yaniv Heled, Allison Hoffman, Craig Konnoth, Andy Koppelman, Allan Jacobs, Jill Wieber Lens, Myrisha Lewis, Annie Lysterly, Tim Lytton, Eric Mathison, Amy McGuire, Melanie McPhail, Max Mehlman, Michelle Mello, Sean Murphy, Doug NeJaime, Michelle Oberman, Govind Persad, Natalie Ram, Sam Rickless, Jessica Roberts, Mark Rothstein, Rachel Sachs, Bill Sage, Joanna Sax, Nadia Sawicki, Rich Schragger, Micah Schwartzman, Udo Schüklenk, Liz Sepper, Shelly Simana, Ronit Stahl, Debbie Stulberg, Chris Tollefsen, Eugene Volokh, Jen Wagner, Jessica Waters, Brad Wendel, Mark Wickclair, Dan Wikler, Robin Fretwell Wilson, Leslie Wolf, and Mary Ziegler. Their insights improved these ideas at every turn.

¹ Alan Braid, Opinion, *Why I Violated Texas’s Extreme Abortion Ban*, WASH. POST (Sept. 18, 2021, 4:01 PM), <https://www.washingtonpost.com/opinions/2021/09/18/texas-abortion-provider-alan-braid> [https://perma.cc/W62B-H9CU].

² 410 U.S. 113 (1973), *overruled by Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228 (2022).

I saw three teenagers die from illegal abortions. One I will never forget. When she came into the ER, her vaginal cavity was packed with rags. She died a few days later from massive organ failure, caused by septic infection. . . . And that is why, on the morning of Sept. 6, [2021,] I provided an abortion to a woman who, though still in her first trimester, was beyond the state's new limit.³

The Texas Heartbeat Act,⁴ also known as S.B. 8, authorizes private citizens to sue anyone who “aids or abets” an abortion after “cardiac activity” can be detected (usually at about about six weeks), before many women know they’re pregnant.⁵ Multiple \$10,000 lawsuits⁶ forced Braid to refer hundreds of patients across the border to Oklahoma.⁷ But on May 3, 2022, a day after the Supreme Court’s draft opinion leaked in *Dobbs v. Jackson Women’s Health Organization*,⁸ Oklahoma enacted its own similar ban,⁹ later piling on damages of \$100,000 and adding up to ten years in prison.¹⁰ *Roe* fell on June 24, 2022.¹¹

Within weeks, more than a dozen states criminalized abortion with almost no exceptions.¹² Not for the ten-year-old rape victim in Ohio.¹³ Not for the Louisiana mother whose fetus was doomed by a fatal condition that prevents a skull from forming.¹⁴ Not for the cervical cancer

³ Braid, *supra* note 1.

⁴ Texas Heartbeat Act, 2021 Tex. Gen. Laws ch. 62 (codified at TEX. HEALTH & SAFETY CODE ANN. §§ 171.201–212 (West 2021)).

⁵ See TEX. HEALTH & SAFETY CODE ANN. § 171.208(a)(2) (West 2021). Aiding-or-abetting laws apply to other medical professionals too, beyond just the doctor who performs an abortion. Nurses, anesthesiologists, and any others who take part in ending a pregnancy could also be taken to court. See *id.* § 171.208 (a)(1)–(2).

⁶ See Ann E. Marimow, *Texas Doctor Who Violated State’s Abortion Ban Is Sued, Launching Test of Constitutionality*, WASH. POST (Sept. 20, 2021, 7:07 PM), https://www.washingtonpost.com/politics/courts_law/texas-abortion-doctor-sued/2021/09/20/f5ab5c56-1a1c-11ec-bcb8-0cb135811007_story [<https://perma.cc/NP63-PCJ8>].

⁷ See Caroline Kitchener, *A Refuge for Texas Patients, Oklahoma Clinics Brace for Abortion Ban*, WASH. POST (Apr. 9, 2022, 6:00 AM), <https://www.washingtonpost.com/politics/2022/04/09/texas-abortion-ban-oklahoma> [<https://perma.cc/J96D-A5M2>].

⁸ 142 S. Ct. 2228 (2022).

⁹ See OKLA. STAT. ANN. tit. 63, § 1-745.31 (West 2022).

¹⁰ See 2022 Okla. Sess. Laws Serv. ch. 11 (West) (to be codified at OKLA. STAT. ANN. tit. 63, § 1-731.4).

¹¹ See *Dobbs*, 142 S. Ct. at 2242.

¹² See Megan Messerly & Alice Miranda Ollstein, *Abortion Access Crumbles: 4 More States Enact New Restrictions This Week*, POLITICO (Aug. 25, 2022, 4:30 AM), <https://www.politico.com/news/2022/08/25/abortion-access-restrictions-00053622> [<https://perma.cc/XJ4K-3MSP>].

¹³ See David Folkenflik & Sarah McCammon, *A Rape, An Abortion, and a One-Source Story: A Child’s Ordeal Becomes National News*, NPR (July 13, 2022, 10:28 PM), <https://www.npr.org/2022/07/13/1111285143/abortion-10-year-old-raped-ohio> [<https://perma.cc/GAT6-Y4RS>]; see also Marty Schladen, *Affidavits: 2 More Pregnant Minors Who Were Raped Were Denied Ohio Abortions*, OHIO CAP. J. (Sept. 22, 2022, 5:00 AM), <https://ohiocapitaljournal.com/2022/09/22/affidavits-more-pregnant-minors-who-were-raped-denied-ohio-abortions> [<https://perma.cc/7CLE-U968>].

¹⁴ See Ava Sasani & Emily Cochrane, *“I’m Carrying This Baby Just to Bury It”: The Struggle to Decode Abortion Laws*, N.Y. TIMES (Aug. 19, 2022), <https://www.nytimes.com/2022/08/19/us/politics/louisiana-abortion-law.html> [<https://perma.cc/NG6L-HV45>]. Similar cases are described in

survivor, facing dangerous complications herself, forced to drive ten hours to New Mexico.¹⁵ Not for the Texas woman, too sick to travel when she was turned away after her water broke, who nearly died.¹⁶

Michigan's Chief Medical Executive Natasha Bagdasarian explains that doctors are being forced "to choose between breaking" the law they're bound to obey as citizens or the "oath we have taken on behalf of our patients."¹⁷ Sherry Reddix from Mississippi, who recently graduated from medical school, vows to keep performing abortions "[u]ntil someone physically takes the tools out of my hand."¹⁸ New York clinician Linda Prine is using telehealth to prescribe medication by mail to patients in places that deny access.¹⁹ "I don't want younger physicians to be embroiled in lawsuits or criminally charged. . . . Doctors like me who are at the end of our careers, we should be the ones to step up."²⁰ One nurse reports that by September 2022, she was already "receiving bulk shipments of 150 abortion pills and consulting with women across eight states," even though she could lose her license or "go to jail."²¹

Bridget Grumet, Opinion, *Under New Law, Women at Risk*, AUSTIN AM.-STATESMAN, Oct. 23, 2022, at B1; Julian Gill, *Texas' Abortion Laws Led to 3-Day Delay for Houston Woman's Pregnancy Loss Treatment, Doctor Says*, HOUS. CHRON. (Sept. 10, 2022, 7:55 AM), <https://www.houstonchronicle.com/news/houston-texas/health/article/Waiting-in-vain-Texas-abortion-laws-stymie-17424262.php> [<https://perma.cc/2ASV-ATT8>].

¹⁵ See Mitchell Willetts, *Texan Has Out-of-State Abortion to End Heartbreaking and Dangerous Pregnancy, She Says*, FORT WORTH STAR-TELEGRAM (July 3, 2022, 12:25 PM), <https://www.star-telegram.com/news/state/texas/article263141343.html> [<https://perma.cc/QA2L-V6KN>].

¹⁶ See Elizabeth Cohen & John Bonifield, *Texas Woman Almost Dies Because She Couldn't Get an Abortion*, CNN HEALTH (Nov. 16, 2022, 9:44 PM), <https://www.cnn.com/2022/11/16/health/abortion-texas-sepsis> [<https://perma.cc/6YK8-4C6M>].

¹⁷ Natasha Bagdasarian, Opinion, *I'm the State's Chief Medical Officer. Overturning Roe Threatens Public Health*, DET. FREE PRESS (June 27, 2022, 11:50 AM), <https://www.freep.com/story/opinion/contributors/2022/06/26/supreme-court-abortion-ruling-roe/7724609001> [<https://perma.cc/TXJ7-52B3>]; see also Anita Wadhvani, *In Open Letter, 700 Tennessee Healthcare Providers Call on Legislature to "Reconsider" Abortion Ban*, TENN. LOOKOUT (Oct. 10, 2022, 6:00 AM), <https://tennesseelookout.com/briefs/in-open-letter-700-tennessee-healthcare-providers-call-on-legislature-to-reconsider-abortion-ban> [<https://perma.cc/7AW2-EYKA>] (decrying abortion ban for "forc[ing] health care providers to balance appropriate medical care with the risk of criminal prosecution").

¹⁸ Christina Sturdivant Sani, *The Potential End of Roe Won't Stop This Abortion Provider-in-Training*, WASH. POST MAG. (May 11, 2022, 1:22 PM), <https://www.washingtonpost.com/magazine/2022/05/11/abortion-provider-in-training> [<https://perma.cc/8PL2-J82F>].

¹⁹ Emily Bazelon, *Risking Everything to Offer Abortions Across State Lines*, N.Y. TIMES MAG. (Oct. 7, 2022), <https://www.nytimes.com/2022/10/04/magazine/abortion-interstate-travel-post-roe.html> [<https://perma.cc/H2K7-RZNN>].

²⁰ *Id.*

²¹ Caroline Kitchener, *Covert Network Provides Pills for Thousands of Abortions in U.S. post Roe*, WASH. POST (Oct. 18, 2022, 6:00 AM), <https://www.washingtonpost.com/politics/2022/10/18/illegal-abortion-pill-network> [<https://perma.cc/53G5-CGXZ>]; see also Stephania Taladrid, *The Post-Roe Abortion Underground*, NEW YORKER (Oct. 10, 2022), <https://www.newyorker.com/magazine/2022/10/17/the-post-roe-abortion-underground> [<https://perma.cc/9JN3-6NZ4>] (comparing Chicago's Jane Collective that provided surgical abortions before *Roe* to networks like Las Libres and Plan C that connect abortion-pill providers in Mexico and abroad with Americans in states that banned abortion after *Dobbs*); *infra* note 559 and accompanying text.

Texas-based family-medicine doctor Bhavik Kumar says that “having to deny people the essential health care” they “seek in their time of need” isn’t just hard for providers like him to bear: “[W]e are forced to violate our conscience.”²² For obstetrician-gynecologist David Eisenberg from Missouri,²³ providing patients with abortion care is “a part of my moral and religious worldview.”²⁴ “I’m a conscientious provider.”²⁵

Conscientious providers find scarce refuge in the manifold safeguards to practice medicine according to conscience.²⁶ Conscience clauses are broadly reserved for denials of care. Only refusers get immunity from torts like malpractice and breach of informed consent — they’re even exempt from crimes of endangering patients or abandoning them.²⁷ These one-way liability shields are mostly indifferent to whether patients can get treatment elsewhere.²⁸ So a hospital can deny emergency contraception.²⁹ A genetic counselor is free not to tell a patient about results she might rely on to decide to end a pregnancy.³⁰ A doctor could even decline cancer treatment to transgender patients.³¹

²² *Examining the Harm to Patients from Abortion Restrictions and the Threat of a National Abortion Ban: Hearing Before the H. Comm. on Oversight & Reform*, 117th Cong. 2 (2022) (testimony of Bhavik Kumar, Medical Director for Primary and Trans Care, Planned Parenthood Gulf Coast), <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Dr.%20Kumar%20Testimony.pdf> [<https://perma.cc/YB6G-QHVX>].

²³ *The Daily, A Post-Roe America, Part 2: The Abortion Providers*, N.Y. TIMES, at 20:54 (May 11, 2022), <https://www.nytimes.com/2022/05/11/podcasts/the-daily/roe-v-wade-abortion-providers.html> [<https://perma.cc/PR8X-BKLP>].

²⁴ *Id.* at 25:59.

²⁵ *Id.*; see also *infra* notes 81–82, 164 and accompanying text.

²⁶ For the handful of exceptions, see *infra* notes 154–56 and 292–96 and accompanying text.

²⁷ See *infra* notes 130–37 and accompanying text.

²⁸ See *infra* notes 283, 304, 314, 325–28 and accompanying text. The federal government imposes just two limits: emergency room physicians can’t turn away patients who need urgent care; and no clinicians can discriminate based on sex, race, age, or disability. See *infra* notes 120–23 and accompanying text.

²⁹ See *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 242 (Cal. Ct. App. 1989).

³⁰ See Shea Bonine et al., *Conscience Clauses in Genetic Counseling: Awareness and Attitudes*, 30 J. GENETIC COUNSELING 1468, 1469 (2021) (discussing conscience clauses in Oklahoma, Nebraska, and Virginia).

³¹ Recent civil rights protections might now prohibit such discrimination based on gender identity or sexual orientation. See Susan Donaldson James, *Trans Man Denied Cancer Treatment; Now Feds Say It’s Illegal*, ABC NEWS (Aug. 7, 2012, 2:24 PM), <https://abcnews.go.com/Health/transgender-bias-now-banned-federal-law/story?id=16949817> [<https://perma.cc/7D39-2J5F>]; cf. Abby Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents and There’s Nothing Illegal About It*, WASH. POST (Feb. 19, 2015, 4:36 PM), <https://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it> [<https://perma.cc/UGH7-8UPL>].

Conscientious refusers needn't invoke religion.³² Federal and state laws insulate harmful denials of care on any moral ground, secular too.³³ Unwilling clinicians might object that preventing pregnancy isn't compatible with a vision of medicine that's limited to treating illness.³⁴ Or that restoring sexual minorities back to health would endorse a way of living that they see as wrong but not sinful.³⁵ These reasons for declining to intervene don't have to be spiritual. Nor do claimants have to refer patients elsewhere or even tell them about their medical options.³⁶ Almost every state still shelters their withholding.

For all the solicitude afforded conscientious refusers, there's next to none for conscientious providers. In 2012, Professor Elizabeth Sepper observed that conscience exemptions from workplace policies are limited to the denial of care that institutions require; there's rarely any such accommodation for the delivery of care that employers forbid.³⁷ The decade since her trenchant study has seen vastly greater restrictions on whom clinicians can treat and how: imposed by either the state or entity where they work.³⁸

³² As they might against government intrusions under the First Amendment or Religious Freedom Restoration Act (RFRA). See, e.g., *Franciscan All., Inc. v. Becerra*, No. 21-11174, 2022 WL 3700044, at *1-3 (5th Cir. Aug. 26, 2022) (holding that RFRA bars the Department of Health and Human Services from interpreting the Affordable Care Act's ban on sex discrimination to make a Catholic hospital perform abortions or gender-reassignment surgeries at odds with its religious mission).

³³ See Kent Greenawalt, *Objections in Conscience to Medical Procedures: Does Religion Make a Difference?*, 2006 U. ILL. L. REV. 799, 824.

³⁴ See FARR CURLIN & CHRISTOPHER TOLLEFSEN, *THE WAY OF MEDICINE* 186 (2021).

³⁵ See Douglas NeJaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2575-78 (2015).

³⁶ See Nadia N. Sawicki, *The Conscience Defense to Malpractice*, 108 CALIF. L. REV. 1255, 1276 (2020).

³⁷ See Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1512 (2012). It was Sepper who exposed the imbalance of a regime that protects clinicians who invoke conscience to deny care but not conscientious clinicians who would deliver care. See *id.* at 1509-13. That's not all. She unraveled the presumption that conscientious refusal always deserves greater protection. See *id.* at 1536-38. And she developed a novel remedy: protect conscientious providers of abortion, birth control, and end-of-life care from being fired or demoted in the ways that conscientious refusers are protected from discrimination on the job. *Id.* at 1532-35. Sepper set the terms of the debate that this Article seeks to build on in a few ways. It interrogates not just employer policies but also legislative restrictions, more than a dozen at the federal and state level; it introduces an affirmative defense that would partially excuse the provision of clinically reasonable services that government forbids; and it advances objector fees, disclosure mandates, and distancing measures to offset the costs of accommodating refusers and providers alike. These inquiries have been enriched by Sepper's searching examinations of religious liberty and health law.

³⁸ There's no reliable safe harbor even when that procedure is the only way to save a patient's life. See *infra* notes 497-515 and accompanying text. One pregnant woman was hemorrhaging badly, having developed a 106-degree fever, her fetus beyond rescue. See Sepper, *supra* note 37, at 1502-03. The ethics committee at her sectarian hospital forbade an abortion because a heartbeat could be detected. See Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774, 1777 (2008). The attending doctor recalled: "Her bleeding was so bad that the sclera, the white of her eyes, were red,

Dr. Barbara Morris specialized in elder care for over forty years, most recently at Centura Health in Colorado.³⁹ In 2019, the Christian hospital fired her for seeking to help a patient end his own life after incurable Stage 4 cancer had reduced the man's body to a skeleton shrouded in painful lesions.⁴⁰ Colorado is one of ten states to allow assisted suicide under limited circumstances.⁴¹ But Centura forbids aid-in-dying as incompatible with its mission to promote "the sacredness of every human life."⁴² When Morris sought a court order to help her patient hasten his death, the hospital fired her for "encourag[ing] a morally unacceptable option."⁴³ Morris loved her job but felt she had no choice: "To be forced to abandon patients has just been intolerable for me."⁴⁴

It's not only at the beginning and end of life that clinicians claim conscience to supply prohibited care. Twenty-six states strictly limit opioids, including for excruciating pain that nothing else can ease.⁴⁵ Doctors are threatened with professional and legal sanctions for prescribing higher doses, even to people who have taken them safely for years.⁴⁶ Palliative medicine specialist Charles von Gunten can't stand to risk pushing someone in agony to black-market heroin or even suicide because of a policy that tells doctors it's "[b]etter to let the patient suffer than be suspected of causing a rise in the number of addicts."⁴⁷

filled with blood. . . . I said, 'I just can't do this.'" *Id.* The physician ultimately severed the umbilical cord when no one was looking, causing the heartbeat to stop so the ethics committee would allow the abortion to save the patient's life. *Id.* The episode led him to quit. *Id.*

³⁹ "It's a Slap of Reality": *Terminally Ill Man at Center of Aid-in-Dying Battle*, CBS COLO. (Sept. 6, 2019, 11:59 PM) [hereinafter "It's a Slap of Reality"], <https://denver.cbslocal.com/2019/09/06/neil-mahoney-aid-dying-centura-barbara-morris> [<https://perma.cc/JD49-85SA>].

⁴⁰ See JoNel Aleccia, *Terminally Ill, A Colorado Man Wanted Aid-In-Dying. His Catholic Hospital Said No.*, KAISER HEALTH NEWS (Jan. 29, 2020, 5:06 PM), <https://khn.org/news/when-aid-in-dying-is-legal-but-the-medicine-is-out-of-reach> [<https://perma.cc/Q3P6-PMJJ>].

⁴¹ COLO. REV. STAT. §§ 25-48-101 to -123 (2016); *Physician-Assisted Suicide Fast Facts*, CNN (May 26, 2022, 11:40 AM), <https://www.cnn.com/2014/11/26/us/physician-assisted-suicide-fast-facts> [<https://perma.cc/RQ5E-7U6M>].

⁴² "It's a Slap of Reality," *supra* note 39.

⁴³ *Id.*

⁴⁴ Colleen Slevin, *Firing of Doctor Sets Off Fight over Assisted Suicide Law*, ASSOCIATED PRESS (Sept. 4, 2019), <https://apnews.com/article/fb940964985343d1ba44dd19944ea7ff> [<https://perma.cc/46QR-2KAN>]. It's easy to think doctors like Morris should just seek out work where they'll be allowed to follow their conscience. But in certain parts of the country, religious institutions so dominate the healthcare market that other employers are in short supply. See *infra* notes 311–12 and accompanying text. Besides, the rejoinder that conscientious providers should just work someplace else can be put with equal force to refusers. See Sepper, *supra* note 37, at 1535.

⁴⁵ See Corey S. Davis et al., *Laws Limiting the Prescribing or Dispensing of Opioids for Acute Pain in the United States: A National Systematic Legal Review*, DRUG & ALCOHOL DEPENDENCE, 2019, at 166, 167.

⁴⁶ See Kelly K. Dineen & James M. DuBois, *Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?*, 42 AM. J.L. & MED. 7, 24–25, 35 (2016).

⁴⁷ Charles F. von Gunten, Editorial, *The Pendulum Swings for Opioid Prescribing*, 19 J. PALLIATIVE MED. 348, 348 (2016); see Sarah E. Wakeman & Michael L. Barnett, *Primary Care and the Opioid-Overdose Crisis: Buprenorphine Myths and Realities*, 397 NEW ENG. J. MED. 1, 3–4 (2018).

Another example: several states have criminalized puberty blockers to affirm a minor's gender identity.⁴⁸ One pediatrician said that "practic[ing] in the best interests of the patient" now risks "my medical license, my employment, or even my freedom."⁴⁹ For doctors like Daphna Stroumsa, gender-affirming care is "a matter of conscience[.] I am *called* to do this work."⁵⁰ Other conscientious providers defy limits on prescribing marijuana, psychedelics, and ivermectin; or they resist restrictions on procedures like shock therapy, ritual genital cutting, and paid-for organ transplants.⁵¹

Such contested interventions bear crucial differences. Some are legal, others not. Some are safer than others. Some require costly facilities or staff; others just a prescription pad. Some fall within the medical norm, while others push its boundaries. These particulars matter.⁵² But the conviction to take people in can be as noble as the reasons to turn them away. Also, conscientious providers honor their patients' wishes that conscientious refusers override. Shielding denials of care, while punishing its delivery without exception, isn't just unprincipled. This radical asymmetry is pernicious too: it selectively burdens providers and drives patients underground.⁵³

America's medical conscience regime is broken. This Article sets out to fix it. Part I spells out the meaning, significance, and history of conscience in United States healthcare. Part II charts the modern landscape of conscientious provision across more than a dozen restricted practices that clinicians invoke moral convictions to supply.⁵⁴ Part III appraises the three strongest moral justifications for why our legal system comes down hard on anyone who conscientiously delivers these contested forms of care at the same time that it so zealously protects the person who conscientiously denies them. One reason is that forcing doctors to perform a procedure they oppose is worse than preventing them from

⁴⁸ See, e.g., Press Release, Off. of the Att'y Gen., State of Ala., Attorney General Steve Marshall Announces Plaintiffs' Dismissal of Their Lawsuits Challenging Alabama's Vulnerable Child Compassion and Protection Act (Apr. 16, 2022), <https://www.alabamaag.gov/newsviewer/eco5fcod-1692-4072-a919-3ea45636eaa1> [<https://perma.cc/6ZVJ-D5Q3>]; Letter from Greg Abbott, Governor of Tex., to Jaime Masters, Comm'r, Tex. Dep't of Fam. & Protective Servs. (Feb. 22, 2022), <https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf> [<https://perma.cc/NFE7-CGAE>].

⁴⁹ Landon D. Hughes et al., "These Laws Will Be Devastating": Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents, 69 J. ADOLESCENT HEALTH 976, 979 (2021).

⁵⁰ Holly Fernandez Lynch & Ronit Y. Stahl, Opinion, *Protecting Conscientious Providers of Health Care*, N.Y. TIMES (Jan. 26, 2018), <https://www.nytimes.com/2018/01/26/opinion/protecting-conscientious-providers-of-health-care.html> [<https://perma.cc/RSU8-B2DN>].

⁵¹ See *infra* Part II, pp. 1052–63.

⁵² Especially what's clinically reasonable. See *infra* notes 388–93 and accompanying text.

⁵³ See *infra* section IV.B.2.b, pp. 1090–94.

⁵⁴ Fifteen examples appear in the text, including multiple under the headings for IUDs, Plan B, IVF, and conversion therapy. Several additional contested practices are discussed below the line. See *infra* notes 175, 221, 235, 457 and accompanying text.

undertaking one their scruples compel them to. Then there's the idea that entitling clinicians to decline care costs their employers or states less than having to equip those third parties with the resources they would need to furnish it. And finally, exempting refusers needn't prevent the people they turn away from accessing permitted treatment elsewhere, whereas exempting providers does defeat whatever interest an institution or government has in banning it. This Part finds these rationales insufficient to save the striking imbalance that distinguishes U.S. conscience protections from the rest of the developed world. Two points stand out: the ethical obligations that doctors owe their patients and the practical harms that blanket release from those duties can foist on people who need care and the places they go to get it.

Part IV seeks to dislodge the refusal/provision divide that governs conscience clauses in American medicine. A principled commitment to pluralism would condition exemptions from employer policies on whether treatment is available elsewhere, and offset the costs of accommodation through disclosure mandates, objector fees, and institutional distancing. The upshot: level down the near-absolute protections for conscientious refusers, while leveling up protections for conscientious providers that are virtually absent. As for government restrictions and carve-outs, states must stop insulating malpractice and abandonment. Meanwhile, a limited defense should partially excuse the conscientious supply of prohibited services that are consented to and clinically reasonable. Making this measure of space for dissent from the medical profession and society at large would go a ways toward repairing the frayed relationship between the practice of medicine and the rule of law.

I. RECLAIMING CONSCIENCE

Freedom of conscience is having a heyday in U.S. politics and law.⁵⁵ That ideal resonates with doctors and nurses whose work confronts them with dilemmas that pit professional obligations against personal ones or place patient and state interests at odds.⁵⁶ Some practitioners navigate these conflicts under the mantle of conscience.⁵⁷

⁵⁵ The Supreme Court hasn't weighed in on conscience accommodations in healthcare specifically. But the Court has increasingly granted religious-liberty exemptions in contexts that range from pandemic limits on worship attendance to insurance requirements for contraception coverage. See *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 66 (2020); *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367, 2373 (2020). For discussion, see Lee Epstein & Eric A. Posner, *The Roberts Court and the Transformation of Constitutional Protections for Religion: A Statistical Portrait*, 2021 SUP. CT. REV. 315, 315–16 (2022).

⁵⁶ See Sean Murphy & Stephen J. Genuis, *Freedom of Conscience in Health Care: Distinctions and Limits*, 10 J. BIOETHICAL INQUIRY 347, 348 (2013).

⁵⁷ See Mark R. Wicclair, *Conscientious Objection in Medicine*, 14 BIOETHICS 205, 217 (2000).

This concept carries baggage too.⁵⁸ Many Americans are convinced that the culture wars have reduced conscience to little more than a card that one side plays when it loses on anything from marriage rights to contraception-coverage mandates.⁵⁹ Rather than accept democratic defeats at the ballot box or in the courthouse, parties don the cloak of conscience to relitigate those disputes, this time as a marginalized minority.⁶⁰ On this view, conscience is a just cover, a convenient tool to exploit. These conscience skeptics see a similar social agenda reflected in refusals to provide reproductive medicine.⁶¹ Physicians who won't prescribe Plan B and pharmacists who won't dispense it are no different from conservative-backed pastry chefs who won't serve gay customers seeking to celebrate their wedding.⁶² They're all just "scoring political points."⁶³

But conscience is more than just politics in disguise.⁶⁴ It can also reflect the heartfelt convictions that someone feels compelled to live by. Taking conscience seriously treats appeals to it as "genuine and not pretextual" and assumes that conscience clauses really are about vindicating people's moral values.⁶⁵ Which isn't to say that conscience operates the same in every context or that all claims are created equal. Invoking conscience in the practice of healthcare raises the stakes and implicates distinct norms. Doctors are not bakers. Clinical treatment is not culinary art. Abortions are not cakes.

Medicine isn't a service industry but a social good that's held in the public trust for people in need of specialized care. Licensing laws give certified clinicians exclusive control over almost all scans and pills, shots and surgeries.⁶⁶ In turn, a complex system of disciplinary sanctions enforces regulations designed to respect patients as individuals and to

⁵⁸ See ANDREW R. LEWIS, *THE RIGHTS TURN IN CONSERVATIVE CHRISTIAN POLITICS* 92–97 (2017).

⁵⁹ See *Masterpiece Cakeshop, Ltd. v. Colo. C.R. Comm'n*, 138 S. Ct. 1719, 1729 (2018); *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 691 (2014).

⁶⁰ Professors Douglas NeJaime and Reva Siegel show how some claimants shift from "speaking as a majority" to "speaking as a minority." NeJaime & Siegel, *supra* note 35, at 2561.

⁶¹ See Adam Sonfield, *In Bad Faith: How Conservatives Are Weaponizing "Religious Liberty" to Allow Institutions to Discriminate*, 21 GUTTMACHER POL'Y REV. 23 (2018); see also T.S. Mendola, *Why Pregnant People Can't Trust Catholic Health Care*, REWIRE NEWS GRP. (Sept. 27, 2022, 9:05 AM), <https://rewirenewsgroup.com/2022/09/27/why-pregnant-people-cant-trust-the-catholic-health-care> [<https://perma.cc/VK5W-GRQP>].

⁶² See *Masterpiece Cakeshop*, 138 S. Ct. at 1724.

⁶³ Dennis Thompson, *Most Say Health Workers Shouldn't Refuse Care on Moral Grounds: Poll*, HEALTHDAY (May 28, 2022), <https://consumer.healthday.com/public-health-information-30/health-care-access-and-disparities-news-752/most-say-health-workers-shouldn-t-refuse-care-on-moral-grounds-poll-730894.html> [<https://perma.cc/3SX9-7AG3>] (quoting Dr. Robert Truog).

⁶⁴ See NeJaime & Siegel, *supra* note 35, at 2553, 2589.

⁶⁵ See Sepper, *supra* note 37, at 1505 & n.12.

⁶⁶ See JAMES G. BURROW, *ORGANIZED MEDICINE IN THE PROGRESSIVE ERA* 58–60 (1977); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 102 (1982).

balance the risks and benefits that various courses of treatment would pose for their health and well-being.⁶⁷

Standards set forth by the medical establishment have traditionally lined up with legal duties that share similar goals. So complying with clinical requirements doesn't just make you a member in good standing. It also insulates you against fines, jail time, and suspended licenses.⁶⁸ But some states today make demands on physicians that diverge from what their profession expects of them.⁶⁹ That distance between legal and medical rules risks landing doctors in court, even prison, for putting their patients first. These are the laws that more and more providers are taking a stand against today.⁷⁰ Some are just trying to do their jobs. Others resist in the name of conscience.

A. *What It Is*

Conscience consists of deeply held moral beliefs, the kind that center individuals to the commitments they cherish most.⁷¹ What makes these beliefs *moral* is how they bear on ways of being or doing that aren't just useful or inconvenient, but right or wrong.⁷² Conscience can move people who subscribe to distinct values in different directions: the Supreme Court has recognized that abortion "inspires" "deep and seemingly absolute convictions" in those who hold "vigorous opposing views"⁷³ about matters from a woman's "place in society" to "spiritual imperatives" about when life begins.⁷⁴ The Court advises taking claimants mostly at

⁶⁷ See, e.g., Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 223 (3d Cir. 2000).

⁶⁸ See Nadia N. Sawicki, *Ethical Malpractice*, 59 HOUS. L. REV. 1069, 1098 n.129 (2022).

⁶⁹ See, e.g., *infra* sections II.A.1–2, pp. 1053–54.

⁷⁰ See, e.g., examples discussed *infra* Part II, pp. 1052–63.

⁷¹ The notion of conscience is reserved for thinking, feeling beings who can exercise moral judgment in particular contexts. This makes *institutional* conscience a stretch: even if a hospital helps members to express *their* collective values, this doesn't imbue the entity with a conscience of its own. See Sepper, *supra* note 37, at 1544. Nevertheless, healthcare institutions still have similar and important interests in free association based on their founding principles and shared values. The strength of these interests depends on factors like institutional size, cohesiveness, and mission. See *infra* notes 342–45 and accompanying text. For thoughtful defenses of institutional conscience, see Elliott Louis Bedford, *The Reality of Institutional Conscience*, 16 NAT'L CATH. BIOETHICS Q. 255, 262–64 (2016); Kevin Wm. Wildes, *Institutional Identity, Integrity, and Conscience*, 7 KENNEDY INST. ETHICS J. 413, 416–17 (1997).

⁷² The kind of nonmoral objections that don't count for purposes of conscience include, for example, pragmatic considerations about money or convenience. See Doug McConnell & Robert F. Card, *Public Reason in Justifications of Conscientious Objection in Health Care*, 33 BIOETHICS 625, 625 (2019).

⁷³ *Roe v. Wade*, 410 U.S. 113, 116 (1973), *overruled by* *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022).

⁷⁴ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 852 (1992), *overruled by* *Dobbs*, 142 S. Ct. 2228.

their word.⁷⁵ But that doesn't make conscience hopelessly subjective or impervious to judicial scrutiny that can weed out animus or bad faith.⁷⁶

Conscience is usually anchored to a source of ethical wisdom that's bigger than oneself and independent of what an individual believes.⁷⁷ An objective account of conscience traces these beliefs to an affiliation or ideology that sets forth what it means to do good or to live well.⁷⁸ Religion is a classic wellspring of such beliefs, but secular sources of moral authority qualify too.⁷⁹ A conscientious refuser might object to abortion because of a Catholic teaching that life is sacred at conception, or based on a Kantian imperative not to treat unborn humans as a mere means to others' ends.⁸⁰ Conscientious providers also invoke conscience in both religious and secular terms: as either a spiritual "calling" to pursue "salvation" by supplying abortion healthcare to people in need,⁸¹ or an egalitarian concern for the equal dignity of persons.⁸²

⁷⁵ When it comes to the kind of religious belief that an individual might invoke in the First Amendment context, the Supreme Court has said that it's qualified to assess only whether someone does in fact believe it, and not whether the belief itself is reasonable: "dissect[ing]" a belief's validity does "not [lie] within the judicial function [or] competence." *Thomas v. Rev. Bd. of the Ind. Emp. Sec. Div.*, 450 U.S. 707, 715–16 (1981). For discussion, see generally Nathan S. Chapman, *Adjudicating Religious Sincerity*, 92 WASH. L. REV. 1185 (2017).

⁷⁶ The Court has speculated, again in the religion context, that some "asserted claim[s]" might be "so bizarre" as "not to be entitled to protection." *Thomas*, 450 U.S. at 715. Take the refuser who opposes access to abortion in cases of sexual assault based on the specious notion of "legitimate rape." See John Eligon & Michael Schwartz, *In Rapes, Candidate Says, Body Can Block Pregnancy*, N.Y. TIMES, Aug. 20, 2012, at A13. Others might wonder about conscience claimants who would have an abortion as a holy ritual in the name of Satan. *Complaint Seeking Declaratory and Injunctive Relief ¶ 46, Satanic Temple, Inc. v. Hellerstedt*, No. 21-CV-00387 (S.D. Tex. Feb. 5, 2021).

⁷⁷ See Steven D. Smith, *The Tenuous Case for Conscience*, 10 ROGER WILLIAMS U. L. REV. 325, 332 (2005).

⁷⁸ See *id.*

⁷⁹ Most conscience clauses extend protections to healthcare entities of all kinds, rather than applying exclusively, for example, to either private or public institutions or to just for-profit organizations as opposed to not-for-profit ones. See Sepper, *supra* note 37, at 1514.

⁸⁰ See Dov Fox, *Retracing Liberalism and Remaking Nature: Designer Children, Research Embryos, and Featherless Chickens*, 24 BIOETHICS 170, 172 (2010).

⁸¹ Rebecca J. Cook & Bernard M. Dickens, Opinion, *The Growing Abuse of Conscientious Objection*, 8 VIRTUAL MENTOR 337, 337 (2006). As one midwestern nurse puts it: "Here's this person . . . who needs help. Would my God that I believe in and worship want me to turn my back on her and just stand there and judge her instead of help her?" Mara Buchbinder & Raymond De Vries, *The Ought and Is of Conscience: The Value of Empirical Bioethics for Reframing Normative Analysis*, 11 AJOB EMPIRICAL BIOETHICS 27, 28 (2020). Dr. Cassing Hammond makes clear her moral conviction that "[t]here's no more spiritual component of my life than practicing medicine, and that includes providing safe abortions to those in need." Lauren Barbato, *Faithful Providers*, CONSCIENCE MAG. (Dec. 12, 2019), <https://www.catholicsforchoice.org/resource-library/faithful-providers> [<https://perma.cc/87LQ-3ZY7>]. Ob-gyn Laura Gil is committed to terminating unwanted pregnancies because, she says, "to be a true Christian, I must support women who have abortions." *Id.*; see also Willie Parker, *Personal Jesus*, CONSCIENCE MAG. (Aug. 22, 2016), <https://www.catholicsforchoice.org/resource-library/personal-jesus-3> [<https://perma.cc/YJ9T-QNXB>] (describing doctor's religiously inspired conviction to provide abortion care).

⁸² Lisa H. Harris, *Recognizing Conscience in Abortion Provision*, 367 NEW ENG. J. MED. 981, 982 (2012); see also Sepper, *supra* note 37, at 1533–34.

The practice of medicine is another external source of moral wisdom. It aims chiefly to make patients better and keep them well.⁸³ Doctors and nurses carry out that overarching purpose in three ways. First, they heal patients by curing disease, repairing injury, and restoring functioning. They also promote patient health through interventions that include vaccinations, cancer screening, and prenatal checkups. Finally, they relieve the suffering that can accompany terrible pain and dying.⁸⁴

These patient-centered aspirations are contested around the edges amid disagreements about the meaning of health and what counts as care.⁸⁵ What's clear is that tending to the sick and vulnerable is a deeply normative enterprise. The evidence-based weighing of benefits and risks operates as the North Star for affirmative appeals to clinician conscience: not the pursuit of profit, attention, or any other motive that's not about what's in the patient's interest. This commitment to patient welfare is as real an expression of conscience as any.⁸⁶

B. *Why It Matters*

There are two reasons to accommodate invocations of conscience in the practice of medicine. The first is for the person who claims it: to respect her agency or preserve her integrity as someone who's deeply committed to core values.⁸⁷ Violating those values can take a psychological toll that alienates a clinician from what she stands for and consumes her with the sense that she can't forgive herself.⁸⁸ This moral

⁸³ Debates endure about whether patient interests extend beyond the absence of infirmity and about which interventions accordingly qualify as medical: cosmetic surgery, genetic counseling, IVF, sex selection, hospice care, autopsies, state-ordered executions, forensic psychiatric evaluations, and growth hormone for healthy short stature are all practices whose clinical status is contested. See Tom L. Beauchamp, *Internal and External Standards for Medical Morality*, 26 J. MED. & PHIL. 601, 603 (2001); Dov Fox, *Safety, Efficacy, and Authenticity: The Gap Between Ethics and Law in FDA Decisionmaking*, 2005 MICH. STATE L. REV. 1135, 1137–38.

⁸⁴ Some argue that medicine has one fixed objective: to treat disease and disability, and nothing else. See Edmund D. Pellegrino, *The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions*, 26 J. MED. & PHIL. 559, 569 (2001). A more persuasive view sees the end of medicine as unfolding dynamically in creative tension with transformations in culture and technology. See Franklin G. Miller & Howard Brody, *The Internal Morality of Medicine: An Evolutionary Perspective*, 26 J. MED. & PHIL. 581, 586–87 (2001).

⁸⁵ See O. CARTER SNEAD, *WHAT IT MEANS TO BE HUMAN* 2 (2020).

⁸⁶ See Dov Fox, *Medical Disobedience and the Conscientious Provision of Prohibited Care*, AM. J. BIOETHICS, Aug. 2021, at 72, 73.

⁸⁷ See, e.g., CÉCILE LABORDE, *LIBERALISM'S RELIGION* 66 (2017); CAROLYN MCLEOD, *CONSCIENCE IN REPRODUCTIVE HEALTH CARE* 19 (2020); Daniel P. Sulmasy, *What Is Conscience and Why Is Respect for It So Important?*, 29 THEORETICAL MED. & BIOETHICS 135, 138 (2008); Mark R. Wicclair, *Conscientious Objection in Healthcare and Moral Integrity*, 26 CAMBRIDGE Q. HEALTHCARE ETHICS 7, 8–9 (2017).

⁸⁸ See, e.g., Whitney Arey et al., *A Preview of the Dangerous Future of Abortion Bans — Texas Senate Bill 8*, 387 NEW ENG. J. MED. 388, 390 (2022); Sophia Fantus, *Social Work Perspective: Moral Distress*, in *MORAL DISTRESS IN THE HEALTH PROFESSIONS* 33, 33 (Connie M. Ulrich & Christine Grady eds., 2018).

vertigo is bad in itself, and it can burn a specialist out, pushing her to move states, change fields, or quit healthcare.⁸⁹

Protecting conscience for the sake of claimants evokes the Jewish medic who sought exemption from uniform regulations to wear a yarmulke in the Air Force⁹⁰ or the Tuskegee whistleblower who exposed the federal government's withholding of penicillin from poor Black men with syphilis.⁹¹ Following rules or obeying orders struck at these healers' identities as people of faith who honor human dignity and care for the sick and vulnerable.⁹²

This individualistic account captures the stakes in restrictions on religious dress or unjust abuses of power, when vindicating conscience wouldn't impose meaningful costs on third parties whose interests matter.⁹³ But a doctor's claim to live up to her own moral code can't justify unconditional license to hurt patients.⁹⁴

A more expansive rationale for freedom of conscience reaches beyond any one person to the larger spirit of openness to dissent that sustains a diverse society and dynamic profession.⁹⁵ Both democracy and medicine reflect evolving norms and differences of opinion about what's

⁸⁹ See Michele LeClaire et al., *Compromised Integrity, Burnout, and Intent to Leave the Job in Critical Care Nurses and Physicians*, CRITICAL CARE EXPLS., Feb. 2022, at 1, 6; see also Laura Kusisto, *Doctors Struggle with Navigating Abortion Bans in Medical Emergencies*, WALL ST. J. (Oct. 13, 2022, 2:03 PM), <https://www.wsj.com/articles/doctors-struggle-with-navigating-abortion-bans-in-medical-emergencies-11665684225> [<https://perma.cc/AQ9G-HLVS>] (discussing Dr. Leilah Zahedi-Spung's plans to leave Tennessee for Colorado to practice high-risk obstetrics where abortion is legal).

⁹⁰ See *Goldman v. Weinberger*, 475 U.S. 503, 506 (1986).

⁹¹ See Carl Elliott, *Tuskegee Truth Teller*, AM. SCHOLAR, Winter 2018, at 44, 44–45; see also Dov Fox, *Subversive Science*, 124 PENN STATE L. REV. 153, 156 n.9 (2019) (discussing the Tuskegee study and other ethically dubious experiments).

⁹² Consider too a hypothetical doctor who defies her state's mandate to mislead pregnant patients; she refuses to tell them that abortion causes suicide or breast cancer. Cf. Mara Buchbinder et al., *Reframing Conscientious Care: Providing Abortion Care When Law and Conscience Collide*, HASTINGS CTR. REP., Mar.–Apr. 2016, at 22, 26.

⁹³ There were also the Dutch physicians who defied Nazi commands to euthanize sick patients. See Leo Alexander, *Medical Science Under Dictatorship*, 241 NEW ENG. J. MED. 39, 45 (1949). They certainly acted from conscience too. But their resistance doesn't support special exemptions from a just social order so much as wholesale revolution against an abjectly unjust one.

⁹⁴ The threat of third-party harm was lower in the Supreme Court's midcentury religion cases, involving claims by unpopular or insular minorities like the Jehovah's Witnesses, Seventh-day Adventists, or Amish. See, e.g., *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943); *Sherbert v. Verner*, 374 U.S. 398 (1963); *Wisconsin v. Yoder*, 406 U.S. 205 (1972). The Court exempted these claimants sparingly “out of a liberal respect for the integrity of personality or . . . a healthy appreciation of the unholy capacity of religious convictions to undermine civil peace.” Robert Post, *The Politics of Religion: Democracy and the Conscience Wars*, in *THE CONSCIENCE WARS* 473, 484 (Susanna Mancini & Michel Rosenfeld eds., 2018). While the religious exemptions of yesteryear had little impact on democratic processes or third parties, more claimants today come from groups with greater numbers, enjoy more political clout, and may seek exemptions to “disable” the rules or entitlements that they unsuccessfully “opposed in politics.” *Id.* at 483.

⁹⁵ See, e.g., Abner S. Greene, *Religious Freedom and (Other) Civil Liberties: Is There a Middle Ground?*, 9 HARV. L. & POL'Y REV. 161, 164 (2015); Daniel P. Sulmasy, *Conscience, Tolerance, and Pluralism in Health Care*, 40 THEORETICAL MED. & BIOETHICS 507, 520 (2019).

right and good.⁹⁶ Carving out space for reasonable expressions of conscience — neither invidious nor arbitrary — could preserve those objections as a repository for potentially worthy reforms in the future.⁹⁷

This release valve isn't for catering to nasty prejudice or stubborn idiosyncrasy: whether for the sake of toleration itself, or even to avoid civil violence. The point of making room for a multiplicity of values is to facilitate peaceful coexistence on terms that are equal and reasoned. This pluralism argument says that accommodating conscience holds the potential to equip heterogeneous institutions to navigate divisive controversies and adapt to change from within.

But that promise is frustrated if exemptions are deployed to delay or deny valued services, even those secured by constitutional rights or statutory guarantees.⁹⁸ As Professors Douglas NeJaime and Reva Siegel lay bare, it is a cramped vision of pluralism that respects only those who object to being made complicit in a practice that they perceive as sinful or wrong.⁹⁹ An inclusive system also shows concern for patients who think differently: their beliefs and interests matter too.¹⁰⁰ Because licensed professionals keep the gates of medicine, letting too many refuse care at will could withhold the blessings that clinical science bestows.¹⁰¹ A genuinely pluralistic regime must mediate the harms that accommodating such claims can visit on third parties, especially patients.¹⁰²

C. *How It's Protected*

Courts are rightly reluctant to release people from the rules that everyone else has to follow just because their own objections sound in the register of conscience. Indiscriminate exemptions risk resentment: why should I have to follow a rule that others don't? Or even anarchy, if exceptions swallow the rule. So in most spheres of life, conscientious objectors are expected to comply with regulations that apply generally.¹⁰³ Those who disobey out of conscience must still face the

⁹⁶ See Eric J. Kim & Kyle Ferguson, *Conscientious Objections, the Nature of Medicine, and the Need for Reformability*, 36 *BIOETHICS* 63, 68 (2022).

⁹⁷ See *id.* at 65–66; HOLLY FERNANDEZ LYNCH, *CONFLICTS OF CONSCIENCE IN HEALTH CARE* 86 (2008).

⁹⁸ See NeJaime & Siegel, *supra* note 35, at 2526–29.

⁹⁹ See *id.* at 2590. For an example of a religious entity objecting to being made complicit in sin, see Brief for Respondents at 3, *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014) (No. 13-354) (claiming that covering insured workers' contraception would "risk killing an embryo" and thereby make the crafts store "complicit in the practice of abortion").

¹⁰⁰ See Micah Schwartzman, Nelson Tebbe & Richard Schragger, *The Costs of Conscience*, 106 *KY. L.J.* 781, 785 (2018) ("Citizens who bear costs so that others may observe their faith can rightfully complain that their liberty of conscience has been implicated.").

¹⁰¹ See, e.g., *Braidwood Mgmt., Inc. v. Becerra*, No. 20-cv-00283, 2022 WL 4091215, at *19 (N.D. Tex. Sept. 7, 2022) (holding that employer could deny federally mandated coverage for drugs to prevent HIV transmission on the ground that being forced to buy that insurance would "substantially burden" its Christian faith, which condemns "homosexual behavior," *id.* at *18).

¹⁰² See *infra* notes 301–04 and accompanying text.

¹⁰³ See JOHN RAWLS, *A THEORY OF JUSTICE* 320–24 (1971).

consequences and resign themselves to redouble any ambitions for larger reforms through democratic channels like protest and lobbying.¹⁰⁴

In just two contexts do secular appeals to conscience stand a stronger chance of accommodation under the law.¹⁰⁵ One involves the pacifist who gets drafted in wartime.¹⁰⁶ Conscientious exemption from military service is a privilege that's conditioned on sharing in other forms of civic sacrifice. Objectors must still prepare meals or dress wounds for soldiers on the battlefield, or else contribute in comparable ways on the civilian side: for example, to national conservation or elder care, and for at least as long as they would have served in the armed forces.¹⁰⁷ These consequences offset the moral and practical costs that accommodation imposes on others.

The other setting in which Americans can count on having their appeals to conscience reliably vindicated is the clinical refusal of healthcare that patients want.¹⁰⁸ Members of no other profession are entitled to invoke conscience and be excused from exercising the usual skill, judgment, or conduct expected from someone trained to do that job well.¹⁰⁹ What could justify this sort of medical exceptionalism? Do doctors, nurses, and therapists face moral choices so much harder than lawyers, accountants, and teachers do? Why single out clinicians for conscientious exemptions that no one else gets? One answer is a resemblance that this line of work sometimes shares with combat: medicine too can demand life-and-death decisions that evoke particularly intense convictions.

But unlike the peace lover who's called to fight, the clinician who opposes emergency contraception or aid-in-dying isn't conscripted into service against his will. Physicians and pharmacists choose a vocation that expects them to undertake certain practices — albeit against the background of far-reaching exceptions that unwilling clinicians might rely on when they enter the profession.¹¹⁰ Conscience carve-outs are codified in a handful of federal statutes and the clauses of almost every

¹⁰⁴ Not all claimants seek to issue a rallying cry or mobilize others to their cause. Maybe they lack the resources or temperament to marshal such support, or think it's counterproductive or futile to try to change hearts and minds. These individuals aren't trying to effect social change. They appeal to conscience only to distance themselves from what they see as wicked or corrupt. See KIMBERLEY BROWNLEE, *CONSCIENCE AND CONVICTION* 104–07 (2012).

¹⁰⁵ Cf. *Cath. Health Care Sys. v. Burwell*, 796 F.3d 207, 220 (2d Cir. 2015) (recognizing “statutory and regulatory schemes” distinctive to “the military draft and medical conscience clauses”).

¹⁰⁶ Nadia N. Sawicki, *The Hollow Promise of Freedom of Conscience*, 33 CARDOZO L. REV. 1389, 1416–17 (2012).

¹⁰⁷ See, e.g., MULFORD Q. SIBLEY & PHILIP E. JACOB, *CONSCRIPTION OF CONSCIENCE* 124–27 (1952).

¹⁰⁸ See James F. Childress, *Civil Disobedience, Conscientious Objection, and Evasive Noncompliance: A Framework for the Analysis and Assessment of Illegal Actions in Health Care*, 10 J. MED. & PHIL. 63, 65 (1985).

¹⁰⁹ See Sawicki, *supra* note 106, at 1409–27.

¹¹⁰ See LYNCH, *supra* note 97, at 54.

state that insulate refusers who violate institutional policies and even laws against civil malpractice or criminal abandonment.¹¹¹

Crucially, clinicians who invoke conscience to withhold otherwise-expected services bear nothing like the burdens that military objectors do.¹¹² Many states protect conscientious medical refusers in all but unqualified terms, even when their harmful denial of standard treatment would ordinarily violate civil or criminal laws.¹¹³ By contrast, clinicians who claim conscience to provide prohibited care find no such shelter against being fired or disciplined, or any leniency in the face of fines or jail.¹¹⁴

It didn't get this way by accident. "[C]onscience talk" spread in the 1960s and early 1970s "from conflict over war to conflict over abortion."¹¹⁵ Within two years after the Supreme Court legalized abortion nationwide, more than half of states authorized doctors and hospitals to refuse patients seeking to prevent pregnancy or end it.¹¹⁶ The regime that emerged from *Roe's* shadow wasn't designed to vindicate conscience with a fair mind or an even hand.¹¹⁷ It was architected by a political movement to restrict access to practices like abortion and birth control that activists saw as threats to traditional family values and sexual morality.¹¹⁸ That movement's success in chipping away at those rights over the ensuing decades relied in part on bending the conscience

¹¹¹ See, e.g., 42 U.S.C. § 300a-7(c)(1); MISS. CODE ANN. §§ 41-107-5, -7 (2013); see also Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 289 (2010) (explaining that states' authority to regulate medicine is grounded in their unenumerated powers under the Tenth Amendment).

¹¹² See ROSAMOND RHODES, *THE TRUSTED DOCTOR: MEDICAL ETHICS & PROFESSIONALISM* 336-37 (2020).

¹¹³ See Sawicki, *supra* note 36, at 1272-73; James A. Sonne, *Firing Thoreau: Conscience and At-Will Employment*, 9 U. PA. J. LAB. & EMP. L. 235, 284 (2007). Some forbid states, healthcare employers, or medical boards from penalizing doctors, nurses, and others who conscientiously deny services like abortion, sterilization, contraception, and aid-in-dying. See Sepper, *supra* note 37, at 1511; Elizabeth Sepper, *Not Only the Doctor's Dilemma: The Complexity of Conscience in Medicine*, 4 FAULKNER L. REV. 385, 395-96 (2013). Others immunize individuals and institutions from civil, criminal, and professional liability, without requiring them to offset any burdens that their refusal places on access or even disclose their objection to patients. See *infra* notes 134-40 and accompanying text.

¹¹⁴ See Sepper, *supra* note 37, at 1512-13; *infra* notes 163-73 and accompanying text.

¹¹⁵ NeJaime & Siegel, *supra* note 35, at 2536 n.79.

¹¹⁶ See *A Review of State Abortion Laws Enacted Since January 1973*, 3 FAM. PLAN./POPULATION REP. 88, 90-92 (1974).

¹¹⁷ See Harriet F. Pilpel & Dorothy E. Patton, *Abortion, Conscience and the Constitution: An Examination of Federal Institutional Conscience Clauses*, 6 COLUM. HUM. RTS. L. REV. 279, 280 (1975). Religious leaders with conscientious bona fides actually opposed the very abortion bans that were championed by adherents within the social conservative movement. See GILLIAN FRANK, *MAKING CHOICE SACRED: LIBERAL RELIGION AND REPRODUCTIVE RIGHTS IN THE UNITED STATES, 1965-1980* (forthcoming) (on file with the Harvard Law School Library). For discussion, see *infra* notes 557-58.

¹¹⁸ See MELINDA COOPER, *FAMILY VALUES: BETWEEN NEOLIBERALISM AND THE NEW SOCIAL CONSERVATISM* 278 (2017); NeJaime & Siegel, *supra* note 35, at 2538-41. Some pro-life refusers claimed conscience before *Roe* as well. See Kathleen J. Frydl, *Taking Liberties with Religious Liberty*, WASH. MONTHLY, Jan.-Feb. 2016, at 21, 22.

clauses even more lopsided still in the direction of clinicians who turn patients away.¹¹⁹

1. *Refusal.* — Our legal system rarely forces clinicians to treat patients. Doctors and nurses can almost always deny medical care that they're qualified to provide. There are just two times they can't: if they seek to discriminate based on race, ethnicity, age, or disability;¹²⁰ or when a hospital emergency department receives patients in need of urgent care.¹²¹ Physicians are otherwise free to withhold any service that's not too exigent, or even one that *is*, if they don't work in an ER.¹²² They can also decline to treat patients for any reason that civil rights laws don't forbid.¹²³ Or to refer or counsel them, or to disclose that their objection is based on reasons that are more moral than medical.¹²⁴ Refusers get conscience without conditions or consequences.

Conspicuous protections for healthcare refusals arrived on the scene with the 1973 Church Amendment, named for Frank Church, the Democratic Senator from Idaho who introduced the bill in Congress.¹²⁵ Enacted by near consensus, that law gave clinicians a right to choose whether to participate in a sterilization or abortion — a right parallel to the one that *Roe* afforded patients to undertake those procedures.¹²⁶ The Church Amendment shields federally funded entities and their

¹¹⁹ Douglas NeJaime & Reva Siegel, *Conscience Wars in Transnational Perspective: Religious Liberty, Third-Party Harm, and Pluralism*, in *THE CONSCIENCE WARS*, *supra* note 94, at 187, 210–13.

¹²⁰ See, e.g., Civil Rights Act of 1871, 42 U.S.C. § 1983; Americans with Disabilities Act, 42 U.S.C. §§ 12101–12213; Rehabilitation Act of 1973, 29 U.S.C. §§ 701–796.

¹²¹ See Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd. Challenges to federal conscience regulations are pending on the ground that they conflict with EMTALA. See, e.g., *New York v. U.S. Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475, 509 (S.D.N.Y. 2019).

¹²² Forced medical provision is rarely alleged; the odd complaint usually comes in the emergency room context. See *Verified Complaint* at 2, 14–15, *Danquah v. Univ. of Med. & Dentistry of N.J.*, No. 11-cv-06377 (D.N.J. 2011); *Memorandum in Support of Motion for Preliminary Injunction*, *Cenzon-Decarlo v. Mount Sinai Hosp.*, No. 09-3120 (E.D.N.Y. 2010), 2010 WL 169485, *aff'd*, 626 F.3d 695 (2d Cir. 2010).

¹²³ See, e.g., Abram Brummett, *When Conscientious Objection Runs Amok: A Physician Refusing HIV Preventative to a Bisexual Patient*, 16 *CLINICAL ETHICS* 151, 151 (2021) (describing a doctor's conscientious objection to prescribing drugs to reduce the HIV risks from men having sex with men). Even in states that forbid discrimination based on sexual orientation, courts often hold that such protections yield to religious objections. See *HUMAN RTS. WATCH*, "ALL WE WANT IS EQUALITY": RELIGIOUS EXEMPTIONS AND DISCRIMINATION AGAINST LGBT PEOPLE IN THE UNITED STATES 13 (2018). For an exceptional case, see *North Coast Women's Care Medical Group, Inc. v. San Diego County Superior Court*, 189 P.3d 959, 962 (Cal. 2008).

¹²⁴ See Sawicki, *supra* note 36, at 1279–80.

¹²⁵ Health Programs Extension Act of 1973, Pub. L. No. 93-45, § 401, 87 Stat. 91, 95.

¹²⁶ See Sara Dubow, "A Constitutional Right Rendered Utterly Meaningless": *Religious Exemptions and Reproductive Politics, 1973–2014*, 27 *J. POL'Y HIST.* 1, 5 (2015).

workers from performing any abortion or sterilization at odds with their “religious beliefs or moral convictions.”¹²⁷

The biggest impact of that Amendment isn’t what it said, or what its provisions did, but the “conscience creep” that the federal law inspired. Most states in the years to follow passed their own safeguards that went much further and skewed sharply in a particular direction. In the wake of the Church Amendment, states entrenched the one-way conscience clauses that keep refusers alone from losing a job or medical license, even when denying care would predictably hurt patients.¹²⁸

These exemptions are all-encompassing. Some states accommodate conscientious refusals for services that range from emergency contraception and aid-in-dying to assisted reproduction and stem cell research.¹²⁹ The laws also excuse unwilling clinicians from a sweeping array of duties imposed by statutory law, common law, tort liability, state medical boards, and licensing regimes.¹³⁰ And they also protect nonpractitioners who don’t themselves treat patients or provide contested procedures hands-on: from admitting clerks and social workers to HMOs and insurance plans.¹³¹

Conscience clauses cover involvement that’s as indirect and attenuated as hospital admission, medical training, and claim reimbursements.¹³² Mississippi’s law allows claimants to refuse care in “any phase of patient medical care, treatment or procedure, including, but not limited to, the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health-care providers or health-care institutions.”¹³³

In thirty-three states today, conscience laws immunize a conscientious refuser from any civil penalties at all.¹³⁴ It doesn’t matter if that denial of care harms patients in serious ways that ordinarily constitute negligence, malpractice, or wrongful death, or if the failure to disclose a medically indicated alternative would otherwise breach informed

¹²⁷ 42 U.S.C. § 300a-7(b)(2)(A). Its ban on employment discrimination isn’t limited to conscientious refusal; it extends to conscientious provision as well. But this ostensible matching feature for providers has lain largely dormant. See *infra* notes 151–52 and accompanying text.

¹²⁸ See Nadia N. Sawicki, *Unilateral Burdens and Third-Party Harms: Abortion Conscience Laws as Policy Outliers*, 96 IND. L.J. 1221, 1222 (2021). The only exceptions are Colorado, D.C., Mississippi, Vermont, and New Hampshire. Sawicki, *supra* note 36, at 1311–12.

¹²⁹ See, e.g., LA. STAT. ANN. § 40:1061.20 (2015).

¹³⁰ See NeJaime & Siegel, *supra* note 35, at 2534.

¹³¹ See, e.g., Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 508(d), 118 Stat. 2809, 3163 (2004).

¹³² See, e.g., Balanced Budget Act of 1997, Pub. L. No. 105-33, § 1852(j)(3)(B), 111 Stat. 251, 295 (codified as amended at 42 U.S.C. § 1395w-22(j)(3)(B) (2012)).

¹³³ MISS. CODE ANN. § 41-107-3(a) (2019).

¹³⁴ See Sawicki, *supra* note 36, at 1286.

consent.¹³⁵ Professor Nadia Sawicki documents how state law still insulates conscientious refusers from liability or discipline.¹³⁶ Even the other seventeen states that do allow patients to bring civil suits keep a tight rein on tort recovery for any harms that result from the conscientious unwillingness to treat, limiting damages to emergency situations.¹³⁷

Sawicki's study also reveals that seven of those thirty-three states that shield refusers from civil liability go even further.¹³⁸ These seven states exempt conscientious refusers from criminal prosecution for what would typically constitute felonies like recklessly endangering patients or abandoning them, when violating practice standards during a critical stage of treatment puts them in peril.¹³⁹ The only time that conscientious refusers could be held accountable is when their failure to intervene demonstrably jeopardizes a patient's life.¹⁴⁰ For any other care that's needed to avoid grave risks or serious complications, the laws explicitly authorize them to deny it.

2. *Provision.* — Conscience doesn't receive any such deference when clinicians claim it to deliver care.¹⁴¹ Employers and states enjoy broad authority to enforce treatment bans over the objection of conscientious providers.¹⁴² The political economy of American healthcare has undergone a sea change of late: until the early 2010s, private practice was the norm, with a majority of physicians operating free of constraints on how they cared for patients.¹⁴³ They still had to abide by safety regulations, informed consent standards, and requirements to secure insurance coverage — but beyond that, clinicians were their own bosses.¹⁴⁴

Now most doctors and nurses answer to the entity where they work, whether as an employee or independent contractor. Driving this turn to big medicine is a historic consolidation of acquisitions, affiliations, and mergers with faith-based organizations.¹⁴⁵ These moves exempt even

¹³⁵ See *id.* at 1280.

¹³⁶ *Id.* at 1261.

¹³⁷ See *id.* at 1286.

¹³⁸ *Id.* at 1311–12.

¹³⁹ *Id.*

¹⁴⁰ See Lawrence Nelson, *Provider Conscientious Refusal of Abortion, Obstetrical Emergencies, and Criminal Homicide Law*, AM. J. BIOETHICS, July 2018, at 43, 43.

¹⁴¹ See Elizabeth Sepper, *Conscientious Refusals of Care*, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW 354, 368 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017).

¹⁴² See *id.*

¹⁴³ Travis Singleton & Philip Miller, *The Physician Employment Trend: What You Need to Know*, 22 FAM. PRAC. MGMT. 11, 11 (2015).

¹⁴⁴ See CAROL K. KANE, RECENT CHANGES IN PHYSICIAN PRACTICE ARRANGEMENTS 1 (2021), <https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf> [<https://perma.cc/CY3S-6TNT>].

¹⁴⁵ TESS SOLOMON ET AL., COMMUNITY CATALYST, BIGGER AND BIGGER: THE GROWTH OF CATHOLIC HEALTH SYSTEMS 3–4, 6 (2020), <https://www.communitycatalyst.org/resources/publications/document/2020-Cath-Hosp-Report-2020-31.pdf> [<https://perma.cc/F4JZ-FJDY>].

government hospitals from Establishment Clause rules governing the separation of church and state.¹⁴⁶ Religious directives now govern 235 trauma centers and 654 hospitals nationwide.¹⁴⁷ That comprises at least a third of the beds available for acute care in ten states.¹⁴⁸ The million or so clinicians who work at these facilities risk losing their jobs if they provide any medical service that's not "animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church."¹⁴⁹ Off limits is everything from vasectomies, tubal ligations, birth control, and emergency contraception to abortion, assisted reproduction, gender-affirming care, and aid-in-dying.¹⁵⁰

It's true that the Church Amendment includes some protection for providers too. It tells federally funded hospitals that they can't grant or deny staffing privileges on the ground that a clinician has "assisted in the performance of a lawful sterilization procedure or abortion" somewhere else.¹⁵¹ But there's no meaningful way to enforce that rule: courts have held that providers can't sue a hospital that discriminates against them in hiring or firing, interpreting the statute as leaving it up to Congress to withhold funds from an institution that's penalized someone for favoring abortion or sterilization.¹⁵²

And in 1980, the Supreme Court rebuffed both Free Exercise and Establishment Clause challenges that doctors and patients leveled against the Hyde Amendment's limits on abortion funding for people who can't afford the procedure and for whom forced pregnancy

¹⁴⁶ See *Hammons v. Univ. of Md. Med. Sys. Corp.*, 551 F. Supp. 3d 567, 584 (D. Md. 2021); *Saeemodarae v. Mercy Health Servs.*, 456 F. Supp. 2d 1021, 1040 (N.D. Iowa 2006). For discussion, see Elizabeth Sepper & James D. Nelson, *Government's Religious Hospitals*, 109 VA. L. REV. (forthcoming 2023).

¹⁴⁷ CATH. HEALTH ASS'N OF THE U.S., U.S. CATHOLIC HEALTH CARE (2022), <https://www.chausa.org/docs/default-source/default-document-library/the-strategic-profile.pdf> [https://perma.cc/S8RQ-CQ6Y].

¹⁴⁸ See Elizabeth Sepper, *Zombie Religious Institutions*, 112 NW. U. L. REV. 929, 935 (2018).

¹⁴⁹ U.S. CONF. OF CATH. BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATH. HEALTH SERVS. 8 (6th ed. 2018)

¹⁵⁰ See, e.g., Yuan Liu et al., "Am I Going to Be in Trouble for What I'm Doing?": Providing Contraceptive Care in Religious Health Systems, 51 PERSPS. ON SEXUAL AND REPROD. HEALTH 193, 193 (2019); Katie Hafner, *As Catholic Hospitals Expand, So Do Limits on Some Procedures*, N.Y. TIMES (Aug. 10, 2018), <https://www.nytimes.com/2018/08/10/health/catholic-hospitals-procedures.html> [https://perma.cc/BM9P-2CMN]. That accommodation would have the effect of reducing access to medical care has led some European courts to determine that certain countries had violated international guarantees of access to healthcare. See, e.g., *International Planned Parenthood Federation — European Network (IPPF EN) v. Italy*, Complaint No. 87/2012, Decision on the Merits, ¶¶ 174–177 (Eur. Comm. of Soc. Rts. Mar. 10, 2014).

¹⁵¹ Health Programs Extension Act of 1973, Pub. L. No. 93-45, § 401(c)(2), 87 Stat. 91, 95; see *supra* note 127.

¹⁵² See *Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695, 699 (2d Cir. 2010); *Nead v. Bd. of Trs. of E. Ill. Univ.*, No. 05-2137, 2006 WL 1582454, at *5 (C.D. Ill. June 6, 2006); cf. *Horvath-Cosper v. MedStar Wash. Hosp. Ctr. (Health & Hum. Serv. Off. of Civ. Rts. May 2, 2016) (Compl.)* (alleging discrimination under the Church Amendment and filing a complaint with the Office for Civil Rights (OCR) to seek remedy).

implicates matters of faith.¹⁵³ The handful of states that came to extend any additional safeguards to conscientious providers limit those to workplace penalties for having supported or participated in an abortion.¹⁵⁴

The only exception is Vermont. That state recently turned the usual asymmetry on its head. Its 2019 Freedom of Choice Act¹⁵⁵ exempts just conscientious providers, and not refusers, by barring public entities from interfering with clinicians who seek to take part in an abortion.¹⁵⁶ In other states, refusers get dramatically greater protection from policies enforced by employers and governments too than do equally conscientious providers who exercise professional judgment in the service of patient interests.¹⁵⁷

II. PROHIBITED CARE

Not that job security alone would be much comfort to the doctor whose delivery of prohibited care in the name of conscience can still land her in court. Before *Dobbs*, it was mostly a practitioner's job or license at risk. Now providing contested services in many places risks civil liability and even felony prosecution that come with steep fines and long jail sentences. This Part canvasses conscientious appeals to provide treatments that are banned. It maps more than a dozen such practices into three categories: (1) reproduction and dying; (2) impairment and identity; and (3) interventions to treat other chronic conditions ranging from serious pain to kidney disease. None of these restrictions meaningfully exempts conscientious providers.

A. Reproduction and Dying

First are practices at life's beginning and end. *Dobbs* authorized states to ban abortion from the moment of conception.¹⁵⁸ And it imperiled services that prevent pregnancy, destroy nascent life, or create extra embryos to treat infertility. Then there are patients' clear wishes that, if they end up in a permanent coma, they want the feeding tubes removed and breathing machines turned off, even when that would have the effect of extinguishing a fetus that's growing inside. Next are death-

¹⁵³ See *Harris v. McRae*, 448 U.S. 297, 320–21 (1980) (rejected on standing grounds). For discussion, see MARY ZIEGLER, *ABORTION AND THE LAW IN AMERICA: ROE V. WADE TO THE PRESENT* 52 (2020); and Mary Ziegler, *The Jurisprudence of Uncertainty: Knowledge, Science, and Abortion*, 2018 WIS. L. REV. 317, 322–33.

¹⁵⁴ See MICH. COMP. LAWS § 333.20184 (1978); IOWA CODE § 146.1 (1976); KY. REV. STAT. ANN. § 311.800(5)(b)–(c) (West 1980); 43 PA. STAT. AND CONS. STAT. ANN. § 955.2(b)(2) (West 1986); S.D. CODIFIED LAWS § 34-23A-13 (1973); TEX. OCC. CODE ANN. § 103.002(b) (West 1999). And New Hampshire doesn't protect conscience for anyone, either refusers or providers. It lets healthcare institutions and licensing boards enforce clinical policies over any conscientious objection. Sawicki, *supra* note 36, at 1309, 1312–13.

¹⁵⁵ VT. STAT. ANN. tit. 18, § 9497 (2019).

¹⁵⁶ *Id.*

¹⁵⁷ See *supra* notes 71–86 and accompanying text.

¹⁵⁸ See *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2242 (2022).

hastening drugs to help terminally ill patients avoid extreme suffering in their final days.

Abortion, IVF, advance directives, and assisted suicide implicate people's intimate visions about everything from forming a family to dying with dignity. Prohibitions on each in turn thwart patients' interests in having matters that profoundly reflect their personal values. Respect for patients' agency and freedom explains why many providers defy this initial class of restrictions in the name of conscience.

1. *Abortion*. — Clinicians who've "felt called to" perform abortions have been fired or forced out by sectarian employers for having ended any pregnancy in the past or while moonlighting elsewhere.¹⁵⁹ As for government restrictions on abortion, twenty-five medical groups argued in an amicus brief in *Dobbs* that legal prohibitions force clinicians into "an impossible choice between upholding their ethical obligations and following the law."¹⁶⁰ Since *Dobbs*, more than a dozen states have banned virtually any abortion that isn't necessary to save a woman's life.¹⁶¹ Now some clinicians are pressing the limits of these laws.¹⁶² Many more of them did before *Roe*, when abortion bans were less punitive and enforcement was less strict.¹⁶³ Whether they broke the law covertly or out in the open, the disobedients of that earlier era are what sociologist Carole Joffe calls "[d]octors of [c]onscience."¹⁶⁴

2. *IUDs, Plan B, IVF*. — The draft opinion in *Dobbs v. Jackson Women's Health Organization* presaged *Roe*'s pending reversal to protect "potential life" from its earliest stirrings.¹⁶⁵ Within days of the opinion's leak, states introduced bills to "[f]ully recognize the human

¹⁵⁹ Mara Gordon, *For Doctors Who Want to Provide Abortions, Employment Contracts Often Tie Their Hands*, NPR (Nov. 26, 2018, 11:55 AM), <https://www.npr.org/sections/health-shots/2018/11/26/668347657/for-doctors-who-want-to-provide-abortions-employment-contracts-often-tie-their-h> [<https://perma.cc/QH6R-XMFZ>]; see also Ian Fisher, *Casualty of the Abortion Debate; A Doctor, Aiming at Conciliation, Instead Loses a Post*, N.Y. TIMES (Mar. 24, 1998) <https://www.nytimes.com/1998/03/24/nyregion/casualty-abortion-debate-doctor-aiming-conciliation-instead-loses-post.html> [<https://perma.cc/89WS-XSHM>]; Dr. X, *A Doctor Tells Why She Performed Abortions — And Still Would*, 29 HEALTH AFFS. 1264, 1266–67 (2010).

¹⁶⁰ Brief for American College of Obstetricians and Gynecologists et al. as Amici Curiae in Support of Respondents at 26, *Dobbs* (No. 19-1392).

¹⁶¹ See, e.g., ARK. CODE ANN. § 5-61-304 (2019); FLA. STAT. § 390.0111 (2022); IDAHO CODE § 18-622 (2020); S.D. CODIFIED LAWS §§ 22-17-1 to 22-7-14 (2021).

¹⁶² See, e.g., *supra* notes 17–25 and accompanying text.

¹⁶³ See, e.g., *infra* notes 477–82, 557–58 and accompanying text.

¹⁶⁴ See CAROLE JOFFE, DOCTORS OF CONSCIENCE 92–95 (1995); see also Physicians for Reproductive Health, *Voices of Choice: Physicians Who Provided Abortions Before Roe v. Wade*, YOUTUBE, at 14:29 (Jan. 21, 2013), <https://www.youtube.com/watch?v=GPN-MjnSknM> [<https://perma.cc/SAD6-BLVR>].

¹⁶⁵ Read Justice Alito's Initial Draft Abortion Opinion Which Would Overturn Roe v. Wade, POLITICO (May 2, 2022, 9:20 PM), <https://www.politico.com/news/2022/05/02/read-justice-alito-initial-abortion-opinion-overturn-roe-v-wade-pdf-00029504> [<https://perma.cc/KMU2-T4V6>].

personhood of an unborn child . . . from the moment of fertilization.”¹⁶⁶ Lawmakers called for interpreting these measures to forbid any interventions that involve the deliberate loss of a fertilized egg even before it implants in the uterus to begin a pregnancy.¹⁶⁷ Clinical services at risk of prohibition under such laws include certain kinds of long-term birth control (e.g., IUDs),¹⁶⁸ emergency contraception (e.g., Plan B),¹⁶⁹ and assisted reproduction (e.g., IVF).¹⁷⁰

3. *Advance Directives.* — Clinicians are typically bound to follow patient instructions at the end of life: whether to continue potentially futile life-sustaining treatment, or to decline it if they permanently lose brain function.¹⁷¹ But twenty-six states exclude pregnant patients from this tenet of medical ethics and constitutional law.¹⁷² And another five do more than just allow doctors and nurses to ignore a pregnant patient’s wish to forego life-sustaining measures if she ends up permanently unconscious, as in a permanent vegetative state.¹⁷³ These policies actually forbid clinicians from honoring that advance directive, even when a patient explicitly considered the fact of her pregnancy in

¹⁶⁶ E.g., H.B. 813, 2022 Leg., Reg. Sess. (La. 2022); see also H.R. 4327, 58th Leg., Reg. Sess. (Okla. 2022); UTAH CODE ANN. § 76-7-301.1 (LexisNexis 2022); KY. REV. STAT. ANN. § 311.772 (West 2022).

¹⁶⁷ See, e.g., Tessa Weinberg, “Anything’s on the Table”: Missouri Legislature May Revisit Contraceptive Limits Post-Roe, MO. INDEP. (May 20, 2022, 9:00 AM), <https://missouriindependent.com/2022/05/20/anything-s-on-the-table-missouri-legislature-may-revisit-contraceptive-limits-post-roe> [<https://perma.cc/6TGW-Z9FV>].

¹⁶⁸ See, e.g., Abigail Higgins, *Abortion Rights Advocates Fear Access to Birth Control Could Be Curtailed*, WASH. POST (June 24, 2022, 4:05 PM), <https://www.washingtonpost.com/nation/2022/06/24/birth-control-access-supreme-court-abortion-ruling> [<https://perma.cc/MN6K-RY3Z>].

¹⁶⁹ Some women are acquiring emergency contraception preemptively in anticipation of coming bans. See Katherine Rosman & Gina Cherelus, *As Abortion Access Narrows, Some Women Think Ahead*, N.Y. TIMES, June 30, 2022, at D2.

¹⁷⁰ See, e.g., Jan Hoffman, *Ruling Raises Alarm on Fate of I.V.F. Care*, N.Y. TIMES, July 6, 2022, at A1. When *Dobbs* took away the constitutional right to abortion, the majority insisted that its appeal to “history and tradition” wouldn’t doom other due process rights like same-sex marriage and intimacy because only abortion “destroys . . . an ‘unborn human being.’” *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2258–61 (2022) (quoting the Gestational Age Act, 2018 Miss. Laws Adv. Sh. 393 (LexisNexis)). On its own terms, the decision raises hard questions about whether, for example, “a fertility doctor commit[s] a felony by complying with a patient’s request to thaw and discard frozen embryos.” I. Glenn Cohen, Judith Daar & Eli Y. Adashi, *What the Supreme Court’s Abortion Reversal Means for In Vitro Fertilization*, BOS. GLOBE, June 30, 2022, at A9. In concurrence, Justice Thomas invited legislatures and litigants to directly challenge the right to access not only emergency or long-term contraception, but also any form of birth control. See *Dobbs*, 142 S. Ct. at 2301 (Thomas, J., concurring) (citing *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965)).

¹⁷¹ See *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 270 (1990).

¹⁷² See Erin S. DeMartino et al., *US State Regulation of Decisions for Pregnant Women Without Decisional Capacity*, 321 JAMA 1629, 1630 (2019).

¹⁷³ See Manny Fernandez & Erik Eckholm, *Pregnant, And Forced to Stay on Life Support*, N.Y. TIMES, Jan. 8, 2014, at A1. The moral and legal difference between assisting suicide and withdrawing life-sustaining treatment has long been subject to dispute. See, e.g., *Vacco v. Quill*, 521 U.S. 793, 800–08 (1997).

deciding to discontinue her life under those circumstances.¹⁷⁴ Some doctors morally object to such interferences with their ability to honor their patients' expressed preferences.¹⁷⁵

4. *Aid-in-Dying*. — State law forbids the vast majority of American doctors and nurses from helping their badly suffering, terminally ill patients to hasten their own deaths.¹⁷⁶ Forty states make it a crime to prescribe lethal medication to patients enduring extraordinary pain with just weeks to live, no matter how many safeguards ensure voluntary consent and prevent pressure or abuse.¹⁷⁷ Even in the ten states where physician-assisted suicide is sometimes legal, many sectarian healthcare institutions still make it grounds for termination.¹⁷⁸ Anonymous surveys indicate that eleven percent of physicians are willing to prescribe lethal medication under certain circumstances even if their institution won't let them.¹⁷⁹ And one in five oncologists also say they'd help a suffering patient who wants to die.¹⁸⁰ Those who seek to defy these euthanasia bans under state law or employer policy point out that America's restrictive approach to assisted suicide is an outlier.¹⁸¹ A growing number of developed countries now allow clinicians to help terminal patients hasten death to relieve their suffering and die with dignity — not just Switzerland and the Netherlands, but also Belgium, Canada, Luxembourg, New Zealand, and Spain.¹⁸²

B. *Impairment and Identity*

These next case studies have to do with how patients think of themselves and how others think about them. First, hormone blockers to delay puberty in teens who want their changing body to align with their gender identity. Then, conversion therapy to integrate a person's sexual orientation into his faith and family, usually by trying to impel attraction

¹⁷⁴ DeMartino et al., *supra* note 172, at 1630.

¹⁷⁵ See Jeffrey L. Ecker, *Death in Pregnancy — An American Tragedy*, 370 *NEW ENG. J. MED.* 889, 890 (2014). Withdrawing life-sustaining care from pregnant people who signed advance directives is different from withdrawing such care from people who never consented to decline treatment that would keep them alive, or from babies who aren't capable of such consent when they're born with gravely debilitating conditions. See *Child Abuse Amendments of 1984*, Pub. L. No. 98-457, 98 Stat. 1749.

¹⁷⁶ See, e.g., *Krischer v. McIver*, 697 So. 2d 97, 99, 104 (Fla. 1997); *Sampson v. State*, 31 P.3d 88, 90 (Alaska 2001).

¹⁷⁷ See *Physician-Assisted Suicide Fast Facts*, *supra* note 41.

¹⁷⁸ See Zachary R. Carstens, Note, *The Right to Conscience vs. The Right to Die: Physician-Assisted Suicide, Catholic Hospitals, and the Rising Threat to Institutional Free Exercise in Healthcare*, 48 *PEPP. L. REV.* 175, 195-97 (2021).

¹⁷⁹ See, e.g., Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 *NEW ENG. J. MED.* 1193, 1193 (1998).

¹⁸⁰ See Ezekiel J. Emanuel et al., *Attitudes and Practices of U.S. Oncologists Regarding Euthanasia and Physician-Assisted Suicide*, 133 *ANNALS INTERNAL MED.* 527, 529 (2000).

¹⁸¹ Peter T. Hetzler III et al., *A Report of Physicians' Beliefs About Physician-Assisted Suicide: A National Study*, 92 *YALE J. BIOLOGY & MED.* 575, 576, 583 (2019).

¹⁸² See, e.g., Richard Hurley et al., *Assisted Dying: A Question of When, Not If*, 374 *BMJ* 2128, 2128-29 (2021).

to the opposite sex. Third, a shallow clitoral incision that's meant to avoid the more dangerous forms of ritual genital cutting that patients might otherwise undergo outside of a clinical setting. The last example involves amputation for people with a rare compulsion to have a healthy limb removed. All of these raise questions about whether such interventions respond to an "impairment" or "identity," and the extent to which that distinction matters when doctors would conscientiously provide this treatment that the law forbids.

1. *Puberty Blockers.* — An estimated 0.7% of thirteen- to seventeen-year-olds persistently identify with a gender that doesn't match their bodies' sex-based traits.¹⁸³ Some also experience serious distress associated with their biological sex or its relation to their gender identity.¹⁸⁴ Those who seek help start with psychosocial counseling and behavioral support, which might accompany a social transition: different names or pronouns, haircuts, or styles of dress.¹⁸⁵ That's as far as gender-affirming care usually goes before puberty, nothing medical.¹⁸⁶

In their early teens, some adolescents, with their parents' support, seek to block the hormones associated with changes to breasts, muscle, and voice.¹⁸⁷ Puberty-blocking injections or implants are meant to buy time for those who consistently identify as transgender to make more permanent medical decisions.¹⁸⁸ Puberty blockers can help, as they get older, to make their gender identity easier for themselves and others to perceive, while reducing reliance on more invasive and less reversible interventions like cross-sex hormones and chest or genital reassignment surgeries that aren't recommended until later on.¹⁸⁹

¹⁸³ See JODY L. HERMAN ET AL., WILLIAMS INST., AGE OF INDIVIDUALS WHO IDENTIFY AS TRANSGENDER IN THE UNITED STATES 4 (2017), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Age-Trans-Individuals-Jan-2017.pdf> [<https://perma.cc/5THW-HZP9>].

¹⁸⁴ See Johanna Olson et al., *Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria*, 57 J. ADOLESCENT HEALTH 374, 375, 378 tbl.5 (2015).

¹⁸⁵ Ilana Sherer & Madeleine Hanks, *Affirming Pediatric Care for Transgender and Gender Expansive Youth*, 50 PEDIATRIC ANNALS e65, e68 (2021).

¹⁸⁶ Gender-affirming care reflects individualized needs, so there aren't hard-and-fast age limits. See Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3894 (2017). But before adulthood, clinical guidelines generally advise against any medical intervention other than puberty blockers. See Caroline Salas-Humara et al., *Gender Affirming Medical Care of Transgender Youth*, CURRENT PROBS. PEDIATRIC & ADOLESCENT HEALTH CARE, Sept. 2019, at 1, 2.

¹⁸⁷ See Emily Bazelon, *The Battle over Gender Therapy*, N.Y. TIMES MAG. (June 24, 2022), <https://www.nytimes.com/2022/06/15/magazine/gender-therapy.html> [<https://perma.cc/G6YC-9Q83>].

¹⁸⁸ See Lena Wilson, *What Are Puberty Blockers?*, N.Y. TIMES (May 11, 2021), <https://www.nytimes.com/2021/05/11/well/family/what-are-puberty-blockers.html> [<https://perma.cc/77TJ-CPV9>].

¹⁸⁹ Physicians don't start cross-sex hormones to boost testosterone or estrogen until patients are at least fourteen, or consider performing chest surgery on those under fifteen, or genital reassignment any earlier than seventeen. See Azeen Ghorayshi, *Doctors Debate Whether Trans Teens Need Therapy Before Hormones*, N.Y. TIMES (Jan. 13, 2022), <https://www.nytimes.com/2022/01/13/health/transgender-teens-hormones.html> [<https://perma.cc/QJ24-K8PE>].

Some research also suggests that young people who experience distress associated with their gender identity experience lower rates of anxiety, depression, and suicidal ideation if they take puberty blockers, as compared with similar youth who don't.¹⁹⁰ Studies in this population are still new enough that they don't decisively exclude potential long-term risks to fertility, sexual function, or bone development.¹⁹¹ Several states have exploited such possibilities to criminalize puberty blockers regardless of people's individual circumstances.¹⁹² Some make it a felony to refer any minor for that treatment or even to order the bloodwork that's needed to monitor hormone levels in patients who'd already started taking them before bans went into effect.¹⁹³ Pediatricians are left to rail against these laws or defy them out of a conscientious commitment to patient care.¹⁹⁴

2. *Conversion Therapy.* — Medicine has been enlisted not only to affirm gender identity, but also to try to suppress attraction to the same sex or kindle it to a different one.¹⁹⁵ Clinical attempts to change sexual

¹⁹⁰ See Kristina R. Olson et al., *Gender Identity 5 Years After Social Transition*, PEDIATRICS, Aug. 2022, at 1–2; Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS, Feb. 2020, at 1, 5. But see Michael Biggs, *Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria*, 49 ARCHIVES SEXUAL BEHAV. 2227, 2227 (2020) (criticizing Turban's study as unreliable for baking in faulty assumptions).

¹⁹¹ See Cristyn Davies et al., *The Importance of Informed Fertility Counselling for Trans Young People*, 5 LANCET CHILD & ADOLESCENT HEALTH e36, e36 (2021). Sweden and Finland recommend curtailing the use of puberty blockers in recognition of these potential risks. See NAT'L BD. OF HEALTH & WELFARE, CARE OF CHILDREN AND ADOLESCENTS WITH GENDER DYSPHORIA 3 (2022), <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf> [<https://perma.cc/A47R-PC99>]; COUNCIL FOR CHOICES IN HEALTH CARE IN FIN., MEDICAL TREATMENT METHODS FOR DYSPHORIA RELATED TO GENDER VARIANCE IN MINORS 6–7 (2020), https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf [<https://perma.cc/9T7M-APL5>]. In February 2022, France advised caution about the use of puberty blockers due to their potential side effects. See Press Release, French Nat'l Acad. of Med., Medicine and Gender Transidentity in Children and Adolescents (Feb. 25, 2022), <https://www.academie-medicine.fr/wp-content/uploads/2022/03/22.2.25-Communique-PCRA-19-Gender-identity-ENG.pdf> [<https://perma.cc/CA9D-NUQF>]. In July 2022, England overhauled its gender care model, citing in part the need for more comprehensive studies. See THE CASS REVIEW, INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE: INTERIM REPORT 39 (2022), <https://cass.independent-review.uk/publications/interim-report> [<https://perma.cc/7EJ4-7ZA3>].

¹⁹² Bills in Alabama, Arizona, and Arkansas have become law. For discussion of these and twenty-two others, see Katherine L. Kraschel et al., *Legislation Restricting Gender-Affirming Care for Transgender Youth: Politics Eclipse Healthcare*, CELL REPS. MED., Aug. 2022, at 2–3.

¹⁹³ See *id.*

¹⁹⁴ See Laura Thompson, *Meet the Southern Doctor Fighting to Help Trans Kids*, MOTHER JONES (May 23, 2022), <https://www.motherjones.com/politics/2022/05/zizzy-lowell-alabama-south-doctor-transgender-kids-trans> [<https://perma.cc/ZMF3-AVYJ>]; see also Mike Cason, *Doctors Testify in Lawsuit to Block Alabama Ban on Medical Treatments for Transgender Minors*, AL.COM (May 6, 2022, 6:32 AM), <https://www.al.com/news/2022/05/doctors-to-testify-in-lawsuit-to-block-alabama-ban-on-medical-treatments-for-transgender-minors.html> [<https://perma.cc/T9SF-GVM3>].

¹⁹⁵ See AM. PSYCH. ASS'N, REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION TASK FORCE ON APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION 22 (2009).

orientation used to be brutally invasive: lobotomy and castration.¹⁹⁶ Today, counseling, psychoanalysis, and hypnosis are the norm.¹⁹⁷ Twenty-one states and Washington, D.C., ban any such intervention in minors.¹⁹⁸ Some providers object that conversion therapy can help young people to mitigate deeply distressing conflicts with a disapproving family or faith, even if patients accordingly seek to change their sexual orientation only “out of internalized social pressure.”¹⁹⁹

Electroconvulsive therapy for minors — another form that conversion efforts used to take²⁰⁰ — is also prohibited in a number of states for any use, whether or not it’s related to sexual orientation.²⁰¹ These laws ban shock therapy even when it’s been shown to relieve youths’ severe and treatment-resistant self-harm or suicidality.²⁰²

3. *Genital Cutting.* — The federal government and forty states criminalize genital cutting of girls as torture, felony sex crime, ritualized child abuse, or first-degree assault and battery of a minor.²⁰³ But some doctors say that a less invasive incision, “a ritual nick under analgesia to adolescent girls able to assent,” does no more physical harm than male circumcision or ear piercings do.²⁰⁴ Self-identified “compassionate practitioners” would perform “de minimis procedures”²⁰⁵ to save girls who are capable of voluntarily agreeing from “more extensive and damaging”²⁰⁶ cuts that “worsen health outcomes by driving the practice underground.”²⁰⁷ These physicians claim it’s better to undertake superficial

¹⁹⁶ Susan L. Morrow & A. Lee Beckstead, *Conversion Therapies for Same-Sex Attracted Clients in Religious Conflict: Context, Predisposing Factors, Experiences, and Implications for Therapy*, 32 COUNSELING PSYCH. 641, 642 (2004).

¹⁹⁷ See AM. PSYCH. ASS’N, *supra* note 195, at 130.

¹⁹⁸ See, e.g., *Otto v. City of Boca Raton*, 981 F.3d 854, 859 (11th Cir. 2020); *Doe v. Christie*, 33 F. Supp. 3d 518, 520 (D.N.J. 2014); *Pickup v. Brown*, 740 F.3d 1208, 1223 (9th Cir. 2014); *King v. Governor of New Jersey*, 767 F.3d 216, 220 (3d Cir. 2014); *Welch v. Brown*, 907 F. Supp. 2d 1102, 1105 (E.D. Cal. 2012); *Equality Maps: Conversion “Therapy” Laws*, MOVEMENT ADVANCEMENT PROJECT, https://www.lgbtmap.org/equality-maps/conversion_therapy [<https://perma.cc/T6MW-8M3Q>].

¹⁹⁹ Douglas C. Haldeman, *Gay Rights, Patient Rights: The Implications of Sexual Orientation Conversion Therapy*, 33 PRO. PSYCH.: RSCH. & PRAC. 260, 263 (2002).

²⁰⁰ See AM. PSYCH. ASS’N, *supra* note 195, at 22.

²⁰¹ See Robin Livingston et al., *Regulation of Electroconvulsive Therapy: A Systematic Review of US State Laws*, 34 J. ELECTROCONVULSIVE THERAPY 60, 61–66 (2018).

²⁰² See, e.g., *Randall T. Espinoza & Charles H. Kellner, Electroconvulsive Therapy*, 386 NEW ENG. J. MED. 667, 667–68 (2022).

²⁰³ See Strengthening the Opposition to Female Genital Mutilation Act of 2020, Pub. L. No. 116-309, § 3, 134 Stat. 4922, 4923 (codified at 18 U.S.C. § 1116); Limor Ezioni, *Contemporary Aspects of Female Genital Mutilation Prohibitions in the United States*, 28 AM. U. J. GENDER SOC. POL’Y & L. 39, 50–61 (2019) (surveying state laws).

²⁰⁴ Kavita Shah Arora & Allan J. Jacobs, *Female Genital Alteration: A Compromise Solution*, 42 J. MED. ETHICS 148, 153 (2016); see *id.* at 149–50.

²⁰⁵ *Id.* at 151.

²⁰⁶ *Id.* at 153.

²⁰⁷ *Id.* at 148.

cuts in a sterilized clinical setting with numbing for the pain than risk these girls having “horrendous things done to them.”²⁰⁸

4. *Amputation.* — Body integrity identity disorder (BIID) is the intensely and persistently felt need to amputate one or more healthy limbs because they “do not feel like they belong to me, and should not be there.”²⁰⁹ This unshakable compulsion resists known forms of medication and therapy.²¹⁰ People with BIID seek to have their healthy limbs surgically removed.²¹¹ But that operation isn’t approved by medical licensing boards, and doctors who perform it risk prosecution for grievous bodily harm, maiming, mutilation, or murder.²¹² In 2000, surgeon Robert Smith amputated the healthy legs of two people whose BIID left them “in a state of permanent mental torment.”²¹³ His patients had expressed such a desperate need that “if they [did] not achieve their amputation by medical means,” he feared “they [would] try and achieve it by self-injury.”²¹⁴ Some lay their arms or legs “on a railway line,” while others “shoot their limbs off” with a gun.²¹⁵ Hospital officials initially gave Dr. Smith permission to undertake the procedure, but blowback led the institution to prohibit it from being performed again.²¹⁶

C. Chronic Controversies

Also restricted by law or policy are treatments for chronic conditions that range from pain, addiction, and depression to cancer, kidney disease, and long COVID. These infirmities limit the basic activities of daily living and require ongoing medical attention to organs, mental health, or nervous or respiratory systems. Organ transplants, opioids, marijuana, and ivermectin make up the last category of services that governments or institutions restrict. All four treatments are meant to treat persistent ailments, though some are safer and more effective than others. Prohibitions on each have been met with varying levels of resistance from providers who invoke conscience.

²⁰⁸ Tom Brune, *Refugees’ Beliefs Don’t Travel Well*, CHI. TRIB., Oct. 28, 1996, at 10.

²⁰⁹ Rianne M. Blom et al., *Body Integrity Identity Disorder*, PLOS ONE, Apr. 2012, at 1, 2 (emphasis omitted).

²¹⁰ See Michael B. First, *Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder*, 35 PSYCH. MED. 919, 925–26 (2005).

²¹¹ See Nadia N. Sawicki, *Choosing Medical Malpractice*, 93 WASH. L. REV. 891, 908 (2018).

²¹² See Robin Marantz Henig, *At War with Their Bodies, They Seek to Sever Limbs*, N.Y. TIMES (Mar. 22, 2005), <https://www.nytimes.com/2005/03/22/health/psychology/at-war-with-their-bodies-they-seek-to-sever-limbs.html> [<https://perma.cc/28MS-REYD>].

²¹³ WHOLE (Melody Gilbert & FRZN Productions 2003).

²¹⁴ *Horizon: Complete Obsession* (BBC television broadcast Feb. 17, 2000), https://www.bbc.co.uk/science/horizon/1999/obsession_script.shtml [<https://perma.cc/7PDM-YYMP>].

²¹⁵ *Id.*; see Henig, *supra* note 212.

²¹⁶ See Clare Dyer, *Surgeon Amputated Healthy Legs*, 320 BMJ 332, 332 (2000); Sue Leonard, *Woman Asks Falkirk Hospital to Cut Off Healthy Legs*, SUNDAY TIMES (Apr. 3, 2005, 1:00 AM), <https://www.thetimes.co.uk/article/woman-asks-falkirk-hospital-to-cut-off-healthy-legs-6cqlz56lg22> [<https://perma.cc/5NF2-LS9F>].

1. *Transplants*. — In 1984, the U.S. Congress made it a felony for a doctor to transplant a human organ that was obtained for “valuable consideration.”²¹⁷ Meanwhile, tens of thousands of Americans die each year for want of a lifesaving kidney because there are so few deceased donors, or living ones willing to incur the pain and risk without the kind of compensation that the law forbids as a way to incentivize organs for transplant.²¹⁸ Some surgeons defy that prohibition by transplanting kidneys that have been bought and sold.²¹⁹ Such doctors oppose the paid-for-organ ban on moral grounds: they say that it has the effect of “sentencing” many of their “transplant candidates to death.”²²⁰ These providers are “engaged in ethical struggle at every step, balancing ‘ethics’ as defined by law” against those ethical “values of saving life” that guide “their personal conscience.”²²¹

²¹⁷ National Organ Transplant Act, 42 U.S.C. § 274e(a); see *id.* § 274e(b).

²¹⁸ Catherine R. Butler et al., *End-of-Life Care Among US Adults with ESKD Who Were Waitlisted or Received a Kidney Transplant, 2005–2014*, 31 J. AM. SOC’Y NEPHROLOGY 2424, 2427 (2020); Philip J. Held et al., *Would Government Compensation of Living Kidney Donors Exploit the Poor? An Empirical Analysis*, PLOS ONE, Nov. 2018, at 1, 2.

²¹⁹ Associated Press, *Do U.S. Hospitals Push Organ Black Market?*, CBS NEWS (July 30, 2009, 11:22 AM), <https://www.cbsnews.com/news/do-us-hospitals-push-organ-black-market> [https://perma.cc/V28D-5G3V].

²²⁰ Arthur J. Matas, *Why We Should Develop a Regulated System of Kidney Sales: A Call for Action!*, 1 CLINICAL J. AM. SOC’Y NEPHROLOGY 1129, 1131 (2006).

²²¹ Aslihan Sanal, *“Robin Hood” of Techno-Turkey or Organ Trafficking in the State of Ethical Beings*, 28 CULTURE MED. & PSYCHIATRY 281, 284 (2004) (describing a similar phenomenon among doctors in Turkey). Dialysis is a related example of conscientious provision. Here, it isn’t the practice itself that’s illegal, but misleading the government to pretend that supplying that care qualifies for the federal reimbursement that’s required to cover its cost. Patients with end-stage kidney disease need the waste products from their blood filtered using a dialysis process that costs over \$70,000 per year. The United States foots the bill for all patients who can’t afford it, with one exception: undocumented immigrants. See Lilia Cervantes et al., *The Status of Provision of Standard Outpatient Dialysis for US Undocumented Immigrants with ESKD*, 14 CLINICAL J. AM. SOC’Y NEPHROLOGY 1258, 1259 (2019). For more than 5000 undocumented immigrants who live with the condition in the United States, dialysis is funded only when their kidneys are about to fail. See G. Adam Campbell et al., *Care of the Undocumented Immigrant in the United States with ESRD*, 55 AM. J. KIDNEY DISEASES 181, 182 (2010). Some nephrologists are unwilling to deny the not-yet-emergency dialysis that’s proven to keep things from getting that dire. See Areeba Jawed et al., *High Moral Distress in Clinicians Involved in the Care of Undocumented Immigrants Needing Dialysis in the United States*, 5 HEALTH EQUITY 484, 485 (2021). To get such dialysis covered by insurance, these doctors miscode it as an “emergency” by misreporting test results, fudging laboratory cutoffs, and exaggerating symptoms, in violation of federal fraud laws. See Lilia Cervantes et al., *Clinicians’ Perspectives on Providing Emergency-Only Hemodialysis to Undocumented Immigrants*, 169 ANNALS INTERNAL MED. 78, 83 (2018). “I try and ‘sell it’ . . . ‘Oh, it looks like they have a little bit of pulmonary edema,’ even though they are not . . . short of breath.” *Id.* at 82 tbl.2. It’s not just dialysis eligibility that physicians mislead insurers about. A 2000 survey of more than seven hundred American doctors found that forty percent had submitted fraudulent claims to secure needed care for their patients. See Matthew K. Wynia et al., *Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 283 JAMA 1858, 1861 (2000).

2. *Opioids*. — Millions of Americans suffer from chronic pain after an injury or surgery, or due to an illness like cancer.²²² Opioids relieve this pain but they're highly addictive and can be dangerous: the CDC reported more than 80,000 opioid-overdose deaths in 2021.²²³ In 2016, the agency urged tapering or discontinuing opioid prescriptions “in outpatient settings, outside of active cancer treatment, palliative care, and end-of-life care.”²²⁴ Many states and medical boards codified these recommendations.²²⁵ Some clinicians argue that the opioid crackdown has gone too far as applied to patients with chronic severe pain who have taken high doses for years without becoming addicted.²²⁶ These restrictions lead some patients to suffer so badly that they're driven to black-market alternatives; others even try to take their own lives.²²⁷ To spare their patients these terrible fates, some doctors invoke conscience to prescribe more than the legal limits allow.²²⁸

3. *Marijuana*. — A growing body of medical research suggests that marijuana can be safe and effective to treat opioid dependency, muscle spasms associated with multiple sclerosis, and severe nausea and loss of appetite in people with cancer or AIDS.²²⁹ But the federal government and thirteen states prohibit medical marijuana for these purposes.²³⁰ These laws date back to the social consensus of 1950s America that branded cannabis a “gateway drug” to more addictive and dangerous

²²² See James Dahlhamer et al., *Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults — United States, 2016*, 67 MORBIDITY & MORTALITY WKLY. REP. 1002, 1003 (2018).

²²³ Nat'l Ctr. for Health Stat., *Provisional Drug Overdose Death Counts*, CTRES. FOR DISEASE CONTROL & PREVENTION (Oct. 12, 2022), <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm> [<https://perma.cc/LJ45-S6PX>]. Many of these deaths were not from opioids that were prescribed. See *id.*

²²⁴ Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*, 65 MORBIDITY & MORALITY WKLY. REP. 1, 2 (2016).

²²⁵ See Michael E. Schatman & Hannah Shapiro, *Damaging State Legislation Regarding Opioids: The Need to Scrutinize Sources of Inaccurate Information Provided to Lawmakers*, 12 J. PAIN RSCH. 3049, 3050–51 (2019); Jennifer D. Oliva, *Dosing Discrimination: Regulating PDMP Risk Scores*, 110 CALIF. L. REV. 47, 81 (2022).

²²⁶ See *Health Professionals Call on the CDC: The Letter*, HEALTH PROS. FOR PATIENTS IN PAIN (Mar. 6, 2019), <https://healthprofessionalsforpatientsinpain.org/the-letter-1> [<https://perma.cc/YY39-JCYZ>].

²²⁷ See Alicia Agnoli et al., *Association of Dose Tapering with Overdose or Mental Health Crisis Among Patients Prescribed Long-Term Opioids*, 326 JAMA 411, 412 (2021); Maia Szalavitz, *Opinion, The Other Victims of the Opioid Crisis*, N.Y. TIMES, Mar. 13, 2022, at SR3.

²²⁸ See Maia Szalavitz, *Opinion, The War on Drugs Has a Warning for Post-Roe America*, N.Y. TIMES (July 26, 2022), <https://www.nytimes.com/2022/07/26/opinion/medicine-criminal-law.html> [<https://perma.cc/AVT3-N8BK>].

²²⁹ See, e.g., Ashley C. Bradford et al., *Association Between US State Medical Cannabis Laws and Opioid Prescribing in the Medicare Part D Population*, 178 JAMA INTERNAL MED. 667, 668 (2018); Allison Karst, *Weighing the Benefits and Risks of Medical Marijuana Use: A Brief Review*, PHARMACY, Dec. 2018, at 3.

²³⁰ See *Marijuana Legality by State*, DISA (Nov. 2022), <https://disa.com/map-of-marijuana-legality-by-state> [<https://perma.cc/6JLK-E3SH>].

drugs like cocaine and heroin.²³¹ Even in the majority of states that have since legalized marijuana under certain circumstances, doctors who prescribe it for those specified uses still risk prosecution under the Controlled Substances Act²³² and suspension of their drug licenses.²³³ Some clinicians have advocated changing or else circumventing these laws.²³⁴ Others appear willing to risk breaking them.²³⁵

4. *Ivermectin*. — Early in the pandemic, scientists launched clinical trials to see if any existing drugs could be repurposed to treat COVID.²³⁶ The FDA had previously authorized the antiviral ivermectin for treating head lice and infections caused by parasitic worms. But ivermectin is not approved for COVID because it hasn't been shown to prevent transmission of the illness or reduce its severity.²³⁷ The FDA has warned

²³¹ See RICHARD J. BONNIE & CHARLES H. WHITEBREAD II, *THE MARIHUANA CONVICTION: A HISTORY OF MARIHUANA PROHIBITION IN THE UNITED STATES* 214–15 (1974).

²³² 21 U.S.C. §§ 801–904.

²³³ See, e.g., *Conant v. Walters*, 309 F.3d 629, 632 (9th Cir. 2002); Michael Redinger et al., *An Ethical Framework to Manage Patient Requests for Medical Marijuana*, 33 J. AM. BD. FAM. MED. 147, 147–48 (2020). But see Rachel M. LaBruyere & Slaters C. Veazey, *Attorney General Garland Reconfirms the DOJ's Hands-Off Approach Toward Federal Marijuana Prosecution*, NAT'L L. REV. (May 2, 2022), <https://www.natlawreview.com/article/attorney-general-garland-reconfirms-doj-s-hands-approach-toward-federal-marijuana> [<https://perma.cc/8ZHJ-YPH2>]; Will Yakowicz, *President Biden Says It's Time to Change America's Cannabis Laws*, FORBES (Oct. 7, 2022, 11:45 AM), <https://www.forbes.com/sites/willyakowicz/2022/10/07/president-biden-pardon-marijuana-possession-time-to-change-americas-cannabis-laws> [<https://perma.cc/DF8H-ULCQ>].

²³⁴ See, e.g., Letter from Bryon Adinoff, M.D., to Kansas Senate (Mar. 14, 2022), <https://www.dfc.org/post/kansas-senate-bill-sb-560> [<https://perma.cc/UY7Q-YASM>]; Pedro Oliveros, Opinion, *Medical Marijuana Can Help Reduce Our Opioid Dependency: Physician*, ORLANDO SENTINEL (Feb. 9, 2018, 5:40 PM), <https://www.orlandosentinel.com/opinion/os-ed-medical-marijuana-can-cut-opioid-dependency-20180207-story.html> [<https://perma.cc/6WTG-PMFA>]; Marisa Taylor & Melissa Bailey, *Medical Marijuana's "Catch-22": Limits on Research Hinder Patient Relief*, NPR (Apr. 7, 2018, 7:00 AM), <https://www.npr.org/sections/health-shots/2018/04/07/600209754/medical-marijuanas-catch-22-limits-on-research-hinders-patient-relief> [<https://perma.cc/28L4-P4EH>]; see also J. Michael Bostwick, *Medical Marijuana Regulations: You Can't Make Sense of Nonsense*, 96 MAYO CLINIC PROC. 2514, 2516 (2021).

²³⁵ See, e.g., Dara Kam, *State Seeks to Throw the Book at Tallahassee Pot Doctor After Undercover Investigation*, TALLAHASSEE DEMOCRAT (Feb. 21, 2022, 8:56 PM), <https://www.tallahassee.com/story/news/politics/2022/02/21/tallatallah-doctor-joseph-dorn-medical-marijuana-treatment-clinics-investigation/6884108001> [<https://perma.cc/KV96-W4SB>]; Sandra Young, *Marijuana Stops Child's Severe Seizures*, CNN (Aug. 7, 2013, 4:51 PM), <https://www.cnn.com/2013/08/07/health/charlotte-child-medical-marijuana> [<https://perma.cc/GP75-AEN2>]. Other providers might look beyond marijuana to psychedelics: clinical studies into LSD, ecstasy, and mushrooms show some efficacy in treating anxiety, depression, addiction, PTSD, and alcoholism. E.g., Jennifer M. Mitchell et al., *MDMA-Assisted Therapy for Severe PTSD: A Randomized, Double-Blind, Placebo-Controlled Phase 3 Study*, 27 NATURE MED. 1025, 1026 (2021); Alec J. DiVito & Robert F. Leger, *Psychedelics as an Emerging Novel Intervention in the Treatment of Substance Use Disorder: A Review*, 47 MOLECULAR BIOLOGY REPS. 9791, 9796–97 (2020); Matthew W. Johnson & Roland R. Griffiths, *Potential Therapeutic Effects of Psilocybin*, 14 NEUROTHEAPEUTICS 734, 736 (2017).

²³⁶ See, e.g., Maria Popp et al., *Ivermectin for Preventing and Treating COVID-19*, COCHRANE DATABASE SYSTEMATIC REVS., 2021, at 1, 12.

²³⁷ See Gilmar Reis et al., *Effect of Early Treatment with Ivermectin Among Patients with Covid-19*, 386 NEW ENG. J. MED. 1721, 1730 (2022).

that too-big doses of the drug can risk “seizures, coma and even death.”²³⁸ Prescribing an ineffective and dangerous medication like ivermectin can get doctors fired or their licenses suspended.²³⁹ Indeed, even if they believe strongly — against the weight of medical evidence — that it works well to treat COVID.²⁴⁰ Some have insisted that prescribing ivermectin for that contraindicated use preserves “the ability to honor their Hippocratic Oath . . . to treat our patients the best we know how.”²⁴¹

* * *

Just because providers talk in the moral vocabulary of conscience doesn’t make their appeals worth vindicating. Certainly not if they flout reliable proof that a restricted intervention poses greater risks than benefits.²⁴² But neither should claimants get short shrift simply because the thing that they invoke conscience to do is deliver contested services, especially when equally conscientious clinicians are afforded generous latitude to deny such treatment.

III. AN OVERSTATED DISTINCTION

Legal protection for clinician conscience almost always turns on just one thing: whether it’s invoked to refuse services or to provide them.²⁴³ This Part probes the strongest reasons for preserving this asymmetry and finds them wanting. Protections shouldn’t be absolute for refusers when they’re absent for providers. The same principles of pluralism and commitments to professionalism should govern exemptions for both the conscientious supply and withholding of care.

A. *Doing and Allowing*

Singling out conscientious refusal for protection traces back to the reproductive politics of the 1970s: backlash against *Roe* led states to shield abortion-opposed institutions and clinicians from being forced to terminate pregnancies against their will.²⁴⁴ But the refusal/provision

²³⁸ *Why You Should Not Use Ivermectin to Treat or Prevent COVID-19*, U.S. FOOD & DRUG ADMIN. (Dec. 10, 2021), <https://www.fda.gov/consumers/consumer-updates/why-you-should-not-use-ivermectin-treat-or-prevent-covid-19> [<https://perma.cc/6W93-7A7M>].

²³⁹ See Johnny Diaz, *Pennsylvania Doctor Accused of Prescribing Ivermectin for Covid Is Fired*, N.Y. TIMES (Feb. 4, 2022), <https://www.nytimes.com/2022/02/04/us/pennsylvania-doctor-ivermectin-fired.html> [<https://perma.cc/V2SY-UVY9>].

²⁴⁰ See, e.g., *Marik v. Sentara Healthcare*, 109 Va. Cir. 88 (2021).

²⁴¹ Press Release, Front Line COVID-19 Critical Care All., World’s Leading ICU Doctor Files Lawsuit Against Hospital System After Being Barred from Administering Safe and Effective COVID-19 Treatments (Nov. 9, 2021), <https://covid19criticalcare.com/wp-content/uploads/2021/11/FLCCC-Marik-Case-Release-FINAL-Nov-9.pdf> [<https://perma.cc/Y8YW-LESC>].

²⁴² See *infra* section IV.B.2.a, pp. 1087–90.

²⁴³ See *supra* section I.C, pp. 1045–52.

²⁴⁴ See *supra* notes 115–19 and accompanying text.

division isn't just an artifact of the abortion wars. That distinction reemerged a couple decades later in end-of-life cases like Nancy Cruzan and Jack Kevorkian.²⁴⁵ Policymakers and scholars wrestled with whether doctors should be allowed to help terminal patients hasten their deaths, or to withdraw life-sustaining care from those who fell into a permanent coma.²⁴⁶ The line between doing and allowing loomed large in these debates, with active "killing" eliciting greater suspicion than passive "letting die."²⁴⁷

1. *Omission Bias.* — Consequentialists try to explain away the doing/allowing distinction as mere cognitive bias.²⁴⁸ They cite behavioral research to support this view.²⁴⁹ One study found that parents had declined to vaccinate their children against whooping cough, even though they'd been informed that it was extremely safe.²⁵⁰ By contrast to that beneficial doing (giving their kids the shot), allowing them not to be vaccinated left them at risk of the acute respiratory infection.²⁵¹

But the distinction between doing and allowing runs deep in our moral and legal culture.²⁵² A liberal society can prevent people from acting in all sorts of harmful ways, but rarely force them to act to avoid similar harm. Compelling religious sacraments seems crueler than prohibiting them,²⁵³ while making someone say something they deem false or wrong might be thought grimmer than preventing a person from speaking.²⁵⁴ On this view, forcing clinicians to provide care they morally oppose is worse than preventing them from supplying care their

²⁴⁵ See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990); *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994); *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

²⁴⁶ See N.Y. STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 104–09 (1994); GERALD DWORKIN ET AL., EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE 4 (1998).

²⁴⁷ See, e.g., PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN MED. & BIOMEDICAL & BEHAV. RSCH., DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 68 (1983).

²⁴⁸ See JONATHAN BARON, THINKING AND DECIDING 407–08 (4th ed. 2008).

²⁴⁹ See, e.g., Marcel Zeelenberg et al., *Attributions of Responsibility and Affective Reactions to Decision Outcomes*, 104 ACTA PSYCHOLOGICA 303, 304 (2000).

²⁵⁰ David A. Asch et al., *Omission Bias and Pertussis Vaccination*, 14 MED. DECISION MAKING 118, 121 (1994).

²⁵¹ See *id.* This evidence of so-called omission bias connects to a related tendency called "loss aversion." The idea is that people generally care more about losses caused by an affirmative act than they do about otherwise equal gains that a failure to act leads them to miss out on. See Amos Tversky & Daniel Kahneman, *Advances in Prospect Theory: Cumulative Representation of Uncertainty*, 5 J. RISK & UNCERTAINTY 297, 297–98 (1992).

²⁵² See, e.g., J. Morris Clark, *Guidelines for the Free Exercise Clause*, 83 HARV. L. REV. 327, 361 (1969) ("The right of individuals to act positively, in such a way as to harm others in the society, must by its nature be more restricted than the right to refrain from acting.")

²⁵³ Compare *Frazee v. Ill. Dep't of Emp. Sec.*, 489 U.S. 829, 832 (1989) (Sabbath observance), with *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 531 (1993) (animal sacrifice).

²⁵⁴ Compare *Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 138 S. Ct. 2361, 2376 (2018) (abortion disclosures), with *Mahanoy Area Sch. Dist. v. B.L.*, 141 S. Ct. 2038 (2021) (student speech).

scruples command them to.²⁵⁵ Forced actions are more harmful than forced omissions, justifying greater protections for conscientious refusal than for conscientious provision.

This act/omission line matters, but our conscience regime makes too much of it. Even if conscientious refusal sometimes deserves *more* protection, why should all conscientious provision get *none*?²⁵⁶ Every instance of doing harm in medicine isn't worse than every comparable instance of allowing it. Some harmful allowings are just as bad as harmful doings: that's why clinicians owe affirmative obligations to the people they treat.²⁵⁷ This positive duty of care requires benefiting patients too, not just avoiding harm to them. A conscience regime that categorically privileges refusal over provision overstates the difference between them in view of the special relationships that clinicians occupy in relation to the people whose medical needs they agree to respond to.²⁵⁸

2. *Role Obligations.* — The distinction between doing and allowing has less purchase in the healthcare context. Doctors, nurses, and therapists owe professional obligations to the patients whom they're uniquely able and authorized to serve.²⁵⁹ Only licensed practitioners are allowed to supply services that range from prescribing drugs to performing surgeries.²⁶⁰ With this power comes responsibility: not just to avoid inflicting undue harm but also to avoid letting it happen through indifference to the standard of care.²⁶¹

For the most part, the legal duties that Americans bear toward other people extend only as far as refraining from harming them — there's no general duty to save someone's life at no risk to your own even when

²⁵⁵ Complicity can also matter quite apart from consequences. And on the surface, it seems as if being compelled to do something that a person deems immoral could make the individual more complicit in it than a compelled omission that's otherwise similar would. The idea here is that being forced into a practice that one opposes implicates the person more directly or acutely in the perceived wrong. By contrast, a forced omission allows an individual to preserve enough distance to avoid complicity in something that he himself doesn't dissociate from, even if only because he's compelled to. Professors Nicolas Cornell and Amy Sepinwall argue that "even compelled complicity can undermine" one's moral standing "to censure others who commit that wrong willingly." Nicolas Cornell & Amy Sepinwall, *Complicity and Hypocrisy*, 19 POL. PHIL. & ECON. 154, 168 (2020). They reason "that acceding to [self-]interest in escaping the penalties reveals that she does not care absolutely about avoiding the wrong itself." *Id.* But this doesn't meaningfully distinguish forced doing from allowing. Why should someone who's compelled to participate in a putative wrong have less standing to condemn it, as compared with another who's made to allow something that would have prevented a similar wrong? However complicit or hypocritical either is, the other one may well be just as much. *See id.* at 159.

²⁵⁶ On the challenges with establishing operational baselines, see Seth F. Kreimer, *Allocational Sanctions: The Problem of Negative Rights in a Positive State*, 132 U. PA. L. REV. 1293, 1352 (1984).

²⁵⁷ *See* Sepper, *supra* note 37, at 1537.

²⁵⁸ *See id.* (citing Mark R. Wicclair, *Negative and Positive Claims of Conscience*, 18 CAMBRIDGE Q. HEALTHCARE ETHICS 14, 16 (2009)).

²⁵⁹ *See* John Coggon, *On Acts, Omissions and Responsibility*, 34 J. MED. ETHICS 576, 577 (2008).

²⁶⁰ *See* R. Alta Charo, *The Celestial Fire of Conscience — Refusing to Deliver Medical Care*, 352 NEW ENG. J. MED. 2471, 2473 (2005).

²⁶¹ *See* Alberto Giubilini, *Conscientious Objection in Healthcare: Neither a Negative nor a Positive Right*, 31 J. CLINICAL ETHICS 146, 152 (2020).

you're the only one who can.²⁶² Good samaritans could in fact be sued if a rescue attempt ends up doing someone in distress more harm than good.²⁶³ But sometimes, specific individuals do have affirmative obligations with respect to certain vulnerable others. Parents owe duties not to neglect their children's physical, medical, educational, and emotional needs that others are at legal liberty to ignore.²⁶⁴

It's similar with clinicians.²⁶⁵ They can be held accountable for harmful omissions to patients, and in exceptional cases even to non-patients — as when therapists owe a duty to warn a potential third-party victim if there's reason to believe that their psychiatric patient poses a serious risk of substantial bodily injury to that person.²⁶⁶ Other affirmative duties apply as a rule. Informed consent doctrine holds a doctor just as responsible for failing to disclose key risks or benefits of a proposed course of action as she is for telling the patient bad information.²⁶⁷ Likewise, a nurse can be liable for wrongful death whether he recklessly poisons a patient or recklessly lets the patient die by declining to provide a safe and effective intervention.²⁶⁸ It's not just informed consent and drug dosing. Clinical obligations from confidentiality to disease screening rarely turn on whether a clinician *did* something with respect to a patient or *allowed* it. What matters is the risk-benefit profile and moral content that fills in such doing or allowing. These commitments make a physician's duties a function of what promotes her patient's interests, not whether a decision constitutes an act or omission.²⁶⁹

²⁶² See RESTATEMENT (SECOND) OF TORTS § 314 (AM. L. INST. 1965).

²⁶³ See *id.* § 323.

²⁶⁴ Cf. *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 195–96 (1989) (holding that the Due Process Clause imposed no affirmative duty on government to protect children from parental abuse that social worker had reason to suspect).

²⁶⁵ DAN B. DOBBS ET AL., *THE LAW OF TORTS* § 285 (2d ed. 2011); see also Julian Savulescu, *Conscientious Objection in Medicine*, 332 *BMJ* 294, 294–95 (2006).

²⁶⁶ See, e.g., *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 340 (Cal. 1976). Federal and state “good samaritan” laws also exempt clinicians from civil liability for offering good faith medical aid in an emergency. See, e.g., Aviation Medical Assistance Act of 1998, Pub. L. No. 105-170, § 5, 112 Stat. 47, 49 (codified at 49 U.S.C. § 44701); *McDaniel v. Keck*, 861 N.Y.S.2d 516, 518 (App. Div. 2008).

²⁶⁷ That's how informed consent doctrine usually operates, that is, when conscience clauses don't immunize doctors against liability for breaching these legal duties. See *infra* notes 435–42 and accompanying text.

²⁶⁸ See Sepper, *supra* note 37, at 1536.

²⁶⁹ Sepper made this point first: “[P]roviders stand in a special relationship to patients and may harm them through their omissions.” *Id.* at 1537. But she goes too far when she suggests that “the distinction between being compelled to refrain from an act and being forced to perform an act . . . may be legally irrelevant.” *Id.* at 1539. Sepper indeed doubts whether that line is conceptually coherent at all: “[I]t is possible to restate most actions as corresponding inactions with the same effect, and to show that inaction may have the same effects as a forbidden action.” *Id.* at 1536 n.146 (alteration in original) (quoting *Archie v. City of Racine*, 847 F.2d 1211, 1213 (7th Cir. 1988) (en banc)).

Distinguishing doing from allowing assumes diminished significance in the medical domain. Conscientious refusers and providers owe similar duties to put their patients first. This overriding obligation reduces the division between actions and omissions to a less meaningful contrast — like failing to “confer a benefit” rather than to “prevent a harm” — that doesn’t make the decisive difference that our regime ascribes to the line between conscientious provision and refusal.²⁷⁰

B. Third-Party Harms

Even if conscientious provision is just as *worth* protecting, conscientious refusal is more *reasonable* to protect, or less expensive anyway. At first blush, the denial of services seems to require less of whichever entity subsidizes the supply of medical services, whether healthcare institutions or the state. The conscientious refuser asks only that those third parties not force his hand, freeing him to step away. The provider, by contrast, demands that others furnish her with whatever facilities, personnel, or equipment she needs to undertake prohibited treatment. All of these cost money and use up finite resources no longer available for other patients or interventions.²⁷¹ Providing care costs more than refusing it does.²⁷² Asymmetrical protections for refusers and providers are justified by the asymmetrical demands that claimants make on institutional resources.²⁷³

1. *Accommodation Costs.* — But conscientious provision doesn’t *always* incur high costs on third parties. A provider might already have what he needs to treat a patient. Alan Braid, the physician who violated the Texas abortion ban, owned his own clinic.²⁷⁴ His conscientious provision wasn’t likely to externalize significant costs to the state’s reserves of healthcare resources.

When it comes to employer restrictions, some providers need little more than a prescription pad.²⁷⁵ That script is all Dr. Barbara Morris asked for when she was fired for prescribing death-hastening drugs to

²⁷⁰ See, e.g., *Robinson v. Chief Constable of W. Yorkshire Police* [2018] UKSC 4, [2014] AC 736 (HL) 774 (appeal taken from Eng.).

²⁷¹ See AM. HOSP. ASS’N, *MASSIVE GROWTH IN EXPENSES AND RISING INFLATION FUEL CONTINUED FINANCIAL CHALLENGES FOR AMERICA’S HOSPITALS AND HEALTH SYSTEMS 2* (2022).

²⁷² Sepper explains that forcing employers or states to accommodate conscientious providers of surgical abortion, for example, would “require[] the institution to subsidize financially an individual with whom it disagrees” by furnishing that person with “operating rooms, support staff, and instruments.” Sepper, *supra* note 37, at 1550.

²⁷³ See Abram L. Brummett, *Should Positive Claims of Conscience Receive the Same Protection as Negative Claims of Conscience? Clarifying the Asymmetry Debate*, 31 J. CLINICAL ETHICS 136, 140 (2020).

²⁷⁴ See Kitchener, *supra* note 7.

²⁷⁵ A secure connection for telehealth enables some prescriptions remotely. For others, a facility might be useful for meeting patients at. Administrative staff may also be needed to make appointments or communicate with pharmacies. But the costs needn’t be great.

her terminal patient in Colorado, where physician-assisted suicide is legal.²⁷⁶ It doesn't cost much more for a provider to prescribe birth control pills, emergency contraception, or medication abortion.²⁷⁷ Or, indeed, to refer a patient to someone who will.

Hospital charges may also be marginal for add-on surgical procedures like a tubal ligation that accompanies an already-planned cesarean section.²⁷⁸ And the expenditures might actually be lower, and not higher at all, when providers invoke conscience to withdraw treatment, by honoring the advance directive of a comatose patient who is pregnant.²⁷⁹ Some more affirmative interventions might even avoid the need for more expensive ones that would be required without it. For example, abortion costs a fraction of labor and delivery.²⁸⁰

But in many cases, conscientious provision does impose greater costs on identifiable third parties than conscientious refusals do, in the form of hospital staffing and resources. What's less clear is why this cost differential alone should justify protecting all conscientious refusal and no conscientious provision. Externalities matter. But other ones cut in the opposite direction.

After all, refusals aren't costless. They can strain medical systems in other ways that weaken the quality of care. For a state or hospital to maintain the range of services that it's committed to making available, it might be forced to pay more to recruit replacements or backups through complicated systems of accommodation.²⁸¹ These side effects are more dispersed and may seem speculative. But they are no less real or harmful. Sawicki has shown that thirty-three states insulate conscientious refusers from malpractice, however serious the damage, while just eight condition that immunity on either notifying patients that they conscientiously object to providing a clinically indicated intervention or even on telling them what their medical options are.²⁸²

2. *Treatment Access.*—Shielding conscientious refusal but not conscientious provision predictably reduces access to contested care.

²⁷⁶ See *supra* notes 40–43 and accompanying text.

²⁷⁷ See, e.g., Pam Belluck, *Patients and States Turn Focus to Pills*, N.Y. TIMES, June 26, 2022, at A1. After *Dobbs*, more doctors are providing abortion pills by mail. Ruth Reader, *Galvanized by Dobbs, More Doctors Are Distributing Abortion Pills by Mail*, POLITICO (Sept. 21, 2022, 12:00 PM), <https://www.politico.com/news/2022/09/21/dobbs-abortion-pills-roe-00057877> [<https://perma.cc/FHH2-W9TQ>].

²⁷⁸ See Kartik K. Venkatesh et al., *Cost-Effectiveness of Opportunistic Salpingectomy vs Tubal Ligation at the Time of Cesarean Delivery*, 220 AM. J. OBSTETRICS & GYNECOLOGY 106.e1, 106.e4 (2019).

²⁷⁹ See Yujun Zhu & Susan Enguidanos, *Advance Directives Completion and Hospital Out-of-Pocket Expenditures*, 17 J. HOSP. MED. 437, 441 (2022).

²⁸⁰ See Janet L. Agnoletti, *Abortion vs. Birth*, CHI. TRIB., Mar. 22, 1994, at N20. Likewise, regular dialysis is cheaper for anyone with end-stage kidney disease than the emergency dialysis that they'll eventually need otherwise. See Cervantes et al., *Clinicians' Perspectives on Providing Emergency-Only Hemodialysis to Undocumented Immigrants*, *supra* note 221, at 78–79.

²⁸¹ See Sepper, *supra* note 37, at 1551.

²⁸² Sawicki, *supra* note 36, at 1281.

Lopsided protections can make the difference in whether patients are able to obtain time-sensitive services: from cancer screening to emergency contraception, from abortion early enough in pregnancy that it's safe to aid-in-dying before illness consumes sufferers with unbearable pain or deprives them of mental faculties to make their own decisions.²⁸³

Refusals impose costs even if the patients who get turned away can eventually get treatment elsewhere.²⁸⁴ Conscientious denial forces them to find a new doctor, seek out-of-network care, and deal with delays that can leave treatment less effective than it would have been.²⁸⁵ Importantly, even if the care that patients ultimately receive works just as well, being turned away in the first place can still demean or humiliate them.²⁸⁶

These harms of conscientious refusal fall hardest on those least able to bear them: people who live in states that restrict care or regions where willing providers are scarce.²⁸⁷ Recent estimates suggest that nearly thirty million Americans live over an hour from any trauma care.²⁸⁸ And that roughly one in six live at least thirty miles away from the nearest hospital.²⁸⁹ Most affected are individuals who lack the insurance, savings, or social supports they'd need to travel far distances for

²⁸³ See, e.g., Liz Szabo, *ACLU Sues Catholic Hospital Chain over Emergency Abortions*, USA TODAY (Oct. 1, 2015, 5:20 PM), <https://www.usatoday.com/story/news/2015/10/01/aclu-sues-catholic-hospital-chain-over-emergency-abortions/73147778> [<https://perma.cc/G7TK-DTMU>].

²⁸⁴ See Rachel Kogan et al., *Which Legal Approaches Help Limit Harms to Patients from Clinicians' Conscience-Based Refusals?*, 22 AM. MED. ASS'N J. ETHICS E209, E211 (2020).

²⁸⁵ See JULIA KAYE ET AL., ACLU, *HEALTH CARE DENIED* 9, 11–12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf [<https://perma.cc/ZE7M-VCQB>]; Amanda Marcotte, *A Miscarrying Woman Was Denied Medication Because of "Conscience"*, SLATE (Apr. 14, 2015, 3:14 PM), https://www.slate.com/blogs/xx_factor/2015/04/14/miscarrying_woman_denied_medication_misoprostol_can_be_used_for_both_abortion.html [<https://perma.cc/RB53-3FXX>].

²⁸⁶ Conscientious refusals have the potential to inflict dignitary harm even if service denials aren't accompanied by explicit epithets. NeJaime and Siegel explain that the pejorative social meaning of these healthcare refusals may be perfectly "intelligible to the recipient" when it "reflects and reiterates a familiar message about contested sexual norms," a message that can in turn disparage how a patient identifies or lives. NeJaime & Siegel, *supra* note 35, at 2576; see also *id.* at 2577.

²⁸⁷ See Alexis Jones, *Millions of Americans Live in "Care Deserts" — Here's What that Means and Why It's a Huge Problem*, HEALTH (June 7, 2021), <https://www.health.com/mind-body/health-diversity-inclusion/care-deserts> [<https://perma.cc/A5GB-6MSB>]; Susan Haigh & David Crary, *Catholic Hospitals' Growth Impacts Reproductive Health Care*, SAN DIEGO UNION-TRIB. (July 24, 2022, 5:54 AM), <https://www.sandiegouniontribune.com/news/california/story/2022-07-24/catholic-hospitals-growth-impacts-reproductive-health-care> [<https://perma.cc/B72N-MRGK>]; Rachel Silberstein, *Care Shifts amid Catholic-Secular Mergers*, ALBANY TIMES UNION, Aug. 14, 2022, at A1.

²⁸⁸ See Brendan G. Carr et al., *Disparities in Access to Trauma Care in the United States: A Population-Based Analysis*, 48 INJURY 332, 335 (2017).

²⁸⁹ See Caitlin Ostroff & Ciara Bri'd Frisbie, *Millions of Americans Live Nowhere Near a Hospital, Jeopardizing Their Lives*, CNN (Aug. 3, 2017, 5:59 AM), <https://www.cnn.com/2017/08/03/health/hospital-deserts/index.html> [<https://perma.cc/9HCD-4FT3>].

care.²⁹⁰ Or to be away from work and home for long enough without imperiling their jobs or caretaking responsibilities.²⁹¹ It's disproportionately undocumented immigrants and poor women of color who bear the brunt of these foreseeable costs imposed by a conscience system that protects nearly all refusers and no providers.

If the concern is about patients being able to get care, why not just enact measures to expand the availability of treatment so that conscientious refusal doesn't have the effect of blocking the desired level of access, and conscientious provision isn't necessary to secure it? States could step in to provide those scarce services themselves.

In the wake of *Dobbs*, for example, five states enacted protections for doctors who provide abortion care for patients from out of state.²⁹² These laws protect in-state providers from subpoenas or summons to enforce bans against performing abortions on out-of-state residents.²⁹³ California also safeguards patients who seek gender-affirming care that their home states have banned.²⁹⁴ And Massachusetts gives refuge to doctors who provide telehealth abortions to women in states that

²⁹⁰ See Dan Keating et al., *Abortion Access Is More Difficult for Women in Poverty*, WASH. POST (July 10, 2019), <https://www.washingtonpost.com/national/2019/07/10/abortion-access-is-more-difficult-women-poverty> [https://perma.cc/MJP2-X4F3]; Taylor Johnson & Kelsey Butler, *Abortion Desert in US South Is Hurting Black Women the Most*, BLOOMBERG (Aug. 23, 2022, 7:00 AM), <https://www.bloomberg.com/news/articles/2022-08-23/black-women-are-hardest-hit-by-abortion-restrictions-sweeping-the-deep-south> [https://perma.cc/9AVN-MZA7]; Nada Hassanein, *Inside America's Rural Maternal Health Care Crisis: Why Are Women of Color Most at Risk?*, USA TODAY (Aug. 11, 2022, 5:38 AM), <https://www.usatoday.com/in-depth/news/health/2022/08/11/prenatal-maternal-health-care-people-color-history/10084878002> [https://perma.cc/4LX7-MY7P].

²⁹¹ Critics of legal protections for conscientious refusal foresaw as early as 1973 their potential to render access "meaningless" by authorizing "discrimination against persons of lesser means" who can't "afford to go to another hospital . . . hundreds of miles distant." 119 CONG. REC. 17,452 (1973) (statement of Rep. Bella Abzug).

²⁹² See An Act Concerning the Provision of Protections for Persons Receiving and Providing Reproductive Health Care Services in the State, 2022 Conn. Acts 22-19 (Reg. Sess.); An Act to Amend Titles 24, 10, 11, and 18 Relating to the Women's Reproductive Health, 83 Del. Laws ch. 327 (2022); An Act Expanding Protections for Reproductive and Gender Affirming Care, 2022 Mass. Acts ch. 127; An Act Concerning Reproductive Health Care Services, Supplementing Title 2A of the New Jersey Statutes, and Amending P.L. 1978, c.73, 2022 N.J. Laws ch. 51; An Act Barring Extradition of Persons Under Certain Circumstances Related to Actions Concerning Reproductive Health Care Services and Supplementing Chapter 160 of Title 2A of the New Jersey Statutes, 2022 N.J. Laws ch. 50; An Act to Amend the Insurance Law, In Relation to Prohibiting Medical Malpractice Insurance Companies from Taking Any Adverse Action Against a Reproductive Health Care Provider Who Provides Legal Reproductive Health Care, 2022 N.Y. Laws ch. 221 (to be codified at N.Y. INS. § 3436-a).

²⁹³ On the hard interstate conflicts that this dynamic invites, see David S. Cohen, Greer Donley & Rachel Rebouché, *The New Abortion Battleground*, 123 COLUM. L. REV. (forthcoming 2023) (manuscript at 17-19), https://scholarship.law.pitt.edu/cgi/viewcontent.cgi?article=1515&context=fac_articles [https://perma.cc/72PT-2Z5J].

²⁹⁴ See S.B. 107, 2021-2022 Leg., Reg. Sess. (Cal. 2022) (enacted) (to be codified in scattered sections of CAL. CIV. CODE, CAL. CIV. PROC. CODE, CAL. FAM. CODE, and CAL. PENAL CODE). Similarly, Oregon now allows residents from other states to seek aid-in-dying under its Death with Dignity Act. See OR. REV. STAT. §§ 127.800-995 (2021); Settlement Agreement and Release of Claims at 2, *Gideonse v. Brown*, No. 21-cv-01568 (D. Or. Mar. 28, 2022).

prohibit mail-order medications or any other way of ending a pregnancy.²⁹⁵ Some blue cities in red states have also adopted measures to establish themselves as sanctuaries from state prosecutions of abortion crimes.²⁹⁶

But the burdens of travel can still be prohibitive. And policymakers in many parts of the country may not be all that committed to making sure that people can actually get whatever contested treatment the law there permits. Lawmakers could be ambivalent about abortion, on the fence about aid-in-dying, or indifferent to puberty blockers. They may be content to leave any of these treatments available only in a formal sense, whether or not patients may have trouble getting them as a practical matter.²⁹⁷

A “hands-off” policy that enables refusals without offsetting their impact on access isn’t staying neutral. By categorically insulating the conscientious denial of treatment, a state takes a clear side and sends a decisive message: to favor even widespread refusal and to ratify its anticipated harms.²⁹⁸ That consequence is incompatible with the state’s equal commitment to the interests of claimants and nonclaimants alike. An inclusive pluralism requires taking seriously the ways in which accommodating complicity-based claims of conscience can hurt those who don’t share these beliefs.²⁹⁹

C. Government Interests

The final way of trying to distinguish conscientious refusal from provision is the most promising. It asks whether a clinician’s expression of conscience can be vindicated consistent with the background interests that an institution or state has affirmed to provide some form of care or prohibit it. Suppose a hospital or the government has decided that by

²⁹⁵ An Act Expanding Protections for Reproductive and Gender Affirming Care, 2022 Mass. Acts ch. 127, § 11. That refuge from criminal abortion laws extends only as far as the state’s borders: if Massachusetts clinicians cross state lines, they could still be extradited for arrest and prosecution. *See id.* And even that shelter wouldn’t spare conscientious providers from having to be delivered up to face civil liability that might include loss of a medical license. *See* Katherine Florey, Dobbs and the Civil Dimension of Extraterritorial Abortion Regulation, 98 N.Y.U. L. REV. (forthcoming 2023) (manuscript at 23–24), <https://ssrn.com/abstract=4172494> [<https://perma.cc/K9D4-GYTE>].

²⁹⁶ *See, e.g.,* Nicole Narea, *How Blue Cities in Red States Are Resisting Abortion Bans*, VOX (June 29, 2022, 5:10 PM), <https://www.vox.com/policy-and-politics/2022/6/29/23188737/abortion-bans-austin-cincinnati-phoenix-tucson-raleigh> [<https://perma.cc/R3LR-8YAW>]; Morgan Severson, *Austin City Council Passes GRACE Act to Decriminalize Abortion Despite Statewide Ban*, DAILY TEXAN (July 25, 2022), <https://thedailytexan.com/2022/07/25/austin-city-council-passes-grace-act-to-decriminalize-abortion-despite-statewide-ban> [<https://perma.cc/C2Z4-A24T>]; Chris Potter, *Pittsburgh City Council Passes Bills Affirming Abortion Rights in City Limits*, WESA (July 19, 2022, 5:53 PM), <https://www.wesa.fm/politics-government/2022-07-19/pittsburgh-city-council-passes-bills-affirming-abortion-rights-in-city-limits> [<https://perma.cc/N4AS-JTLL>].

²⁹⁷ *See* Jason T. Eberl, *What Makes Conscientious Refusals Concerning Abortion Different*, AM. J. BIOETHICS, July 2021, at 62, 63.

²⁹⁸ *See* Sepper, *supra* note 37, at 1572.

²⁹⁹ *See supra* notes 95–102 and accompanying text.

allowing certain services, people ought to have access to them. That abortions or puberty blockers or advance directives should be available not just in theory but in practice. Conscientious refusal doesn't block them from being obtained elsewhere. So the entity or state can recognize the refuser's conscience while enabling people to access that treatment, thereby satisfying the background policy that they be able to get it.³⁰⁰

By contrast, when an institution or government has determined that people shouldn't have access to reproductive or gender-affirming or end-of-life care, then vindicating a conscientious appeal to provide that care can't help but undermine that interest in keeping people from having it. The conflict here is inescapable: the hospital or state can't honor the provider's conscience consistent with its interest in care not being available. That one comes at the expense of the other is the best reason to accommodate refusal, and not provision. But this argument justifies the legal system's contrasting postures toward them only if it holds up on a closer look.

1. *Permissive Regimes.* — Can a regime really advance its interest in permitting care at the same time that it exempts conscientious refusals? Not if accommodation has the effect of leaving care out of reach for people who need it.

The case of Tamesha Means is instructive. She's a Michigan mother whose amniotic sac ruptured at eighteen weeks.³⁰¹ The closest hospital, thirty minutes away, discharged her with instructions to come back the following week.³⁰² Her doctors at the Catholic-affiliated institution never told her that the fetus she was carrying had no chance to survive, or that removing it was the safest way to reduce the serious risk to her own life.³⁰³ Twice more, she returned to the same emergency department, each time in worse shape, yet again was refused treatment.³⁰⁴

A regime can't supply the care that it seeks to make available if too many of its facilities or staff are unwilling and find refuge in conscience clauses that protect refusers from being penalized or disciplined. Permissive states or institutions may deem that care acceptable or even desirable, but it can remain hard to get there when one-sided safeguards are indifferent to the impact of widespread refusals on patient access. Licensed clinicians and institutions enjoy a state-enforced monopoly on which care is available, even when they operate in strict accordance with religious directives.³⁰⁵

³⁰⁰ See Kyle G. Fritz, *Unjustified Asymmetry: Positive Claims of Conscience and Heartbeat Bills*, AM. J. BIOETHICS, Jan. 2021, at 46, 55.

³⁰¹ See Complaint at 4–5, Means v. U.S. Conf. of Cath. Bishops, No. 15-CV-353, 2015 WL 3970046 (W.D. Mich. June 30, 2015), *aff'd*, 836 F.3d 643 (6th Cir. 2016).

³⁰² See *id.* at 5.

³⁰³ See *id.* at 2.

³⁰⁴ See *id.* at 2–3.

³⁰⁵ See *supra* notes 66–67 and accompanying text.

Many medical entities don't disclose that their practice is governed by spiritual teachings or how such ministerial authority limits which services they provide.³⁰⁶ Hospitals that do make that affiliation known may surprise even adherents of the same faith.³⁰⁷ For example, some Catholic patients don't realize that their Catholic hospital would deny their clear wishes to withdraw life-sustaining care if they're suffering gravely at the end of life.³⁰⁸ And a patient deciding where to go for a tubal ligation, IUD, Plan B, or IVF might have no idea that her local clinic won't provide these services after it's merged or contracted with a Christian ministry.³⁰⁹ "Why would she assume that a nonprofit hospital, buoyed by large infusions of state and federal funds, could legally withhold health care from its patients?"³¹⁰

Institutional consolidation constrains access most in parts of the country where unwilling facilities or clinicians are the only option for miles.³¹¹ Sectarian conglomerates have come to dominate healthcare markets in many rural towns and inner cities.³¹² Their control over healthcare access in these regions gets reinforced by clauses that let them restrict even time-sensitive services that they decline to provide on grounds of conscience.³¹³ That's how legally permitted procedures become unattainable for patients who lack the resources to reach willing providers at great distance and cost.³¹⁴ Vindicating refusals

³⁰⁶ See, e.g., Joelle Takahashi et al., *Disclosure of Religious Identity and Health Care Practices on Catholic Hospital Websites*, 321 JAMA 1103, 1103 (2019). A New York bill would require hospitals to link on their websites to the State Department of Health's list of each institution's "policy-based exclusions," detailing the care that they won't provide. S. 5400, 2021–2022 Leg., Reg. Sess. (N.Y. 2021).

³⁰⁷ See Anna Maria Barry-Jester & Amelia Thomson-DeVeaux, *Why Religious Health Care Restrictions Often Take Patients by Surprise*, FIVETHIRTYEIGHT (Aug. 2, 2018), <https://fivethirtyeight.com/features/why-religious-health-care-restrictions-often-take-patients-by-surprise> [<https://perma.cc/H93B-TSN4>]; Jocelyn M. Wascher et al., *Do Women Know Whether Their Hospital Is Catholic? Results from a National Survey*, 98 CONTRACEPTION 498, 501 (2018).

³⁰⁸ See Judith Graham, *Catholic Hospitals Face Choice*, CHI. TRIB. (Feb. 8, 2010, 12:00 AM), https://articles.chicagotribune.com/2010-02-09/news/1002080254_1_vegetative-statebishops-church-teachings [<https://perma.cc/ZX5B-GS39>]; Debra B. Stulberg et al., *Women's Expectation of Receiving Reproductive Health Care at Catholic and Non-Catholic Hospitals*, 51 PERSPS. SEXUAL & REPROD. HEALTH 135, 136, 141 (2019).

³⁰⁹ See *supra* notes 146–50 and accompanying text.

³¹⁰ Kate Cohen, Opinion, *I Don't Want Your God in Charge of My Health Care*, WASH. POST (Sept. 26, 2022, 7:00 AM), <https://www.washingtonpost.com/opinions/2022/09/26/catholic-hospital-secular-reproductive-health-care> [<https://perma.cc/6CSY-WH3V>].

³¹¹ See Rachel Mosher Henke et al., *Access to Obstetric, Behavioral Health, and Surgical Inpatient Services After Hospital Mergers in Rural Areas*, 40 HEALTH AFFS. 1627, 1631 (2021).

³¹² See Coleman Drake et al., *Market Share of US Catholic Hospitals and Associated Geographic Network Access to Reproductive Health Services*, JAMA NETWORK OPEN, Jan. 2020, at 1, 2; Allison Roberts, *Selling Salvation: Catholic Hospitals in the Healthcare Marketplace*, CANOPY F. (Dec. 19, 2019), <https://canopyforum.org/2019/12/19/selling-salvation-catholic-hospitals-in-the-healthcare-marketplace-by-allison-roberts> [<https://perma.cc/SB57-525V>].

³¹³ See, e.g., Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 140 S. Ct. 2367, 2373 (2020); Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 507(d)(1), 118 Stat. 2809, 3163 (codified at 42 U.S.C. § 18023(b)(4)).

³¹⁴ See *supra* notes 287–91 and accompanying text.

so categorically can crowd out access to care that a state means its residents to have. If lopsided conscience clauses keep people from actually receiving some form of treatment, then these protections end up incompatible with a background commitment to making that treatment available.

2. *Restrictive Regimes.* — Still, accommodating conscientious provision will always undermine another state or hospital's policy goal that people not be able to get a certain procedure or service.³¹⁵ Exempting providers outright defeats the point of the ban by negating the interest that it serves, for example, to promote public morals or an institution's religious mission. This straightforward conflict is the strongest rationale for denying conscientious providers the solicitude that refusers get. But other reasons to protect conscientious providers can be even stronger.

Providers affirm their obligations to put patient interests first by honoring the wishes of people in need of medical treatment. Access to everything from X-rays to operations is too important to release doctors and nurses from core duties like emergency treatment and informed consent.³¹⁶ Also, forcing doctors and nurses to sit by and watch avoidable harms befall the patients they've devoted their professional lives to caring for strikes at their fundamental charge to promote health and relieve suffering.³¹⁷ Laws that generate this crisis of conscience inflict psychological distress and erode the social goods of making people well and keeping them healthy.³¹⁸

Making space for conscientious providers isn't about changing restrictive laws through the back door: trying to poke enough holes in a blanket prohibition so that the exception becomes the rule. The point is to affirm the noble ends of medicine and honor a principled commitment to democratic pluralism.

There's too vast a gulf between liability shields for conscientious denials and full exposure to punishments for conscientiously delivering care. One way to even things out: eliminate conscience protections for refusers and providers alike. Claimants would suffer moral distress and

³¹⁵ See Eric Mathison, *The Wrong Argument for a Bad Law*, AM. J. BIOETHICS, July 2021, at 77, 77. There may be reason to doubt whether the asserted interest in potential life is sincere if the state fails to promote in all sorts of other ways that aren't distinguishable by principled differences, competing tradeoffs, or legislative compromises. See Dov Fox, *The State's Interest in Potential Life*, 43 J.L. MED. & ETHICS 345, 353 (2015). But a colorable challenge would require evidence of illicit motives. It isn't enough to assume that enactment processes were captured or distorted in ways that don't represent the will of the majority, especially when gerrymandering and other democratic deficits have become so pervasive that they're to unlikely to attract momentum for legal reform. See Daniel Markovits, Essay, *Democratic Disobedience*, 114 YALE L.J., 1897, 1952 (2005) (observing growing democratic deficits in general).

³¹⁶ See Ronit Y. Stahl & Ezekiel J. Emanuel, *Physicians, Not Conscripts — Conscientious Objection in Health Care*, 376 NEW ENG. J. MED. 1380, 1382 (2017); Julian Savulescu & Udo Schuklenk, *Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception*, 31 BIOETHICS 162, 168–69 (2017).

³¹⁷ See, e.g., *supra* notes 17–25, 40–44 and accompanying text.

³¹⁸ See *supra* notes 95–98 and accompanying text.

society would lose the dynamism of their dissenting voices from within. But ridding U.S. healthcare of conscience-based exclusions would remain compatible with objectors enlisting the democratic process to reform bad laws.

A practical obstacle stands in the way of conscience abolition, however: conscience clauses are woven deep into the fabric of American law and medicine. Their entrenchment makes doing away with these exemptions politically impractical.³¹⁹ As Sepper explains, “[a]ny workable solution” to accommodating conscience in American healthcare “cannot reject it out of hand.”³²⁰ But patients in underserved parts of the country mustn’t thereby be consigned to a unilateral regime that makes it hard to get treatment, however beneficial or badly needed.

Hence, the case to even things out by protecting refusers less and providers more. A principled approach would narrow the gap from both top and bottom. For conscientious refusal: level down the broadscale immunities that burden patient access. For conscientious provision: level up accommodations — from none to some — while minimizing the potential disruption to institutional missions and state interests. These limited protections may sound reasonable enough, articulated in such generic terms. But under which circumstances? And in what ways? The devil is in the details. Which is what the final Part turns to now.

IV. VINDICATING CONSCIENCE

An ideal of “medical disobedience” informs whether, when, and how to protect clinician conscience that’s invoked to defy institutional policy or law. This concept doesn’t give doctors free rein to break the rules. Rather, it takes the edge off of them in keeping with four principles. First, clinicians are charged to promote health and relieve suffering;³²¹ second, conscience should be vindicated, within limits, in principled ways for all who invoke it in good faith;³²² third, an inclusive pluralism attends to claimants *and* those who don’t share their beliefs;³²³ and finally, conscience exemptions that harm others must offset those costs of accommodation.³²⁴

These propositions underwrite the ideal of medical disobedience that should govern how much room our legal system makes for the expression of conscience in healthcare. That ideal’s overlapping concern for moral integrity and dynamic professionalism guides specific reforms to America’s medical regime. This Part advocates two sets of fixes. One

³¹⁹ See *supra* section I.C.1, pp. 1048–50.

³²⁰ Sepper, *supra* note 37, at 1563.

³²¹ See *supra* section I.A, pp. 1041–43.

³²² See *supra* notes 95–102 and accompanying text.

³²³ See *supra* section I.B, pp. 1043–45.

³²⁴ See *supra* section I.C, pp. 1045–52.

has to do with conscience exemptions from employer policies about legally permitted practices. The other concerns conscientious practices in the face of government regulations.

A. *Employer Exemptions*

Workplace carve-outs for clinician conscience should mediate the strains that conscientious refusal can place on patient access as well as the burdens that conscientious provision can visit to a hospital's mission. Accordingly, those who conscientiously object ought to clearly disclose those objections upfront to employers and to patients. Claimants should also pay a modest fee to offset the resulting harms. A refusal fee would go to boost availability elsewhere, while providers' contributions would help facilities adopt distancing measures to accommodate them.

1. *Accommodation Offsets.* — Most conscience clauses don't make refusers do anything: they don't have to tell patients or employers that they won't supply certain services, let alone explain their reasons for denying treatment; they aren't required to help patients secure that care elsewhere, or assist employers in arranging backups; they don't even have to share low-risk, high-benefit alternatives like informed consent otherwise requires.³²⁵ Conscientious refusers don't lose their jobs for failing to disclose medically indicated options or comply with basic standards of care.³²⁶

Of the thirty-three states that insulate conscientious refusers from malpractice liability, just eight condition those liability shields on refusers having warned patients that they would deny such services, even if only by posting that policy where they could see it.³²⁷ And of those eight, just two require refusers to refer patients to a willing provider or let them know where else they might be able to obtain the procedure that the refusers themselves won't perform.³²⁸

To mitigate these burdens, exemptions for refusing any medically standard and legally permitted treatment should come with a condition:

³²⁵ See Nadia N. Sawicki, *Mandating Disclosure of Conscience-Based Limitations on Medical Practice*, 42 AM. J.L. & MED. 85, 103 (2016).

³²⁶ States seldom even discipline conscientious refusers. A rare exception involved a pharmacist who wouldn't fill or transfer a woman's prescription for birth control. The Wisconsin medical board reprimanded him and placed limiting conditions on his license to dispense medication. See *Noesen v. State Dep't of Regul. & Licensing, Pharmacy Examining Bd.*, 751 N.W.2d 385, 388 (Wis. Ct. App. 2008).

³²⁷ See CAL. HEALTH & SAFETY CODE § 123420(c) (West 2022); 745 ILL. COMP. STAT. 70/6.1 (2019); LA. STAT. ANN. § 40:1061.20(4) (2016); NEB. REV. STAT. ANN. § 28-337 (LexisNexis 2022); N.Y. COMP. CODES R. & REGS. tit. 10, § 405.9(b)(10) (2019); OR. REV. STAT. § 435.475(1) (2022); 16 PA. CODE § 51.31(e) (1999); WYO. STAT. ANN. § 35-6-105 (2019).

³²⁸ See 745 ILL. COMP. STAT. 70/6.1 (2019); N.Y. COMP. CODES R. & REGS. tit. 10, § 405.9(b)(10) (2019). Another couple states make pharmacists return a patient's prescription right away, rather than decline to fill it without notice or explanation. See ARIZ. REV. STAT. ANN. § 36-2154(B) (2022) (requiring pharmacists who object to abortion to return the prescription to the patient); GA. CODE ANN. § 16-12-142(b) (2022) (requiring pharmacists who object to abortion to either refer the patient to another pharmacist or else immediately return the prescription).

that patients be able to get it from qualified clinicians nearby.³²⁹ That's how France handles abortion: it doesn't let sectarian hospitals with certain public affiliations refuse abortions unless enough willing providers in the area are capable of responding to the regional needs for that care.³³⁰ In 2021, Oregon authorized officials to block any healthcare sale, merger, or acquisition that's likely to restrict the availability of essential healthcare.³³¹

Appeals to conscientiously deliver legally permitted services that employers forbid should similarly depend on whether those services can be obtained elsewhere. Providers invoke conscience to promote health or relieve suffering: their claim for exemption is accordingly weaker if institutional restrictions leave that care readily accessible anyway. So vindicating conscientious provision is contingent on there not already being enough clinicians available to perform procedures nearby enough that patients can access them.

Accommodation offsets should also draw on objector fees. The most fitting currency would involve coordination efforts or volunteer service. But money works too. Fees could take form in deferring insurance reimbursements or setting aside salary contributions to help shoulder the institutional costs of accommodation. States would then authorize employers to collect suitably modest sums from workers who conscientiously refuse or provide care in violation of company policy.³³² And that money would be earmarked to defray the practical expenses that exemption incurs to the employer.

³²⁹ See *supra* notes 298–99 and accompanying text.

³³⁰ See CODE DE LA SANTÉ PUBLIQUE [PUBLIC HEALTH CODE] art. L2212-8 (Fr.). Italy's abortion statute has likewise been interpreted to bar long waits or scarce access by requiring measures to “ensure the availability of non-objecting medical practitioners and other health personnel when and where they are required to provide abortion services, taking into account the fact that the number and timing of requests for abortion cannot be predicted in advance.” International Planned Parenthood Federation — European Network (IPPF EN) v. Italy, Complaint No. 87/2012, Decision on the Merits, ¶¶ 174–177 (Eur. Comm. of Soc. Rts. Mar. 10, 2014).

³³¹ See 2021 Or. Laws ch. 615 (codified as amended at OR. REV. STAT. §§ 413.032, 413.037, 413.101, 413.181, 415.013, 415.019, 415.103 (2022)).

³³² For claimants who invoke faith, federal law would limit the amount of any such objector fee to avoid bearing down too hard on the exercise of religion that's embedded in their appeal to conscience. The Religious Freedom Restoration Act would forbid the stipend sum on spiritually motivated refusal or provision from being so costly that they constitute a “substantial burden” on religious exercise — that is, unless enforcing that level of objector fee were the least restrictive means of furthering a compelling government interest in enabling access to essential healthcare. See Religious Freedom Restoration Act of 1993, Pub. L. No. 103-141, 107 Stat. 1488 (codified as amended at 42 U.S.C. §§ 2000bb to 2000bb-4). The RFRA inquiry depends on a number of highly contextual factors: the concentration of similar claims, the availability of willing providers in a particular region, the existence of alternative measures to minimize patient harms that would tax religious claimants less, and the design of accommodations in ways that would promote health more. On the other hand, the Supreme Court's most recent free exercise doctrine has tended to read “[a]ttempts at legislative balance . . . as inappropriate political compromise.” Richard Schragger & Micah Schwartzman, *Religious Freedom and Abortion*, 108 IOWA L. REV. (forthcoming 2023) (manuscript at 26) (on file with the Harvard Law School Library) (discussing Tandon v. Newsom, 141 S. Ct. 1294 (2021)).

The point isn't to punish or deter claims of conscience. It's to make up for the reasonable costs of accommodating them. These payments would acknowledge that freedom of conscience is a privilege whose entitlement is expressly conditioned on medical impact to patients and others. Having doctors pay for this privilege of practicing according to their convictions wouldn't resolve the tension between conscience and its consequences. But this tipping of the scales would reduce the bite of that dilemma in ways that resemble accommodations for the pacifists required to provide nonmilitary service to qualify for exemption.³³³

In the healthcare context, compensation wouldn't be limited to conscientious providers who incur financial expenses to the institutions they work for; conscientious refusers should have to pay a similar stipend. For denials of care, this fee would go toward the costs to get patients ancillary services: for example, by covering the next best available treatment, or perhaps even reimbursing their travel across the border or subsidizing incentives to recruit willing providers to the broader field.³³⁴ Operational details would turn on how best to strike a balance between reducing burdens on patient access and distancing refusers from the practices they oppose.

This same tradeoff informs the rejection of mandatory referrals in favor of plain-language and user-friendly notifications — akin to the standardized nutrition labels on food products.³³⁵ Canadian courts condition conscience exemptions for refusers on their pointing patients to a specific willing provider.³³⁶ The problem with mandating specific referrals is how directly it enlists refusers to facilitate a perceived wrong by making its incidence that much more likely.³³⁷ But mandating general disclosures would avoid such complicity.³³⁸

Sawicki is right that conscientious refusers should be required to give clear, upfront notice about a couple of things: that other clinicians may be available to provide the service, and that the reason they themselves are unwilling to provide it has to do with their own moral or religious beliefs, lest patients be misled into thinking that they're refusing because the medical costs outweigh the benefits.³³⁹

³³³ See *supra* notes 106–07 and accompanying text.

³³⁴ See Kim & Ferguson, *supra* note 96, at 69.

³³⁵ See generally 21 C.F.R. § 101.9 (2022).

³³⁶ See *Christian Med. & Dental Soc'y of Can. v. Coll. of Physicians & Surgeons of Ont.*, [2019] 147 O.R. 3d 398, ¶¶ 2, 7–8 (Can. Ont. C.A.).

³³⁷ See Michael R. Panicola & Ronald P. Hamel, *Conscience, Cooperation, and Full Disclosure*, HEALTH PROGRESS, Jan.–Feb. 2006, at 52, 56.

³³⁸ General disclosure mandates for doctors are unlikely to raise free speech problems. The First Amendment has been interpreted to allow states to compel truthful, nonmisleading speech by physicians in the context of their medical practice. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 834 (1992), *overruled by Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022); Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 950–51.

³³⁹ See Sawicki, *supra* note 325, at 121, 127.

Providers too should have to notify their employer of their conscientious objections to a workplace restriction in order to grant administrators a fair opportunity to minimize the impact of accommodation to the institution's mission. And if there are reasonable ways that these hospitals can make space for those conscience claims, they should be barred from firing or demoting claimants, or from declining to hire them for exercising their conscience.

2. *Institutional Association.* — Conscience clauses also look lopsided from the perspective of healthcare employers that can have interests of their own. One such institutional interest is to affirm values shared by administrators, workers, and/or patients. Another is associating freely with those who buy into the institution's founding mission. That might involve providing services that a hospital deems worthy, or refusing those that it deems sinful.

Sepper observes that this asymmetric regime appears in a new light when it's reflected through that institutional lens.³⁴⁰ The question becomes: Why should an organization that refuses care be entitled to enforce its values against conscientious providers, when another entity that insists on making care available has to accommodate conscientious refusers? It's not simply that only refusing institutions are only refusing institutions affiliated with religion, which grants them privileges under federal and state law. Statutory exemptions are conditioned on how they'd impact others (such as patients) and competing interests (like public health). And the unwillingness of major hospital systems to provide essential care could reduce its availability too much for those in need. In the absence of special protections for religion, protecting only refusers and not providers unfairly prefers employers that advance sectarian values, and selectively burdens those whose shared convictions center on comprehensive access to evidence-based care.³⁴¹

An institution's interest in deciding whom it partners with or serves can also conflict with state interests against discrimination or malpractice. And just as state or individual interests can be more compelling or less, depending on facts and context, so too can institutional interests vary in strength. The Supreme Court has identified "size, purpose, policies, selectivity, [and] congeniality" as factors that "may be pertinent" to determine how strong an institution's interest is "in a particular case."³⁴²

In the medical context, Sepper's framework for adjudicating the strength of institutional interests in free association is informed by

³⁴⁰ See Sepper, *supra* note 37, at 1548 (criticizing the legal fact that "a refusing employer may impose its moral norms on staff," while "a willing institution must accommodate individual providers' refusing consciences with which it disagrees").

³⁴¹ See Lynn D. Wardle, *Protecting the Rights of Conscience of Healthcare Providers*, 14 J. LEGAL MED. 177, 186 (1993).

³⁴² *Roberts v. U.S. Jaycees*, 468 U.S. 609, 620 (1984).

similar considerations: size, cohesion, and message.³⁴³ Smaller, mission-centered practices whose affiliates relate to one another on that basis have greater associational claims to enforce their values — that abortion is murder, or that aid-in-dying is compassionate care — over the objection of those who disagree.³⁴⁴ By contrast, sprawling hospitals have weaker interests that entitle them less to deny standard-of-care services, or to punish the employees who seek to provide them.³⁴⁵

Workers who object to these policies might infringe on their institution's interests to varying degrees. Having to accommodate the occasional conscientious provider needn't completely defeat an institution's authority to enforce its values.³⁴⁶ Exempting the odd outlier at the margins could still leave the institution largely capable of dissociating itself from practices it opposes.³⁴⁷ It might also matter whether the provider asserts conscience in routine cases — abortion for any reason — or only in special cases involving rape, health risks, or serious fetal disability. An institution that opposes abortion can more reasonably be expected to accommodate the provider who conditions her conscience on those more specific grounds.

And there are distancing strategies that an institution can adopt to blunt the expressive burden of accommodating objectors.³⁴⁸ It could consign contested care to an after-hours basement or off-site facility.³⁴⁹ Or it could reserve hands-on participation in that care for outside contractors, while letting affiliates admit patients, take their medical history, administer pain medication, or deliver their meals after the procedures.³⁵⁰

If an employer can't reasonably accommodate a conscientious provider, thereby entitling it to fire or not hire that worker, the

³⁴³ See Sepper, *supra* note 37, at 1563–66.

³⁴⁴ See *id.* at 1564–65.

³⁴⁵ Even the biggest hospitals with the weakest associational interests still may have other sound reasons to decline nonstandard offerings due to a “lack of personnel or facilities or of specialization in non-obstetrical and non-surgical fields.” *Wolfe v. Schroering*, 541 F.2d 523, 527 n.6 (6th Cir. 1976) (nonetheless expressing no opinion as to a hospital's nonethical reasons for refusing abortions).

³⁴⁶ *But see* Christopher O. Tollefsen, *Protecting Positive Claims of Conscience for Employees of Religious Institutions Threatens Religious Liberty*, 15 AM. MED. ASS'N J. ETHICS 236, 237 (2013).

³⁴⁷ See Jeffrey Blustein, *When Doctors Break the Rules: On the Ethics of Physician Noncompliance*, 21 CAMBRIDGE Q. HEALTHCARE ETHICS 249, 258 n.9 (2012).

³⁴⁸ See, e.g., Maryam Guiahi et al., *Impact of Catholic Hospital Affiliation During Obstetrics and Gynecology Residency on the Provision of Family Planning*, 9 J. GRADUATE MED. EDUC. 440, 444 (2017).

³⁴⁹ Sepper notes that when some Catholic facilities are faced with state mandates to provide Plan B to rape victims or condoms to people at risk of HIV, they've agreed to compromises that seek to diminish their “cooperation in acts deemed wrong” by “allow[ing] legally separate entities to operate clinics . . . nearby.” Sepper, *supra* note 37, at 1571.

³⁵⁰ See Danielle Czarnecki et al., *Conscience Reconsidered: The Moral Work of Navigating Participation in Abortion Care on Labor and Delivery*, SOC. SCI. & MED., July 2019, at 181, 182. The United Kingdom limits conscience exemptions to claimants who “tak[e] part in a ‘hands-on’ capacity,” excluding administrative or supervisory tasks from the scope of protection. *Greater Glasgow Health Bd. v. Doogan* [2014] UKSC 68, [38] (appeal taken from Scot.).

institution might still be required to contribute to a fund or agency that promotes, say, women's or children's health in ways that the institution finds less objectionable.³⁵¹ These mediating measures needn't appease the employers that have to accommodate providers or otherwise address their objections: conscience offsets in the workplace are about balancing institutional interests against patient access and clinician conscience.³⁵²

B. *Affirmative Defense*

Government restrictions complicate the case for conscience exemptions. Laws carry more normative force than workplace policies, giving clinicians greater reason to comply. Also, institutional penalties are limited to professional consequences, whereas civil or especially criminal ones exact a higher price in America's modern carceral order.

This section introduces a partial excuse for violating government restrictions. Under certain circumstances, this limited defense would reduce the penalties for clinicians who claim conscience in violation of certain tort or criminal laws. To qualify, the conscientious provision of prohibited care must be compatible with competent consent, clinical reasonableness, and distributive justice. And conscientious refusal must satisfy three nonnegotiable professional duties: informed consent; stabilizing patients in emergencies; and treating them regardless of age, sex, or race.

* * *

Today, doctors who conscientiously provide legally prohibited care have no prospect for relief or mitigation. The options they're stuck with are all futile. First, they can plead necessity: that violating the ban on providing care is the lesser of two evils. But courts have limited this defense to exigencies of last resort, ruling out appeals where there are ways to change the law itself — even if any hoped-for reform would

³⁵¹ See Cornell & Sepinwall, *supra* note 255, at 172.

³⁵² There's precedent for state laws that protect workers for engaging in conduct that their employers don't like. Statutes in Colorado and North Dakota forbid employers from firing someone for engaging in lawful, off-premises activity so long as it isn't incompatible with a "bona fide occupational requirement," COLO. REV. STAT. § 24-34-402.5(1)(a) (2022), or "in direct conflict with the essential business-related interests of the employer," N.D. CENT. CODE § 14-02.4-03(1) (2021). States that don't ban such care themselves could protect conscientious providers for supplying care that employers oppose, even if limited to moonlighting off the job or after hours. This was the middle ground that the Church Amendment found for prohibiting "discriminat[ion] in the extension of staff or other privileges" against clinicians for having "performed or assisted in the performance of a lawful sterilization procedure or abortion." Health Programs Extension Act of 1973, Pub. L. No. 93-45, § 401(c)(2), 87 Stat. 91, 96. That protection applies solely to federally funded hospitals and abortion/sterilization. Even then, the law provides no way for the clinician who's subject to such discrimination to bring suit against her employer or take any step to enforce the nondiscrimination provision other than report the employer to Congress in the hope that it might withhold funding from that offending employer in a way that Congress never has in half a century. See *supra* notes 151–52 and accompanying text.

come too late to help individuals who have urgent needs in the here and now.³⁵³

Courts have also rejected claims of necessity “when the legislature itself has made a determination of values” in the matter, namely, that the state’s interest in prohibiting such care outweighs competing interests that include the ones that patients have in receiving this care and those that doctors have in providing it.³⁵⁴ A similar separation-of-powers reason explains why conscientious providers can’t rely on a second form of clemency: statutes in a dozen states authorize trial court judges to dismiss criminal charges “in furtherance of justice,” but only under circumstances that lawmakers didn’t already foresee and speak to.³⁵⁵ Conflicting legislation preempts.

The final option is to hope against hope that a jury is willing to flout the criminal prohibition that a clinician has plainly violated by providing care. That’s not something that a litigant can explicitly request of jurors. Procedural rules in every state forbid a conscientious provider from arguing that the jury should “nullify” the law, either as it applies generally or under the specific circumstances at issue.³⁵⁶ Defense attorneys aren’t allowed to even inform jurors that returning a verdict that doesn’t follow the law is something that they have the power to do, no explanation needed.³⁵⁷

Jury nullification is so rare and unpredictable that it’s a mistake to count on it. Even scholars who have advanced the practice as a bulwark against abortion bans after *Dobbs* acknowledge nullification’s sharp limits.³⁵⁸ Not only can a judge overrule any nullification of civil sanctions against abortion providers,³⁵⁹ There’s also the threat of multiple criminal prosecutions, each of which will empanel a different jury.

³⁵³ Cf. *Commonwealth v. Hutchins*, 575 N.E.2d 741, 743, 745 (Mass. 1991).

³⁵⁴ *Abigail All. for Better Access to Developmental Drugs v. Eschenbach*, 495 F.3d 695, 708 (D.C. Cir. 2007) (quoting *United States v. Oakland Cannabis Buyers’ Coop.*, 532 U.S. 483, 491 (2001)).

³⁵⁵ See, e.g., *State v. Sauve*, 666 A.2d 1164, 1168 (Vt. 1995); *Commonwealth v. Omar*, 981 A.2d 179, 184 (Pa. 2009); *People v. Izsak*, 416 N.Y.S.2d 1004, 1010 (Crim. Ct. 1979). For discussion, see Anna Roberts, *Dismissals as Justice*, 69 ALA. L. REV. 327, 332–37 (2017).

³⁵⁶ See Lawrence W. Crispo et al., *Jury Nullification: Law Versus Anarchy*, 31 LOY. L.A. L. REV. 1, 23 (1997).

³⁵⁷ The twentieth century saw three reported cases in which a jury appears to have nullified a legal prohibition on providing medical care, one in the United States, another in Canada, and a third in the United Kingdom. A New York grand jury declined to indict a doctor who helped a terminal patient end her life in violation of a ban on assisting suicides. See Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES, July 27, 1991, at A1. A Quebec jury nullified a criminal abortion law in *Morgentaler v. The Queen*, [1976] 1 S.C.R. 616 (Can.). A British jury might have done the same in *Rex v. Bourne* [1938] 3 All ER 615, 621 (KB). All three juries ruled for physicians who provided care ostensibly forbidden by the government. But because juries don’t explain their reasons, it’s possible they determined that the law just didn’t apply to the particular facts.

³⁵⁸ See also Peter N. Salib & Guha Krishnamurthi, *Nullification in Abortion Prosecutions: An Equilibrium Theory*, 72 DUKE L.J. ONLINE 41, 54 (2022).

³⁵⁹ *Lars Noah*, *Civil Jury Nullification*, 86 IOWA L. REV. 1601, 1604 n.7, 1658 (2001).

The willingness of any one of them to go rogue will also vary in unpredictable ways based on the rotating cast of individuals who happen to be seated in judgment each time.

Besides, necessity and nullification are all or nothing. The only options are extremes: the full brunt of legislative sanctions, no matter how punitive; or complete absolution, however egregious the misconduct or grave the harm. Conscience shouldn't insulate unwilling clinicians from even gross violations of the most basic expectations. Blanket immunity to endanger patients and willfully abandon them has no place in a profession whose moral force comes from its motivating regard for healing and health.³⁶⁰

* * *

A partial excuse of medical disobedience would make it possible to customize reduced penalties to fit the violation — when and because they are undertaken conscientiously.³⁶¹ Besides taking the edge off of fines and jail time, this defense could also eliminate the collateral consequences that often accompany a criminal conviction: for example, revoking an offender's license to practice medicine or disqualifying her from voting in elections.³⁶² Mitigation might not be enough to persuade all that many clinicians to follow their conscience. But less-than-total protections may also be more likely to get adopted if their restraint is what attracts the necessary support from those who aren't inclined to go all the way.³⁶³

Just how far such penalties get trimmed would be up to either legislatures based on general factors, or courts in light of the particulars of an individual case. But tempered consequences would pull up short of a complete pardon — except perhaps when conscientiously provided care is imminently necessary to save a patient's life.³⁶⁴ The upshot would be a dramatic reduction of the most punishing crackdowns.

The Oklahoma ob-gyn who conscientiously performs an abortion would pay a fraction of the \$100,000 that his state charges offenders.³⁶⁵ The Idaho pediatrician who prescribes medically indicated puberty blockers in the name of conscience would serve a far lighter sentence than the life in prison that the state imposes for providing gender-

³⁶⁰ See *supra* notes 83–86 and accompanying text.

³⁶¹ See Dov Fox, Opinion, *What Will Happen if Doctors Defy the Law to Provide Abortions?*, N.Y. TIMES (July 17, 2022), <https://www.nytimes.com/2022/07/17/opinion/dobbs-abortion-providers-conscience-protections.html> [<https://perma.cc/2QG6-AK8N>].

³⁶² See *id.*; cf. Matthew R. Hall, *Guilty but Civilly Disobedient: Reconciling Civil Disobedience and the Rule of Law*, 28 CARDOZO L. REV. 2083, 2120–22 (2007).

³⁶³ See *infra* notes 516–25 and accompanying text.

³⁶⁴ Except when conscientiously provided care is necessary to save a patient's life. See *infra* sections IV.B.2.b, pp. 1090–94, and IV.C.1, pp. 1096–103; *supra* notes 353–54 and accompanying text.

³⁶⁵ See OKLA. STAT. ANN. tit. 63, § 1-745.39 (West 2022).

affirming care, or even just pay a fine instead.³⁶⁶ The Minnesota doctor who follows her pregnant patient's advance directive to remove a feeding tube after the patient ends up in an irreversible coma wouldn't be permanently banned from practicing medicine, just suspended for a time.³⁶⁷

This mitigation finds informal resemblance in punishment for euthanasia.³⁶⁸ Murder is the intentional killing of another person, whatever the reason.³⁶⁹ Mercy killings are driven by compassion to relieve the suffering of a loved one or patient the defendant has cared for; sometimes, the person has a terminal illness and consents to die.³⁷⁰ When the compassionate motive is clear and reasonable, the punishment for homicide may get reduced, even greatly, down to manslaughter.³⁷¹ But no state codifies such leniency for mercy killing: it's applied haphazardly and off-the-record through the discretion exercised by prosecutors, judges, and juries.³⁷²

The proposed defense of medical disobedience wouldn't give license to break the law. Rather, it would codify a systematic form of mitigation that vindicates certain expressions of clinician conscience, whether to refuse care or provide it. Conscientious refusers could petition for this partial excuse in a bid to curb tort liability against malpractice or breach of informed consent, or to blunt criminal punishment for abandonment or endangerment — but only to mitigate, never to immunize. And there

³⁶⁶ See IDAHO CODE § 18-1506B (2022).

³⁶⁷ And none would be subject to the loss of rights that come with a felony conviction: from serving on a jury to owning a gun.

³⁶⁸ There are few reported cases. This could reflect the low incidence of mercy killings; that police just don't find out when it happens; or that when they do, prosecutors decline to charge, whether for lack of evidence or moral opposition to putting mercy killers on trial for murder. For principled arguments against prosecuting a different crime that can involve conscientious providers — of not euthanasia but abortion — see Steve Descano, Opinion, *My Governor Can Pass Bad Abortion Laws. But I Won't Enforce Them.*, N.Y. TIMES (May 31, 2022), <https://www.nytimes.com/2022/05/31/opinion/prosecutor-abortion-virginia.html> [<https://perma.cc/XBY8-EAUD>].

³⁶⁹ See, e.g., *People v. Anderson*, No. B276741, 2017 WL 3326831, at *1 (Cal. Ct. App. Aug. 4, 2017); *People v. Johnson*, No. A139389, 2015 WL 7012997, at *1–5 (Cal. Ct. App. Nov. 12, 2015).

³⁷⁰ For doctors prosecuted for killing patients out of mercy, see *Hospital Surgeon Charged with Mercy Killing of N.Y. Patient*, L.A. TIMES, June 29, 1973, at A1; Tamar Jacoby & Cheryl Harrison Miller, “I Helped Her on Her Way,” NEWSWEEK, Nov. 7, 1988, at 101; and *Eight Doctors on Euthanasia Charges*, HEMLOCK Q., Jan. 1989, at 6, 6. See also Russell Porter, *Sander Acquitted in an Hour; Crowd Outside Court Cheers*, N.Y. TIMES, Mar. 10, 1950, at 1, 23.

³⁷¹ See, e.g., Mark Arax, *Love and Death: A Mercy Killer's Anguish*, L.A. TIMES, Jan. 30, 1986, at 1; Sarah Kaplan, *The Millionaire Mom Who Poisoned Her Autistic Son and Called It a Mercy Killing*, WASH. POST (May 29, 2015, 5:11 AM), <https://www.washingtonpost.com/news/morning-mix/wp/2015/05/29/a-murder-or-a-mercy-killing-the-tangled-and-troubling-trial-of-gigi-jordan> [<https://perma.cc/8VR3-AGV2>]; Harrison Keegan, *Mom Pleads Guilty to Killing Blind, Autistic Son; She Could Be Free in 4 Months*, USA TODAY (May 10, 2018, 7:16 PM), <https://www.usatoday.com/story/news/nation-now/2018/05/10/autistic-teen-killed-missouri-mother-pleads-guilty-his-death/600151002/> [<https://perma.cc/XSG8-SHJH>].

³⁷² See Michal Buchhandler-Raphael, *Compassionate Homicide*, 98 WASH. U. L. REV. 189, 206–08 (2020).

can be no break at all from complying with nonnegotiable duties of informed consent, emergency treatment, and nondiscrimination.³⁷³

Nor would every provider who invokes conscience be able to claim the defense. Claimants would have to show, by a preponderance of the evidence, that they supplied services out of deeply held moral beliefs, not profit-seeking or anything else.³⁷⁴ More critical still, they must comply with all three conditions that derive from the moral logic of a professional enterprise centered on patient interests: competent consent, clinical reasonableness, and distributive justice. The following sections elaborate on each.

1. *Competent Consent.* — The first requirement for mitigation is that a competent patient or appropriate surrogate give informed consent to the prohibited procedure. There are three ways to meet this standard, depending on the circumstances. An intervention must be sought by a patient who has the mental capacity to approve it with appreciation of its material effects and alternatives; or, if that patient has impaired or delayed understanding, a spouse, guardian, or family member must have supported him to exercise his own judgment; or, if a patient has permanently lost the comprehension and decisionmaking abilities that he once enjoyed, then an appropriate surrogate may be authorized to speak to the patient's previously expressed wishes.³⁷⁵ This voluntariness condition rules out mitigation for pressurized mercy killings, or for working one's will on kids to improve their performance in school or sports through medical interventions that they themselves don't want.³⁷⁶

The hardest cases arise in the context of contested practices at the intersection of impairment and identity.³⁷⁷ For example, Dr. Robert Smith makes plain that the patients he treats for BIID are clear-thinking adults in whom "careful psychiatric assessment has failed to identify any significant mental illness" to explain their demonstrable and enduring

³⁷³ See LYNCH, *supra* note 97, at 215.

³⁷⁴ Courts take conscience appeals mostly on faith. See *supra* note 75 and accompanying text. Claimants' sincerity might be also reflected in the foreseeable legal and social consequences that they're willing to accept for the sake of their beliefs. See Brendan Dempsey et al., *Providers' Experience of Abortion Care: Protocol for a Scoping Review*, JMIR RSCH. PROTOCOLS, Feb. 2022, at 1, 1–2; Diane J. Horvath-Cosper, Opinion, *Abortion Providers Are Always at Risk*, WASH. POST, Nov. 1, 2015, at B3; Sheryl Gay Stolberg & Ava Sasani, *An Indiana Doctor Speaks Out on Abortion, And Pays a Price*, N.Y. TIMES (July 28, 2022), <https://www.nytimes.com/2022/07/28/us/politics/abortion-doctor-caitlin-bernard-ohio.html> [<https://perma.cc/JY5M-S5JY>].

³⁷⁵ See Eike-Henner W. Kluge, *Incompetent Patients, Substitute Decision Making, and Quality of Life: Some Ethical Considerations*, 10 MEDSCAPE J. MED. 237 (2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2605131> [<https://perma.cc/28FB-GZYA>].

³⁷⁶ See Dov Fox, *Family Planning and Its Limits*, 23 J. CONTEMP. LEGAL ISSUES 87, 93 n.28 (2021); Dov Fox, *Parental Attention Deficit Disorder*, 25 J. APPLIED PHIL. 246, 247 (2008).

³⁷⁷ See *supra* section II.B, pp. 1055–59; notes 184–241 and accompanying text.

suffering.³⁷⁸ Meanwhile, “various forms of therapy available for psychiatric illness”³⁷⁹ haven’t worked:

They fully understand the consequences of what they are requesting, have in-depth knowledge of amputee rehabilitation, and understand the lifestyle of amputees. . . . [A]mputation is the only source of relief. They are fully competent to make informed decisions about their treatment and there is no concern about competency to consent.³⁸⁰

Whether a particular patient is competent and consents with sufficient information depends on age, mental soundness, emotional maturity, and wherewithal to resist undue influence.³⁸¹ This individual assessment is the basis of that voluntariness requirement.

States typically let parents sign off on elective procedures for their child with the child’s apparent buy-in.³⁸² But requests to treat pediatric patients with legally prohibited services call for deeper interrogation into whether kids really appreciate the stakes and make their assent clear.³⁸³ For example, a girl who comes from a culture or region that practices genital cutting might be bullied to undergo a shallow ritual nick that does no permanent physical damage but may not reflect what she wants. That conclusion demands scrutiny, though. It’s not enough simply to assume that she’s:

(a) uneducated and ignorant . . . , (b) a slave of a tradition she herself would like to escape if only she had the option, [or] (c) oppressed and under the thumb of the deplorable men in her family who wish to control their wives and daughters and deprive them of any sexual enjoyment in life.³⁸⁴

Undue influences like these would indeed disqualify medical disobedience claims on voluntariness grounds. But showing that requires an inquiry that’s sensitive to context.³⁸⁵

Adolescents and teenagers might likewise have a hard time weighing the risks that puberty blockers pose for future fertility, or comprehending how conversion therapy implicates their larger aspirations or attachments.³⁸⁶ Distinctive complications arise if illness

³⁷⁸ Robert C. Smith, *Body Integrity Identity Disorder: A Problem of Perception?*, in 1 *BIOETHICS, MEDICINE AND THE CRIMINAL LAW* 71, 86 (Amel Alghrani et al. eds., 2012).

³⁷⁹ *Id.*

³⁸⁰ *Id.*

³⁸¹ See Aviva L. Katz & Sally A. Webb, *Informed Consent in Decision-Making in Pediatric Practice*, *PEDIATRICS*, Aug. 2016, at e1, e3–e4, e7.

³⁸² See generally Bernard M. Dickens & Rebecca J. Cook, *Adolescents and Consent to Treatment*, 89 *INT’L J. GYNECOLOGY & OBSTETRICS* 179, 183 (2005).

³⁸³ See Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 *RUTGERS L. REV.* 345, 375–96 (1996).

³⁸⁴ Richard A. Shweder, *The Prosecution of Dawoodi Bohra Women: Some Reasonable Doubts*, 12 *GLOB. DISCOURSE* 9, 10 (2022).

³⁸⁵ See *id.*

³⁸⁶ See Jack Drescher & Jack Pula, *Ethical Issues Raised by the Treatment of Gender-Variant Prepubescent Children*, *HASTINGS CTR. REP.*, Sept.–Oct. 2014, at S17, S20. When children and

or injury robs an adult of the competence that she once had: then a surrogate can consent on her behalf by appeal to what she would have wanted — assuming she hasn't left an applicable advance directive that spells this out herself, in which case that earlier say-so controls.³⁸⁷

2. *Clinical Reasonableness.* — Besides informed consent by a competent patient or a surrogate, any conscientiously provided treatment must also be clinically reasonable on the balance of medical risks and benefits to patients. This “reasonableness” standard tracks the one that medical malpractice doctrine uses to determine deviations from acceptable care.³⁸⁸ Long tied to “customary medical practice” — even if it “fail[s] to keep pace with developments and advances in medical science”³⁸⁹ — the modern trend requires doctors to conform their conduct to what is “reasonable to expect of a professional” in the relevant specialty “given the state of medical knowledge” and patient-specific facts that a physician is aware of, or should be.³⁹⁰

(a) *Evidence-Based Standard.* — An intervention might be made reasonable to expect in a couple ways. It could be tested and approved in peer-reviewed studies; or validated in sound-enough research models to treat a novel pathogen in an urgent crisis; or it could be proven safe and effective through longstanding clinical practice.³⁹¹ This reasonableness requirement disqualifies mitigation for the conscientious provision of prohibited treatments that are experimental, invalidated, or biologically implausible.³⁹² Fraudsters and science deniers needn't apply for the defense based on baseless or conclusively refuted claims, for example, that vaccines cause autism or that electric shocks can turn gay kids straight.³⁹³

their parents aren't on the same page, the “mature minor” doctrine is how half of states determine whether those kids possess the faculties and resources to choose treatment without parental acquiescence. See Jonathan F. Will, *My God My Choice: The Mature Minor Doctrine and Adolescent Refusal of Life-Saving or Sustaining Medical Treatment Based upon Religious Beliefs*, 22 J. CONTEMP. HEALTH L. & POL'Y 233, 259–60 (2006).

³⁸⁷ See David I. Shalowitz et al., *The Accuracy of Surrogate Decision Makers: A Systematic Review*, 166 ARCHIVES INTERNAL MED. 493, 493 (2006).

³⁸⁸ See, e.g., *Nist v. Mitchell*, 42 N.E.3d 1206, 1216–17 (Ohio Ct. App. 2015).

³⁸⁹ *Nowatske v. Osterloh*, 543 N.W.2d 265, 271 (Wis. 1996), *abrogated by* *Nommensen v. Am. Cont'l Ins. Co.*, 629 N.W.2d 301 (Wis. 2001).

³⁹⁰ *Id.* at 272. For discussion, see Maxwell J. Mehlman, *Professional Power and the Standard of Care in Medicine*, 44 ARIZ. ST. L.J. 1165, 1176–88 (2012).

³⁹¹ See, e.g., *Gallardo v. United States*, 752 F.3d 865, 873–74 (10th Cir. 2014); *Parsons v. Sisters of Charity of Leavenworth Health Sys., Inc.*, 832 F. Supp. 2d 1222, 1223–24 (D. Mont. 2011).

³⁹² See, e.g., NAT'L ACADS. SCIS., ENG'G & MED., *THE HEALTH EFFECTS OF CANNABIS AND CANNABINOIDS* 87–88 (2017) (discussing how patients suffering from chronic pain are replacing opioid medication with cannabis even though medical marijuana is not FDA approved).

³⁹³ See, e.g., JONATHAN SADOWSKY, *ELECTROCONVULSIVE THERAPY IN AMERICA* 83–86 (2017); Anjali Jain et al., *Autism Occurrence by MMR Vaccine Status Among US Children with Older Siblings with and Without Autism*, 313 JAMA 1534, 1536 (2015).

It's usually courts and not legislatures that set the standard of care.³⁹⁴ That expert-informed standard serves as the baseline for malpractice and the evidentiary threshold for admitting medical facts or testimony in civil trials.³⁹⁵ Some services that are deeply contested, politically speaking, are widely accepted as a medical matter.

Take abortion. The *Dobbs* majority cast doubt on the procedure's moral and social standing.³⁹⁶ And the decision itself triggered legal bans in more than a dozen states that make it harder to teach it to the next cohort of doctors training to become obstetrician-gynecologists.³⁹⁷ But none of this changes the clinical benefits that abortion is proven to provide many patients, especially those at risk of anxiety, depression, diabetes, high blood pressure, and emergency circumstances like ectopic pregnancies.³⁹⁸

Stigmatizing the procedure or making it illegal needn't make it any less "recognized and accepted" as clinically sound "within a significant segment of the medical profession and the hospital community."³⁹⁹ Also reasonable in this clinical sense are IUDs, Plan B, and IVF that are medically indicated for certain people of child-bearing age, as well as the withdrawal of life-sustaining care that respects pregnant people's advance directives.⁴⁰⁰

³⁹⁴ See Brian K. Cooke et al., *The Elusive Standard of Care*, 45 J. AM. ACAD. PSYCHIATRY & L. 358, 361 (2017).

³⁹⁵ See DOV FOX, BIRTH RIGHTS AND WRONGS 40–43 (2019); Dov Fox, *Reproductive Negligence*, 117 COLUM. L. REV. 149, 215–16 (2017).

³⁹⁶ See *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2235–36 (2022); see also, e.g., *Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med.*, 865 N.W.2d 252, 269 (Iowa 2015) (contrasting the fierce political disagreement over a rule that prevented abortion medication from being prescribed via telemedicine with the virtual clinical consensus over its medical necessity).

³⁹⁷ See Nick Anderson, *A Race to Teach Abortion Procedures, Before the Bans Begin*, WASH. POST (June 20, 2022, 7:00 AM), <https://www.washingtonpost.com/education/2022/06/20/abortion-training-medical-school/> [<https://perma.cc/A87Y-ABNM>]; Sofia Andrade, *Without Abortion Rights, Medical Students Face a Dangerous Choice*, THE NATION (Sept. 9, 2022), <https://www.thenation.com/article/politics/abortion-ban-dobbs-medical-students/> [<https://perma.cc/X77Z-3SDH>]; see also Marisa E. Giglio et al., *Abortion Training in Medical Education — Implications of the Supreme Court's Upcoming Decision*, 386 NEW ENG. J. MED. 707, 708 (2022) (“[R]estrictions on various aspects of medical education and training related to reproductive health . . . would create crucial gaps in the education of future Ob/Gyns Medical schools and residency programs could end up training generations of physicians who are unable to provide the comprehensive reproductive health care that patients need.”).

³⁹⁸ See, e.g., Lena Sjöberg et al., *Termination of Pregnancy and Sterilisation in Women with Childhood-Onset Type 1 Diabetes*, 60 DIABETOLOGIA 2377, 2378 (2017); Jun Luo et al., *Pregnancy Outcomes in Patients with Pulmonary Arterial Hypertension: A Retrospective Study*, 99 MEDICINE, no. 23, 2020, at 1, 4; DIANA GREENE FOSTER, *THE TURNAWAY STUDY* (2020) (comparing the life experiences of women who wanted an abortion but were denied one because of legal cutoff dates, with those of women who obtained one, and finding that women who had abortions had better mental health outcomes, at least for a time, and a long-term absence of regret).

³⁹⁹ *Brophy v. New Eng. Sinai Hosp., Inc.*, 497 N.E.2d 626, 639 (Mass. 1986). For discussion of how abortion bans implicate the standard of care, see generally Leslie Reagan, *Victim or Accomplice?: Crime, Medical Malpractice, and the Construction of the Aborting Woman in American Case Law, 1860s–1970*, 10 COLUM. J. GENDER & L. 311 (2001).

⁴⁰⁰ See *supra* notes 168–75 and accompanying text.

Other practices are plainly *not* clinically reasonable. Ivermectin is a case in point. The American Medical Association has “strongly oppose[d] the ordering, prescribing, or dispensing of ivermectin to prevent or treat COVID-19” based on reliable evidence that it doesn’t work for that use.⁴⁰¹ Conversion therapy isn’t widely accepted, either. Psychiatric groups agree the practice is more likely to harm than benefit people distressed by a conflict between their sexual desires and their faith or family — especially if it reflects a disparaging view of same-sex attraction that inspires self-hatred.⁴⁰² Conscience is no excuse to provide clinically unsound care.⁴⁰³

Still other cases are closer calls. Hormone blockers are clinically favored to delay puberty in children with precocious puberty and in others who experience severe distress associated with their biological sex or gender identity.⁴⁰⁴ Clinical evidence about certain potential long-term risks and benefits of puberty blockers in that population is still coming into focus.⁴⁰⁵ Some states have weaponized such empirical uncertainty to criminalize gender-affirming care for any patients, whatever their individual circumstances.⁴⁰⁶ The medical board in at least one state has moved to change its clinical standards to mark out puberty blockers as therapeutically unreasonable for all, regardless of particulars.⁴⁰⁷ Courts in other states have pushed back. The Eighth Circuit enjoined Arkansas’s puberty-blocker ban on the ground that the treatment “is supported by medical evidence that has been subject to rigorous study” and reflects “the recognized standard of care [to treat patients diagnosed with] adolescent gender dysphoria.”⁴⁰⁸

Some critics of gender-affirming care oppose it on nonempirical grounds that have nothing to do with the clinical data about how safe or effective it is. Their concern is a normative one about whether prescribing puberty blockers to young people in distress over their

⁴⁰¹ Press Release, Am. Med. Ass’n et al., Statement on Ending Use of Ivermectin to Treat COVID-19 (Sept. 1, 2021), <https://www.ama-assn.org/press-center/press-releases/ama-apha-ashp-statement-ending-use-ivermectin-treat-covid-19> [<https://perma.cc/TG9M-UFVC>].

⁴⁰² See Linda F. Campbell, *The Application of Ethical Principles, Standards, and Practices to Sexual Orientation Change Efforts and Gender Identity Change Efforts*, in *THE CASE AGAINST CONVERSION “THERAPY”* 169, 185 (Douglas C. Haldeman ed., 2022).

⁴⁰³ The same reason explains why state legislatures err to immunize providers from being fired or held liable for malpractice for prescribing ivermectin for COVID-19. See, e.g., N.D. CENT. CODE ANN. § 43-17-31.2 (West 2021); *id.* § 43-12.1-21.

⁴⁰⁴ See Wilson, *supra* note 188.

⁴⁰⁵ See *supra* notes 187–91 and accompanying text.

⁴⁰⁶ See *supra* note 192 and accompanying text.

⁴⁰⁷ See Alex Woodward, *Florida Begins Rule-Changing Process to Ban Gender-Affirming Care for Trans Youth*, THE INDEPENDENT (Aug. 5, 2022, 10:57 PM), <https://www.independent.co.uk/news/world/americas/us-politics/florida-transgender-health-ban-desantis-b2139308.html> [<https://perma.cc/4UM8-NCJZ>].

⁴⁰⁸ *Brandt v. Rutledge*, 47 F.4th 661, 670 (8th Cir. 2022) (quoting *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 891 (E.D. Ark. 2021)).

gender identity supports the goals of medicine.⁴⁰⁹ This challenge about what the clinical enterprise is *for* gets leveled against aid-in-dying, too.⁴¹⁰ One view says that doctors are supposed to heal, nothing more: it flouts that singular purpose, strictly construed, to affirm gender identity or abate suffering by hastening death.⁴¹¹

But a broader understanding of health sees it as one goal among others that include easing people's pain and promoting their well-being.⁴¹² Aid-in-dying probably isn't clinically reasonable yet.⁴¹³ However, even the judge who sentenced Dr. Kevorkian for murder because "[h]is peers look upon him as a menace" granted that "changes may be in order" as "science, technology and the art of medicine advance."⁴¹⁴

(b) *Avoiding Extreme Harm.* — Sometimes patients are so determined to get certain care that they won't take no for an answer. If a conscientious doctor won't treat them safely, using their training and sterile instruments, these patients will pursue dangerous alternatives. One black-market, self-help measure is the "back-alley" or "coat hanger" abortion that was common before *Roe*⁴¹⁵ and may return after its fall.⁴¹⁶ Safely ending a pregnancy lies squarely within the medical norm, so conscientiously providing abortion doesn't require a special harm-avoidance exception to qualify as clinically reasonable: it already is. But abortion isn't the only context in which providing sought-after care might keep desperate patients from dangerously taking matters into their own hands. And these other cases often do involve treatments that fall outside the standard of care.

⁴⁰⁹ See Chad Terhune et al., *As More Transgender Children Seek Medical Care, Families Confront Many Unknowns*, REUTERS (Oct. 6, 2022, 11:00 AM), <https://www.reuters.com/investigates/special-report/usa-transyouth-care> [<https://perma.cc/CD8J-ASN6>]; see also Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH ST., 559–63 (2022) (recommending puberty blockers only after child has questioned gender identity for several years and undergone mental health evaluation).

⁴¹⁰ See, e.g., Dov Fox, *Selective Procreation in Public and Private Law*, 64 UCLA L. REV. DISCOURSE 294, 296 (2016).

⁴¹¹ See, e.g., Leon R. Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, PUB. INT., Winter 1989, at 25, 30.

⁴¹² See Franklin G. Miller & Howard Brody, *Professional Integrity and Physician-Assisted Death*, HASTINGS CTR. REP., May–June 1995, at 8, 11.

⁴¹³ In 2019, the American Medical Association stopped condemning physician-assisted suicide, adopting a neutral stance that neither opposes nor supports it. *New AMA Position on Medical Aid in Dying*, COMPASSION & CHOICES (Nov. 9, 2020), <https://compassionandchoices.org/resource/new-ama-position-on-medical-aid-in-dying> [<https://perma.cc/XB8V-L654>].

⁴¹⁴ *People v. Kevorkian*, No. 90-390963, at 120 (Mich. Cir. Ct. Feb. 5, 1991), *appeal docketed*, No. 138155-6 (Mich. Ct. App. May 18, 1992).

⁴¹⁵ See, e.g., Lisa Rosenbaum, *Perilous Politics — Morbidity and Mortality in the Pre-Roe Era*, 381 NEW ENG. J. MED. 893, 893 (2019); Braid, *supra* note 1; *infra* notes 468–78, 555–59 and accompanying text.

⁴¹⁶ See, e.g., Roni Caryn Rabin, *Some Women "Self-Manage" Abortions as Access Recedes*, N.Y. TIMES (Aug. 11, 2022), <https://www.nytimes.com/2022/08/07/health/abortion-self-managed-medication.html> [<https://perma.cc/MRG6-DSMD>].

Strict opioid limits to avoid addiction and overdose explain why in 2021, a pain clinic halved the drugs that it prescribed to a forty-year-old Kentucky father.⁴¹⁷ This medicine treated the terrible pain that plagued him after a car wreck that required major surgeries and skin grafts.⁴¹⁸ He took more than the FDA-recommended dosage and ran out of pills early.⁴¹⁹ The clinic refused a refill.⁴²⁰ A couple hours later, he texted his wife, “they denied script im done love you,” and took his own life.⁴²¹

Another example: a New York man with BIID got an unlicensed amputation in Tijuana.⁴²² He died from gangrene “associated with dirty surgical conditions and improper wound care” that’s “readily treatable but if untreated can kill in one to two days.”⁴²³ Medical groups tend to characterize the disorder as a preoccupation with perceived flaws in appearance, and none think it’s clinically reasonable to amputate healthy limbs.⁴²⁴

A third case is shallow genital cutting. In 2010, the American Academy of Pediatrics (AAP) briefly approved ritual “pricking or incising the clitoral skin” that’s “no more of an alteration than ear piercing” to spare girls the “disfiguring and life-threatening procedures” they might otherwise undergo outside the clinic.⁴²⁵ But the AAP revoked the recommendation weeks later, after human rights groups condemned it for condoning female oppression.⁴²⁶

Should the conscientious supply of nonstandard care be eligible for mitigation if it’s provided to avoid extreme injuries? That’s what animates the “harm reduction” method of making illicit drugs safer for people addicted to them.⁴²⁷ It gained legitimacy after the AIDS epidemic took the lives of needle users in the 1980s.⁴²⁸ Today, this

⁴¹⁷ Andrew Joseph, *Her Husband Died by Suicide. She Sued His Pain Doctors — A Rare Challenge over an Opioid Dose Reduction*, STAT (Nov. 22, 2021), <https://www.statnews.com/2021/11/22/her-husband-died-by-suicide-she-sued-his-pain-doctors-a-rare-challenge-over-an-opioid-dose-reduction> [https://perma.cc/BVD6-HR4P].

⁴¹⁸ *See id.*

⁴¹⁹ *See id.*

⁴²⁰ *See id.*

⁴²¹ *Id.*

⁴²² *People v. Brown*, 109 Cal. Rptr. 2d 879, 881–82 (Ct. App. 2001).

⁴²³ *Id.* at 882.

⁴²⁴ *See* AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 458 (5th ed. 2013).

⁴²⁵ Dena S. Davis et al., Comm. on Bioethics, Am. Acad. of Pediatrics, *Policy Statement — Ritual Genital Cutting of Female Minors*, 125 PEDIATRICS 1088, 1092 (2010).

⁴²⁶ Stephanie Chen, *Pediatricians Now Reject All Female Genital Cutting*, CNN (May 27, 2010, 4:11 PM), <https://www.cnn.com/2010/HEALTH/05/27/AAP.retracts.female.genital.cutting/index.html> [https://perma.cc/WT49-PLHU].

⁴²⁷ “Harm reduction” has also been used in a wide range of other contexts to justify everything from e-cigarettes to replace tobacco use, to contraception access and sex education to avoid unintended pregnancies and sexual disease transmission. *See* Aila Hoss, *Legalizing Harm Reduction*, 80 OHIO ST. L.J. 825, 829–30 (2019).

⁴²⁸ *See* Gordon Roe, *Harm Reduction as Paradigm: Is Better Than Bad Good Enough? The Origins of Harm Reduction*, 15 CRITICAL PUB. HEALTH 243, 243 (2005).

approach responds most urgently to overdose deaths from tainted fentanyl.⁴²⁹ Harm reduction strategies range from supervised injection sites and biometric screening machines to needle exchanges and wide availability of naloxone kits.⁴³⁰ These policies have received a mixed reception in court.⁴³¹

But judges have affirmed the good samaritan statutes that a handful of states codified to immunize overdose tipsters from prosecution or penalty for the drug-related crimes their reporting would implicate them in.⁴³² These laws amount to a medical necessity defense.⁴³³ The idea is to reduce the fear of reprisal that would keep people from alerting authorities to other users' overdoses in time to save their lives.⁴³⁴

Health law doctrine offers another model for this harm-avoidance exception to the clinical reasonableness requirement. This narrow carve-out comes from the informed consent exception that's known as "therapeutic privilege."⁴³⁵ Tort law requires clinicians, before they undertake any course of medical treatment, to tell patients about significant risks and reasonable alternatives.⁴³⁶ Failure to disclose material stakes almost always constitutes a breach of informed consent.⁴³⁷ Even if clinicians meant well and kept that information

⁴²⁹ Advocates argue that these measures save lives and minimize the worst consequences of still-harmful conduct that can't realistically be eradicated. Critics insist that supplying these drugs and enabling their use is for criminals, not clinicians. See Stephanie Nolen, *Dispensing Fentanyl*, N.Y. TIMES, July 26, 2022, at D1.

⁴³⁰ See, e.g., Holly Hagan et al., *Reduced Risk of Hepatitis B and Hepatitis C Among Injection Drug Users in the Tacoma Syringe Exchange Program*, 85 AM. J. PUB. HEALTH 1531, 1531-32 (1995); Daniel Kim et al., *Expanded Access to Naloxone: Options for Critical Response to the Epidemic of Opioid Overdose Mortality*, 99 AM. J. PUB. HEALTH 402, 405 (2009).

⁴³¹ See, e.g., *United States v. Safehouse*, 985 F.3d 225, 229 (3d Cir. 2021); *Grant Park Neighborhood Ass'n Advocs. v. Cal. Dep't of Pub. Health*, No. 34-2020-80003551, 2021 Cal. Super. LEXIS 8070, at *54 (Super. Ct. July 2, 2021); *AIDS Support Grp. of Cape Cod, Inc. v. Town of Barnstable*, 76 N.E.3d 969, 978 (Mass. 2017); *Roe v. City of New York*, 232 F. Supp. 2d 240, 260 (S.D.N.Y. 2002); *Doe v. Bridgeport Police Dep't*, 198 F.R.D. 325, 350 (D. Conn. 2001).

⁴³² See, e.g., FLA. STAT. § 893.21(1) (2022); IND. CODE § 35-38-1-7.1(b)(12) (2022); NEV. REV. STAT. § 453C.150 (2016); N.H. REV. STAT. ANN. § 318-B:28-b (2021); N.Y. PENAL LAW § 220.78 (McKinney 2021); UTAH CODE ANN. § 58-37-8(16)(a) (LexisNexis 2022); VA. CODE ANN. § 18.2-251.03 (2022).

⁴³³ See Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1826-27 (2007). These "emergency" exceptions invite the same problems that plague such "therapeutic abortion" laws: indeterminacy and unpredictability amidst clinical exigency and the threat of aggressive prosecution. See *infra* notes 468-515 and accompanying text.

⁴³⁴ See Corey S. Davis & Derek H. Carr, *The Law and Policy of Opioids for Pain Management, Addiction Treatment, and Overdose Reversal*, 14 IND. HEALTH L. REV. 1, 32-33 (2017).

⁴³⁵ See Elizabeth G. Patterson, *The Therapeutic Justification for Withholding Medical Information: What You Don't Know Can't Hurt You, Or Can It?*, 64 NEB. L. REV. 721, 731-34 (1985).

⁴³⁶ See Dov Fox, "Fertility Fraud" Legislation — A Turning Point for Informed Consent?, 387 NEW ENG. J. MED. 770, 770 (2022); FOX, *supra* note 395, at 107-08.

⁴³⁷ See, e.g., *Mitchell v. Robinson*, 334 S.W.2d 11, 19 (Mo. 1960); *Tatro v. Lueken*, 512 P.2d 529, 538 (Kan. 1973); *Ritz v. Fla. Patient's Comp. Fund*, 436 So. 2d 987, 989 (Fla. Dist. Ct. App. 1983).

from their patients only to avoid “psychological damage”⁴³⁸ or “psychosomatic ramifications.”⁴³⁹

But there are exceptional conditions under which a clinician may be permitted to withhold certain material healthcare information to avoid unduly traumatizing a patient who’s particularly vulnerable to hearing that news.⁴⁴⁰ These circumstances are rare indeed — this exception might apply only when the “risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view.”⁴⁴¹ In other words, sharing the risks and benefits ordinarily required for informed consent must be so certain to incur such grave harm that telling the patient is bound to trigger a heart attack or suicide attempt.⁴⁴²

A 1970 case involved an acutely anxious and panicky patient who arrived to the hospital in unexplained cardiac distress.⁴⁴³ The only reliable way to tell if the problem with his heart was an aneurysm was an injection that posed an extremely low risk of partial paralysis.⁴⁴⁴ His physician withheld that potential side effect before administering the test.⁴⁴⁵ The court held “that a competent and responsible medical practitioner would not disclose information” that posed a high-enough risk of a sufficiently harmful “reaction in a patient highly apprehensive of his condition.”⁴⁴⁶

This free pass to dispense with informed consent is rightly maligned as a relic of a doctor-knows-best era of medical practice.⁴⁴⁷ What makes the therapeutic privilege objectionably paternalist, however, is that physicians invoke it to impose their judgments about what’s good for a patient without asking the patient himself what he thinks about his own interests.

This conflict between patient and doctor recedes when it comes to the conscientious provision of prohibited care. Here, the physician’s perception of the patient’s interests aligns with the patient’s own view. The defense would be available only where the doctor has secured informed consent from a competent patient or appropriate surrogate.⁴⁴⁸

⁴³⁸ *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972).

⁴³⁹ *Hales v. Pittman*, 576 P.2d 493, 499 n.4 (Ariz. 1978).

⁴⁴⁰ See Bradford Wixen, *Therapeutic Deception: A Comparison of Halacha and American Law*, 13 J. LEGAL MED. 77, 82–83 (1992).

⁴⁴¹ *Canterbury*, 464 F.2d at 789.

⁴⁴² See *Natanson v. Kline*, 350 P.2d 1093, 1103 (Kan. 1960).

⁴⁴³ *Nishi v. Hartwell*, 473 P.2d 116, 119–20 (Haw. 1970).

⁴⁴⁴ See *id.*

⁴⁴⁵ See *id.*

⁴⁴⁶ *Id.* at 121.

⁴⁴⁷ See *Withholding Information from Patients: Code of Medical Ethics Opinion 2.1.3*, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/withholding-information-patients> [<https://perma.cc/3HTL-LD98>].

⁴⁴⁸ See *supra* section IV.B.1, pp. 1085–87.

This variation on the therapeutic privilege furnishes a doctrinal toehold to mitigate penalties for providing evidence-based but nonstandard treatments that can be shown necessary to prevent terrible harms. Straightforward candidates include opioids or puberty blockers that would save someone in unbearable pain or the depths of despair from committing suicide.⁴⁴⁹

What about shallow clitoral cutting or the amputation of healthy limbs to avoid more dangerous procedures in nonclinical settings? The tragic consequences of denying nonstandard treatment might not be enough. Extreme harm avoidance invites confusion about how life-threatening nonintervention would have to be.⁴⁵⁰ Retail exceptions could also devolve into wholesale co-opting of the rule if decisions are manipulated by providers who think that the service in question should be available to all patients, including those who face less certain or severe injuries.⁴⁵¹ These risks may be too great to accommodate practices far outside the medical norm.

3. *Distributive Justice.* — There is one final condition for conscientious providers to qualify for mitigation. The supply of prohibited services can put pressure on all kinds of scarce resources: beds, surgeons, transplant organs, insurance pools, even antibiotics (to the extent using them on some patients makes them less effective for others as bacteria grow resistant).⁴⁵² Besides being consented to and clinically reasonable, conscientiously provided care must also be compatible with a reasonably fair allocation of those healthcare reserves.

Doctors and nurses are supposed to prioritize their particular patient in ways that can lead them to overlook the implications that treating him might have for the broader interests of others with similar needs.⁴⁵³ By contrast, legislatures and agencies are equipped to negotiate this wider perspective on available capital and population-level requirements.⁴⁵⁴ Those policymakers have a better vantage point and motivation to steward a broadscale theme to coordinate healthcare. This system of mutual advantage could break down if individual

⁴⁴⁹ See, e.g., Rachel Cassandra, *Cowgirl Boots, Anxious Nights: Transgender Youth and Families Grapple with Hostile Legislation — And Sky-High Rates of Mental Illness*, MINDSITENEWS (Aug. 17, 2022), <https://mindsitenews.org/2022/08/17/cowgirl-boots-anxious-nights-transgender-youth-and-families-grapple-with-hostile-legislation-and-sky-high-rates-of-mental-illness> [https://perma.cc/LZ6N-D6KJ].

⁴⁵⁰ See *infra* section IV.C.1, pp. 1096–103.

⁴⁵¹ See *infra* notes 462–71 and accompanying text.

⁴⁵² See Jean Carlet et al., *Society's Failure to Protect a Precious Resource: Antibiotics*, 378 LANCET 369, 369 (2011).

⁴⁵³ See E. Haavi Morreim, *Gaming the System: Dodging the Rules, Ruling the Dodgers*, 151 ARCHIVES INTERNAL MED. 443, 444 (1991).

⁴⁵⁴ *Id.* at 445–46.

clinicians were incentivized to secure privileges for just their own patients at the expense of others.⁴⁵⁵

Many conscientiously provided services might be more expensive than an alternative course of treatment. Suppose it costs twenty percent more to the private or public insurer, which in turn passes these extra costs down to taxpayers or others who are covered within the bigger pool. This premium increase may be negligible if the cumulative cost of conscientious provision is spread widely. But the conscientious provider might still be expected to take on a fraction of that cost overrun by accepting lower insurance reimbursement or paying a small fee into the coverage group.

A similar kind of fee would apply to conscientious refusers as well.⁴⁵⁶ They too should have to offset the costs incurred to accommodate that objection — in this case to maintain the system of disclosures and replacements that's needed to accommodate their refusal, consistent with policy interests in making legally permitted care actually available to patients who need it.

Or take life-saving transplants using kidneys acquired through sale.⁴⁵⁷ If that's the only way to get an organ, a surgeon might appeal to conscience to save her patient's life. She might argue that soliciting and paying for an organ wouldn't limit the total number of transplant organs for those who need them: the paid-for organ doesn't take one away from somebody else; it just adds an additional organ to the overall reserves available for transplant. But singling out this patient for a special exception might risk disrupting the system for doling out organs

⁴⁵⁵ See Catherine Régis, *Physicians Gaming the System: Modern-Day Robin Hood?*, HEALTH L. REV., 2004, at 19, 20.

⁴⁵⁶ See *supra* notes 332–34 and accompanying text.

⁴⁵⁷ See Benjamin Hippen et al., *Saving Lives Is More Important than Abstract Moral Concerns: Financial Incentives Should Be Used to Increase Organ Donation*, 88 ANNALS THORACIC SURGERY 1053, 1053 (2009). Still other appeals to the medical disobedience defense might satisfy distributive justice. Take the scheduled dialysis whose cost the federal government covers for all end-stage renal patients, except for undocumented immigrants. Some nephrologists miscode that dialysis as an “emergency,” so that everyone with chronic kidney disease can get the care they need to avoid organ failure. See *supra* note 221. The rationale for selectively funding dialysis isn't to discourage migration but to control public health expenditures and sustain insurance benefit packages by reducing the covered population, and the premiums they have to pay. Cf. Deborah Sontag, *Immigrants Deported*, By U.S. Hospitals, N.Y. TIMES (Aug. 3, 2008), <https://www.nytimes.com/2008/08/03/world/americas/03iht-03deport.t4962642.html> [<https://perma.cc/BL6Y-BKQ5>]; Judith Graham & Deane Williams-Harris, *Fighting to Keep Comatose Man in U.S.*, CHI. TRIB. (Aug. 19, 2008, 12:00 AM), <https://www.chicagotribune.com/news/ct-xpm-2008-08-20-0808190878-story.html> [<https://perma.cc/5ZAC-5HLW>]. But funding nonemergency dialysis in fact saves money by avoiding any need for emergency dialysis, which is far more expensive, and which the government already finances using taxpayer dollars when kidney disease patients get sick enough, whether they're documented or not. See Oanh Kieu Nguyen et al., *Association of Scheduled vs Emergency-Only Dialysis with Health Outcomes and Costs in Undocumented Immigrants with End-Stage Renal Disease*, 179 JAMA INTERNAL MED. 175, 175–78 (2019).

if people lose faith that the donor transplant list is fair.⁴⁵⁸ What matters is whether conscientious providers can show that “the cooperative scheme itself is seriously unjust” and that the costs that compliance incurs to their patients and others “is excessive relative to the benefit from compliance with them.”⁴⁵⁹

C. Practical Considerations

With no prospect of relief from even harsh sanctions, evaders will tend to keep their noncompliance secret, leaving no check beyond a clinician’s own sense of right and wrong, even when the expression of that conscience would harm discrete patients or unduly tax the healthcare system. Those driven to break the rules may not fully appreciate the relevant systems-level facts and complex tradeoffs for all affected. The affirmative defense would bring medical disobedience into the open.

1. *Legal Ambiguities.* — Laws are supposed to spell out whether doing something is prohibited as opposed to permissible or compulsory. Clear rules give notice of the lines that divide what’s outlawed, allowed, and required. Abortion laws illustrate the bind that clinicians can find themselves in when ambiguities blur these lines: criminally punished for ending a pregnancy or liable for malpractice if they don’t end one, buffered only by narrow exceptions that are vague and variable. Torn between these competing commands, without clear space separating them, doctors and nurses struggle to navigate what they’re meant to do in predictably hard cases.⁴⁶⁰

Today, states that mostly prohibit the termination of pregnancy narrowly exempt “therapeutic” abortions that are necessary to avoid a serious risk of grave harm.⁴⁶¹ Applying this standard to complicated, patient-specific conditions gets confounded by clinical obscurities

⁴⁵⁸ Federal policy requires that any American who needs an organ be approved by a transplant hospital to get on a 100,000-long waiting list, where the average wait time is nearly four years. See *Organ Donation and Transplantation Statistics*, NAT’L KIDNEY FOUND., <https://www.kidney.org/news/newsroom/factsheets/Organ-Donation-and-Transplantation-Stats> [https://perma.cc/8LJE-RFTK]. Less than a third of those on the waiting list received kidney transplants last year. See NAT’L RSCH. COUNCIL, *REALIZING THE PROMISE OF EQUITY IN THE ORGAN TRANSPLANTATION SYSTEM* 49 tbl.2-1 (Kenneth W. Kizer et al. eds., 2022). Recipients sit on the list until they’re determined to be the most compatible candidate based on factors that vary by organ and often include size, blood type, medical urgency, time waiting, and geographic proximity to the donor. See *id.* at 94, 117.

⁴⁵⁹ Blustein, *supra* note 347, at 254.

⁴⁶⁰ See, e.g., *Doctors Expect More Maternal Deaths Due to Abortion Bans*, SERMO (July 12, 2022), <https://www.sermo.com/blog/insights/doctors-expect-more-maternal-deaths-due-to-abortion-bans> [https://perma.cc/Q79A-9BVK] (finding that seventy percent of 243 American doctors surveyed weren’t clear about what constitutes a “life-threatening emergency” that would permit them to legally perform an abortion in states where the procedure is otherwise banned).

⁴⁶¹ See Mark Joseph Stern, *The Fall of Roe v. Wade Is Already Damaging Basic Obstetric Care in Red States*, SLATE (Aug. 2, 2022, 3:42 PM), <https://slate.com/news-and-politics/2022/08/abortion-bans-hospitals-obstetric-care-red-states.html> [https://perma.cc/A5XB-ZAHB].

that cloud both factors: the level of risk that's serious enough, and the magnitude of harm that's sufficiently grave. Therapeutic abortion bans exemplify this murky boundary between what's forbidden by doctors and what's required of them.⁴⁶²

Even for women who want to be pregnant and take home a baby, problems can arise that make their pregnancy dangerous to continue.⁴⁶³ Becoming pregnant before seventeen or after thirty-five can heighten the risk of complications, as can conditions like diabetes, kidney disorder, heart disease, and breast cancer.⁴⁶⁴ Abortion is also medically necessary to treat ectopic pregnancy, a separated placenta, and premature rupture of the amniotic sac, which can cause septic infection.⁴⁶⁵ Then there are fetal anomalies. Some of the most lethal can be detected only in the second trimester, after scans can show the structure of fetal organs.⁴⁶⁶ Continuing such pregnancies can visit serious harm on the woman and, in the case of twins or triplets, any multiples that she's carrying.⁴⁶⁷

(a) *Before Roe*. — Many pre-*Roe* abortions “at least bent the law, if they did not fracture it” — these extralegal abortions comprised nearly nine in ten performed at Mt. Sinai Hospital from 1952 to 1956, according to its chief obstetrician/gynecologist Alan Guttmacher.⁴⁶⁸ New York's abortion law was typical of this era: it banned the procedure unless necessary to save a woman's life.⁴⁶⁹ So did California's.⁴⁷⁰ In 1959, criminologist Herbert Packer and doctor/lawyer Ralph Gampell published a groundbreaking study of abortion practices in California against the backdrop of the state's therapeutic abortion law.⁴⁷¹ The authors confidentially surveyed twenty-nine hospitals about whether they generally performed abortions for patients who presented under

⁴⁶² See *id.*; see also *infra* notes 468–80, 497–515 and accompanying text.

⁴⁶³ In the absence of complications, the risk of dying from labor and delivery is roughly fourteen times higher than from having an abortion. See Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *OBSTETRICS & GYNECOLOGY* 215, 216 (2012).

⁴⁶⁴ See *High-Risk Pregnancy*, CLEVELAND CLINIC (Dec. 14, 2021), <https://my.clevelandclinic.org/health/diseases/22190-high-risk-pregnancy> [<https://perma.cc/C4TK-2XM7>].

⁴⁶⁵ See, e.g., Nicole T. Christian & Virginia F. Borges, *What Dobbs Means for Patients with Breast Cancer*, 387 *NEW ENG. J. MED.* 765, 766 (2022).

⁴⁶⁶ See Francesca Bardi et al., *Early Detection of Structural Anomalies in a Primary Care Setting in the Netherlands*, 46 *FETAL DIAGNOSIS & THERAPY* 12, 16–17 (2019).

⁴⁶⁷ See Rosemary Townsend et al., *Perinatal Outcome of Monochorionic Twin Pregnancy Complicated by Selective Fetal Growth Restriction According to Management: Systematic Review and Meta-Analysis*, 53 *ULTRASOUND OBSTETRICS & GYNECOLOGY* 36, 37 (2019).

⁴⁶⁸ Alan F. Guttmacher, *Therapeutic Abortion in a Large General Hospital*, 37 *SURGICAL CLINICS N. AM.* 459, 468 (1957) (emphasis omitted); see *id.* at 464 tbl.1.

⁴⁶⁹ See *id.* at 465; James S. Witherspoon, *Reexamining Roe: Nineteenth-Century Abortion Statutes and the Fourteenth Amendment*, 17 *ST. MARY'S L.J.* 29, 45 (1985).

⁴⁷⁰ See Witherspoon, *supra* note 469, at 45.

⁴⁷¹ Herbert L. Packer & Ralph J. Gampell, *Therapeutic Abortion: A Problem in Law and Medicine*, 11 *STAN. L. REV.* 417, 417–18 (1959).

eleven detailed circumstances.⁴⁷² The responses revealed that doctors “routinely performed therapeutic abortions [that] fall outside any possible . . . legal justification,” while many others that they supplied were “at best of dubious legality.”⁴⁷³

In 1972, psychiatrist Richard Schwartz disclosed the “open secret”⁴⁷⁴ that “many upper middle-class women have been able to obtain so-called therapeutic abortions”⁴⁷⁵ by “find[ing] a psychiatrist who will say she might commit suicide”⁴⁷⁶ even “in cases where they believe the risk of suicide is minimal or nonexistent because they consider” that deceit is “preferable to driving a desperate woman into the hands of a criminal abortionist or forcing her to bear an unwanted child.”⁴⁷⁷ It was no easy thing to find and afford a psychiatrist willing to risk a medical license by vouching that a nonsuicidal patient would take her own life if she couldn’t get an abortion. The cost alone was out of reach for most women who lacked the private insurance and personal connections to acquire the requisite letter.⁴⁷⁸ Meeting the criteria for this exception ended up having less to do with whether their health was actually on the line than whether they could track down and pay for a licensed therapist who was willing to say that it was anyway. In 1955, one ob-gyn explained that what ultimately distinguished criminal from “therapeutic” abortions was less often about risks than resources: “the difference between the one and the other is \$300 and knowing the right person.”⁴⁷⁹ Abortions were effectively allowed for wealthy women, but not for poor ones.⁴⁸⁰

The legal risks to conscientious providers before *Roe* were less acute than they are today. For one, the medical profession enjoyed vastly greater public trust to make these decisions without suspicion by

⁴⁷² See *id.* at 423, 425.

⁴⁷³ *Id.* at 419. Packer and Gampell proposed that states defer to hospital-appointed committees about what counts as a permissibly life-saving abortion. *Id.* at 449–55. California and Colorado variously tried versions of hospital abortion committees. Brian Pendleton, Note, *The California Therapeutic Abortion Act: An Analysis*, 19 HASTINGS L.J. 242, 251 (1967). For critical discussion of such committees, see Howard Hammond, *Therapeutic Abortion: Ten Years' Experience with Hospital Committee Control*, 89 AM. J. OBSTETRICS & GYNECOLOGY 349, 353 (1964); and Rickie Solinger, “A Complete Disaster”: *Abortion and the Politics of Hospital Abortion Committees, 1950–1970*, 19 FEMINIST STUD. 241, 242–43, 248–54 (1993).

⁴⁷⁴ Richard A. Schwartz, *Abortion on Request: The Psychiatric Implications*, 23 CASE W. RES. L. REV. 840, 840 (1972).

⁴⁷⁵ *Id.* at 843.

⁴⁷⁶ *Id.* at 840.

⁴⁷⁷ *Id.* at 845.

⁴⁷⁸ See *id.* at 844; see also LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME, 1867–1973, at 205, 242 (1997).

⁴⁷⁹ Mary Steichen Calderone, *Illegal Abortion as a Public Health Problem*, 50 AM. J. PUB. HEALTH 948, 949 (1960).

⁴⁸⁰ See BEFORE *ROE V. WADE*: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT’S RULING 271 (Linda Greenhouse & Reva Siegel eds., 2012).

patients and the government.⁴⁸¹ This presumption of good faith and deference to healthcare providers might help to explain why “[g]enerally, when abortions were performed safely, prosecutors either didn’t know about the procedures or chose to look the other way.”⁴⁸² The “anti-abortion laws in the mid-20th century” were used instead to go after “unlicensed abortion providers.”⁴⁸³ Those bans made abortion “a misdemeanor or low-grade felony that resulted in a prison sentence of no more than five to seven years.”⁴⁸⁴

(b) *After Dobbs.* — To some modern prosecutors, by contrast, “abortion doctors are unscrupulous violators of the Hippocratic oath who are in the business of killing rather than healing.”⁴⁸⁵ What’s more, exacting abortion laws in many states now make abortion a high-order felony, under which offenders could have their license revoked and even be thrown in jail for the rest of their lives.⁴⁸⁶ Meanwhile, the corporatization of healthcare has replaced private, mom-and-pop practices with healthcare conglomerates that strictly enforce the legal rules against workers whose livelihood depends on it.⁴⁸⁷ And higher-tech and increasingly restrictive policing tools — from social media surveillance to civil bounty enforcement — make providers more likely to get caught.⁴⁸⁸

Of note, some states don’t exempt “therapeutic abortion” from criminal prosecution, but make it an affirmative defense.⁴⁸⁹ So even clinicians who “stand by and watch as a patient” gets sicker and

⁴⁸¹ See Robert J. Blendon et al., *Public Trust in Physicians — U.S. Medicine in International Perspective*, 371 NEW ENG. J. MED 1570, 1571 (2014).

⁴⁸² Evan Hart, Opinion, *Medical Exemptions in Abortion Bans Won't Protect Women's Health*, WASH. POST (Sept. 8, 2022, 6:00 AM), <https://www.washingtonpost.com/made-by-history/2022/09/08/medical-exemptions-abortion-bans-wont-protect-womens-health> [<https://perma.cc/HAK6-27CY>]. But see Stephen G. Gilles, *Roe's Life-or-Health Exception: Self-Defense or Relative-Safety?*, 85 NOTRE DAME L. REV. 525, 543–49 (2010) (discussing the prosecutions of Dr. Milan Vuitch in Washington, D.C. and Dr. Leon Belous in California).

⁴⁸³ Daniel K. Williams, *Old Anti-abortion Laws Are Taking on Unintended Meanings*, THE ATLANTIC (Sept. 20, 2022), <https://www.theatlantic.com/ideas/archive/2022/09/abortion-laws-pre-roe/671409> [<https://perma.cc/Q9FV-RYQX>].

⁴⁸⁴ *Id.*

⁴⁸⁵ *Id.*

⁴⁸⁶ See Leah Torres, *Doctors in Alabama Already Turn Away Miscarrying Patients. This Will Be America's New Normal*, SLATE (May 17, 2022, 3:12 PM), <https://slate.com/news-and-politics/2022/05/roe-dobbs-abortion-ban-reproductive-medicine-alabama.html> [<https://perma.cc/HQ6K-9FQ5>].

⁴⁸⁷ See *supra* notes 143–45 and accompanying text.

⁴⁸⁸ See Judith Levine, *Should Doctors Break the Law?*, THE INTERCEPT (Aug. 6, 2022, 7:00 AM), <https://theintercept.com/2022/08/06/abortion-bans-doctors-civil-disobedience> [<https://perma.cc/3CJY-PHUV>]; Barbara Ortutay, *Why Some Fear that Big Tech Data Could Become a Tool for Abortion Surveillance*, PBS (June 28, 2022, 8:50 PM), <https://www.pbs.org/newshour/economy/why-some-fear-that-big-tech-data-could-become-a-tool-for-abortion-surveillance> [<https://perma.cc/8L26-QZYJ>].

⁴⁸⁹ See, e.g., IDAHO CODE § 18-622 (2022); N.D. CENT. CODE § 12.1-31-12 (2022); TENN. CODE ANN. § 39-15-213 (2022).

sicker,⁴⁹⁰ waiting until she's on death's door to finally end her life-threatening pregnancy, could still face felony indictment, arrest, pretrial detention, and courtroom defense for every such abortion they perform.⁴⁹¹

As one doctor explains, a “case that to a medical provider falls in a ‘gray area’ might appear very much black and white to a prosecutor.”⁴⁹² Ohio physician Tani Malhotra specializes in high-risk pregnancies. She’s “plagued by fears that what she sees as an emergency won’t be” by a hardline prosecutor under the ban that her state imposed shortly after *Roe* fell.⁴⁹³ Dr. Malhotra recounts one recent patient who faced dangerous complications: “She broke down and said, ‘I don’t want to die.’ . . . I thought, ‘I’m really worried about this patient. She’s incredibly sick, but did I do all the paperwork correctly? . . . What kind of trouble am I going to get into if something . . . happens when the patient is already extremely unstable.’”⁴⁹⁴

Little wonder that hospitals and doctors around the country are revising their practices to guard against the threat of aggressive prosecution and punitive sanctions, even in advance of any evidence that they’re actually being enforced.⁴⁹⁵ Instead of treating the patient before them with the best clinical evidence and soundest procedures, doctors are left to ask, “How do you know if a mother’s life is at risk? How do you predict, then prove, that the mother faces potentially irreversible bodily damage?”⁴⁹⁶

Most therapeutic exemptions enacted after *Dobbs* permit abortion only if that care is “necessary in reasonable medical judgment to

⁴⁹⁰ Erika Werner, *I’m a High-Risk OB-GYN: Abortion Helps Me Save Lives*, WBUR (July 1, 2022), <https://www.wbur.org/cognoscenti/2022/07/01/high-risk-obgyn-abortion-access-erika-werner> [https://perma.cc/JG62-N95N].

⁴⁹¹ See Sharon Lurye, *Exceptions to Abortion Bans May Be Hard for Women to Access*, U.S. NEWS & WORLD REP. (June 3, 2022, 11:16 AM), <https://www.usnews.com/news/best-states/articles/2022-06-03/why-exceptions-to-abortion-bans-may-be-hard-for-women-to-access> [https://perma.cc/FX3B-FWCD]; see also David Austin Walsh, *Opinion, New Abortion Laws Won’t Return Us to a Pre-Roe Era. They’ll Do Much Worse.*, WASH. POST (May 17, 2019, 7:00 AM), <https://www.washingtonpost.com/outlook/2019/05/17/new-abortion-laws-wont-return-us-pre-roe-era-theyll-do-much-worse> [https://perma.cc/X2CN-QU3N].

⁴⁹² Mark Joy, *Opinion, Women’s Lives Put at Risk Under State Abortion Bans*, N.Y. TIMES (Sept. 24, 2022), <https://www.nytimes.com/2022/09/24/opinion/letters/abortion-bans.html> [https://perma.cc/UB4Z-Z7H3].

⁴⁹³ Marty Schladen, *Ohio Docs Say New Abortion Law Has Them Working Against Oaths to Do No Harm*, OHIO CAP. J. (Sept. 7, 2022, 4:00 AM), <https://ohiocapitaljournal.com/2022/09/07/ohio-docs-say-new-abortion-law-has-them-working-against-oaths-to-do-no-harm> [https://perma.cc/44UD-USE5].

⁴⁹⁴ *Id.*

⁴⁹⁵ See Stephanie Sinclair & Jamie Lowe, *What a High-Risk Pregnancy Looks Like After Dobbs*, N.Y. TIMES MAG. (Sept. 18, 2022), <https://www.nytimes.com/2022/09/13/magazine/high-risk-pregnancy-dobbs.html> [https://perma.cc/3WAJ-EDJP].

⁴⁹⁶ *Id.*

prevent . . . substantial risk of death.”⁴⁹⁷ Such open-ended terms make these statutes sites of confusion and contestation. Doctors are left to speculate — under clinically variable and time-sensitive circumstances — about precisely when they can intervene to prevent harm to their patients without subjecting themselves to suspension or prison.⁴⁹⁸ Indiana physician Richard Feldman asks: “What is reasonable medical judgment? What conditions are legitimate risks to the mother? At what point is the disease severe enough for an allowed termination?”⁴⁹⁹

Michigan obstetrician-gynecologist Lisa Harris details some of the doubts that “therapeutic exceptions” raise for patient care:

What does the risk of death have to be, and how imminent must it be? Might abortion be permissible in a patient with pulmonary hypertension, [with] a 30-to-50% chance of dying with ongoing pregnancy? Or must it be 100%? When we diagnose a new cancer during pregnancy, some patients decide to end their pregnancy to permit immediate surgery, radiation, or chemotherapy, treatments that can cause significant fetal injury. Will abortion be permissible in these cases, or will patients have to delay treatment until after delivery?⁵⁰⁰

Eve Karkowsky, who specializes in maternal-fetal medicine, elaborates on the impossible choice that doctors face when treating a pregnant patient as her condition deteriorates:

Will I have to wait until she gets a fever, so I can check off that box, that she’s in danger? Is that sufficient or will it require her heart rate to go up or her blood pressure to go down? Will she have to wait until she’s unstable to have this option offered to her? At what point, exactly, will I be risking jail for helping my patient through this, unharmed?⁵⁰¹

⁴⁹⁷ KY. REV. STAT. ANN. § 311.772(4)(a) (West 2022). For discussion, see M. Gregg Bloche & Sarah K. Werner, Opinion, *Abortion Bans Are a Threat to Patients. Doctors Can and Should Resist Them.*, WASH. POST (Aug. 18, 2022, 4:16 PM), <https://www.washingtonpost.com/opinions/2022/08/18/abortion-bans-threat-doctors-standards-overcome> [<https://perma.cc/69FV-G2S6>]; and Ariana Eunjung Cha, *Doctors Face Post-Roe Legal Minefield*, WASH. POST, June 29, 2022, at A1.

⁴⁹⁸ See, e.g., *supra* note 159; see also MARY E. HARNED & INGRID SKOP, PRO-LIFE LAWS PROTECT MOM AND BABY: PREGNANT WOMEN’S LIVES ARE PROTECTED IN ALL STATES 2 (2022), <https://s27589.pcdn.co/wp-content/uploads/2022/07/On-Point-86-Pro-Life-Laws-Protect-Mom-and-Baby-final-pdf.pdf> [<https://perma.cc/FU8C-FSRT>] (affirming that “[p]hysicians are trained to use their best judgment to care for patients” in those “rare and heartbreaking circumstances when it is necessary to save the life of a pregnant woman,” but that “it would be prudent for state medical boards” and societies, and hospital committees, “to provide more detailed guidance to doctors on how to reach a determination that abortion is necessary”).

⁴⁹⁹ Richard Feldman, Opinion, *Abortion Law from a Physician’s Perspective*, THE TRIBUNE (Sept. 24, 2022), <https://tribtown.com/2022/09/24/abortion-law-from-a-physicians-perspective> [<https://perma.cc/G7WX-GAAA>].

⁵⁰⁰ Lisa H. Harris, *Navigating Loss of Abortion Services — A Large Academic Medical Center Prepares for the Overtum of Roe v. Wade*, 386 NEW ENG. J. MED. 2061, 2061–62 (2022).

⁵⁰¹ Chavi Eve Karkowsky, Opinion, *New Abortion Laws Are Especially Cruel to My Patients with High-Risk Pregnancies*, MACOMB DAILY (June 17, 2021, 5:12 AM), <https://www.macombdaily.com/2019/05/25/new-abortion-laws-are-especially-cruel-to-my-patients-with-high-risk-pregnancies> [<https://perma.cc/RDA8-87TA>].

One Texas woman learned in her second trimester that the fetus she was carrying had a fatal condition called triploidy.⁵⁰² The developing child had no chance of survival, but staying pregnant could have killed the woman.⁵⁰³ Doctors and nurses used to intervene whenever medical treatment was safe and effective. Now, clinicians are being forced to hold off while things get riskier for their patients “because they’re not dying *yet*.”⁵⁰⁴ That waiting and second-guessing predictably chill care, sometimes with grave consequences.⁵⁰⁵

A recent study followed twenty-eight women admitted with pregnancy complications to two Dallas hospitals.⁵⁰⁶ This was over the nine months after the Texas ban went into effect, forbidding abortion after about six weeks unless “the mother’s life is in danger.”⁵⁰⁷ Researchers found that the patients had to wait an average of nine extra days for their status to be considered life-threatening enough to justify abortion.⁵⁰⁸ This state-mandated delay caused roughly twice as many of the women to experience preventable health problems so serious that they required intensive care and readmission.⁵⁰⁹ Their resulting hemorrhaging, sepsis, and hysterectomies all could have been avoided by the immediate intervention that was routine before the prohibition.⁵¹⁰

Two weeks after *Dobbs*, the Biden Administration reminded emergency departments of their obligations to comply with a federal law known as the Emergency Medical Treatment and Active Labor Act⁵¹¹ (EMTALA). That 1986 law requires hospital ERs to treat patients who need “stabilizing” care, even if they can’t afford it or if there’s any other reason to turn them away.⁵¹² The executive guidelines made clear that

⁵⁰² See Elizabeth Cohen & Danielle Herman, *Why a Woman’s Doctor Warned Her Not to Get Pregnant in Texas*, CNN HEALTH (Sept. 10, 2022, 8:12 PM), <https://www.cnn.com/2022/09/09/health/abortion-restrictions-texas/index.html> [<https://perma.cc/E3DX-PXKB>].

⁵⁰³ *Id.*

⁵⁰⁴ Nilo Tabrizy et al., “*Do No Harm*”: OB-GYNs Weigh the Legal Impact of Abortion Bans, N.Y. TIMES, at 04:57 (Sept. 10, 2022), <https://www.nytimes.com/video/us/10000008489880/abortion-bans-maternal-health.html> [<https://perma.cc/R8Q2-HMZ4>] (quoting Dr. Rebecca Cohen).

⁵⁰⁵ See Kate Zernike, *Medical Impact of Roe Reversal Goes Well Beyond Abortion Clinics, Doctors Say*, N.Y. TIMES (Sept. 10, 2022), <https://www.nytimes.com/2022/09/10/us/abortion-bans-medical-care-women.html> [<https://perma.cc/V5QN-AMMT>] (“‘There’s such confusion,’ said Dr. Allison Linton, an obstetrician in Milwaukee, ‘and when doctors are hearing this risk of a felony charge, they’re erring on the side of fear.’”).

⁵⁰⁶ Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks’ Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 AM. J. OBSTETRICS & GYNECOLOGY 648, 648–49 (2022).

⁵⁰⁷ *Id.*; Texas Heartbeat Act, 2021 Tex. Gen. Laws ch. 62 (codified at TEX. HEALTH & SAFETY CODE ANN. §§ 171.201–.212 (West 2021)).

⁵⁰⁸ See Nambiar et al., *supra* note 506, at 649.

⁵⁰⁹ See *id.*

⁵¹⁰ See *id.*

⁵¹¹ 42 U.S.C. § 1395dd.

⁵¹² *Id.* § 1395dd(b)(1).

this requirement also applies to pregnant patients who need an abortion, even in states that ban it.⁵¹³

A federal court in Idaho blocked that state's ban for criminalizing life-saving abortions required under EMTALA.⁵¹⁴ But a federal court in Texas came to the opposite conclusion. It temporarily enjoined implementation of the federal guidance about emergency treatment, reasoning that it goes "beyond EMTALA's text, which protects both mothers and unborn children, is silent as to abortion, and preempts state law only when the two directly conflict."⁵¹⁵

When conscientious providers seek to deliver services in this liminal space between what's prohibited and what's permitted, the first-order question shifts from whether they qualify for mitigation to whether they can even be punished in the first place. Sometimes the ambiguities that hover over contested practices will veer into clearer violations of restrictions on healthcare. It's then that conscientious provision of clinically reasonable care should get the leniency that conscientious refusal does.

2. *Implementation.* — This plea for principle won't persuade lawmakers who are deploying conscience as a pretext for enacting policies they promote and restricting practices they oppose. Behind closed doors, those who have championed the cause of conscience might concede that their patronage has always been disingenuous and instrumental: really, just a tool to give special preferences to people who share their values at the exclusion of equally conscientious people who don't. "Of course it's not really about conscience; we're just playing favorites!" This cynical view may capture the political dynamics in some states today.⁵¹⁶

Maybe not in those with divided government: for example, the Democratic Governor of Wisconsin pledged clemency to doctors prosecuted for violating the 1849 abortion ban that the Republican legislature brought back after *Roe* fell.⁵¹⁷ But other states may be content with conscience-for-me-and-not-for-thee. Sepper anticipated this obstacle a decade before *Dobbs*.⁵¹⁸ Even still, she saw merit in

⁵¹³ See Memorandum from Ctrs. for Medicare & Medicaid Servs. on Reinforcement of EMTALA Obligations to State Surv. Agency Dirs. 1, 5–6 (July 11, 2022), <https://www.cms.gov/files/document/qso-22-22-hospitals.pdf> [<https://perma.cc/E7JR-WE7H>].

⁵¹⁴ See *United States v. Idaho*, No. 22-cv-00329, 2022 WL 3692618, at *15 (D. Idaho Aug. 24, 2022).

⁵¹⁵ *Texas v. Becerra*, No. 22-CV-185, 2022 WL 3639525, at *1 (N.D. Tex. Aug. 23, 2022) (emphasis omitted).

⁵¹⁶ See *supra* notes 58–63 and accompanying text.

⁵¹⁷ See Jessica Van Egeren, *Doctors Pressed to Go Political; Medical Society Focuses on Abortion Access*, MILWAUKEE J. SENTINEL, Oct. 15, 2022, at A1.

⁵¹⁸ See Sepper, *supra* note 37, at 1574. Sepper has since extended similar arguments about religious preferentialism beyond the healthcare context to claims involving insurance coverage, employment discrimination, and equal access to social services and public accommodations. See Elizabeth Sepper, *Free Exercise Lochnerism*, 115 COLUM. L. REV. 1453, 1513–18 (2015).

calling out unjustified asymmetry, which could “have the benefit of encouraging frank discussions” in “legislative deliberations, scholarly debates, and judicial proceedings.”⁵¹⁹

Beyond frank discussions, two concrete prospects remain for repairing the good name of conscience in medicine: national legislation and state common law. Passing any federal statute is a long shot, especially when it bears on issues as divisive as abortion, aid-in-dying, and gender-affirming care. But there are two models at the countrywide level for privileging people’s deeply held beliefs in ways that mediate the costs that such protection ends up imposing on others. First is Title VII’s bar on employment discrimination on the basis of religion.⁵²⁰ Second, the prohibition against undue government burdens on religious exercise under the Religious Freedom Restoration Act⁵²¹ (RFRA). Granted, both of these federal laws are about religion and not secular conscience. But each expressly conditions accommodation on how it impacts third parties.⁵²²

And healthcare specifically has seen conscience serve as a unifying force before. In *Roe*’s aftermath, the Church Amendment enjoyed bipartisan support for a law that was supposed to protect conscientious refusers and providers alike.⁵²³ Professor Sara Dubow recounts that “brief moment in 1973” when “[pro-life] and pro-choice legislators saw the conscience clause as a way to diffuse rather than escalate abortion politics.”⁵²⁴ Since then, those unwilling to supply contested forms of healthcare have largely wielded the sword of conscience for themselves.⁵²⁵ But now *Dobbs* has swung the pendulum back.

These factions have drifted further and further apart in the intervening decades.⁵²⁶ That acute polarization over abortion throws a tall hurdle in the path of reform. But conscience offers a glimmer of hope; that ideal resonates across the ideological spectrum and

⁵¹⁹ See Sepper, *supra* note 37, at 1574–75.

⁵²⁰ See Civil Rights Act of 1964, Pub. L. No. 88-352, § 703(a), 78 Stat. 241, 255 (codified as amended at 42 U.S.C. § 2000e-2(a)).

⁵²¹ See Religious Freedom Restoration Act of 1993, Pub. L. No. 103-141, 107 Stat. 1488 (codified as amended at 42 U.S.C. §§ 2000bb to 2000bb-4).

⁵²² See NeJaime & Siegel, *supra* note 35, at 2528–32, 2529 n.54.

⁵²³ See *supra* notes 125–28 and accompanying text.

⁵²⁴ Sara Dubow, *From Conscience Clauses to Conscience Wars*, in *ABORTION CARE AS MORAL WORK* 83, 87 (Johanna Schoen ed., 2022).

⁵²⁵ See LEWIS, *supra* note 58, at 8–9.

⁵²⁶ See *id.* at 85; *Majority of Public Disapproves of Supreme Court’s Decision to Overturn Roe v. Wade*, PEW RSCH. CTR. (July 11, 2022), <https://www.pewresearch.org/politics/2022/07/06/majority-of-public-disapproves-of-supreme-courts-decision-to-overturn-roe-v-wade> [https://perma.cc/9HK7-PFKC].

religious/secular divide, even if it isn't enough on its own to claim common ground once again.⁵²⁷

For Congress to codify the medical disobedience regime, it would have to authorize the sort of enforcement mechanism that the Church Amendment lacks for claimants to bring suit. A private right of action should provide monetary damages where injunctive relief is no longer available after a conscientious objector has already been forced to provide care or refuse it.⁵²⁸ That law must also reach further than the Church Amendment, which applies only to federally funded institutions and those who work there.⁵²⁹ Congress already exercised Commerce Clause authority in the healthcare context when it passed EMTALA.⁵³⁰ For the conscientious provision of prohibited healthcare, lawmakers could use this similar power to mitigate state restrictions on providing services within the medical norm.

State and federal legislation isn't the only way to implement the affirmative defense. Courts can interpret statutes to serve public values that aren't inconsistent with legislative directives.⁵³¹ It's true that even a partial excuse to provide legally prohibited care would expressly contradict statutory bans on making such care available. But most states that permit clinicians to provide it also grant courts discretion to establish mitigating justifications.⁵³² And at least one court has recognized that "the ethical goals of professional conduct are of inestimable social value" because doctors bring to "their public responsibilities the same expertise that marks their calling."⁵³³ That New Jersey court recognized that the physician's charge to treat her patients "deserves judicial protection," at least where failing to care for them would undermine a "clear mandate of public policy"⁵³⁴ through which the practitioner "has sought to vindicate her professional conscience."⁵³⁵

⁵²⁷ Cf. Stephanie Lai, *Bipartisan Abortion-Rights Bill Sets Up a Midterm Debate*, N.Y. TIMES (Aug. 1, 2022), <https://www.nytimes.com/2022/08/01/us/politics/abortion-rights-bill-senate-midterms.html> [<https://perma.cc/4FSH-352R>] (describing a bipartisan legislative effort to create a federal baseline for abortion access).

⁵²⁸ See Robin Fretwell Wilson, *Empowering Private Protection of Conscience*, 9 AVE MARIA L. REV. 101, 119 (2010).

⁵²⁹ See *supra* notes 125–28, 151–52 and accompanying text.

⁵³⁰ 42 U.S.C. § 1395dd. For discussion, see *supra* notes 121, 511–13 and accompanying text.

⁵³¹ "Legisprudence" canons have long authorized courts to narrowly interpret statutes in derogation of common law. See GUIDO CALABRESI, *A COMMON LAW FOR THE AGE OF STATUTES* 4–7, 31–43 (1982).

⁵³² For the rare exception, see *Mays v. State*, 318 S.W.3d 368, 386 & n.59 (Tex. Crim. App. 2010) (citing *Giesberg v. State*, 984 S.W.2d 245, 250 (Tex. Crim. App. 1998); *Willis v. State*, 790 S.W.2d 307, 314 (Tex. Crim. App. 1990)).

⁵³³ *Pierce v. Ortho Pharm. Corp.*, 417 A.2d 505, 515 (N.J. 1980) (Pashman, J., dissenting) (describing the majority's holding).

⁵³⁴ *Id.*

⁵³⁵ *Id.* at 521.

The pursuit of ends as noble as promoting health and relieving suffering is a sound basis for judges to mitigate penalties, even in the absence of statutory authority, so long as the legislature hasn't spoken in a clear voice to foreclose that exercise of judicial discretion. None of this will be easy. It's been more than a century since courts last flexed their common law muscles to fashion new affirmative defenses such as duress, entrapment, insanity, necessity, and self-defense.⁵³⁶ But the crisis of conscience that plagues modern medicine gives reason to recover that muscle memory.

3. *Implications.* — No protections for medical disobedience could guarantee the conscientious provision of prohibited care: states could always sidestep providers altogether and go directly after patients.⁵³⁷ South Carolina and Nevada already criminalize self-managed abortions.⁵³⁸ And since 2000, police officers and prosecutors have used drug laws and other criminal statutes to investigate or arrest more than sixty people suspected of ending their own pregnancies or facilitating an abortion.⁵³⁹

A few points merit mention about a shift in this direction. First is the history of prosecuting women for miscarriage, stillbirths, and drug use during pregnancy.⁵⁴⁰ This record reveals that laws targeting patients are often enforced selectively in ways that fall hardest on the disadvantaged: Black, Latina, and rural white women with low incomes.⁵⁴¹ And enlisting doctors and nurses to report patients to law enforcement leaves patients less willing to open up if “people come to perceive” clinicians more “as pawns in harmful political campaigns” than as fiduciaries they can trust to put their interests first.⁵⁴²

A second observation has to do with politics: policies that punish patients would likely be harder to pass. In response to *Dobbs*, “national and state pro-life organizations[] representing tens of millions of pro-life” activists declared “we do not support any measure seeking to

⁵³⁶ See, e.g., *Brown v. United States*, 256 U.S. 335, 344 (1921); *Baender v. Barnett*, 255 U.S. 224, 225 (1921).

⁵³⁷ See, e.g., The Daily, *The Effort to Punish Women for Having Abortions*, N.Y. TIMES, at 28:39 (Aug. 23, 2022), <https://www.nytimes.com/2022/08/23/podcasts/the-daily/abortion-abolition-roe-v-wade.html> [<https://perma.cc/4B8M-U5YS>]; Elizabeth Dias, *After Abortion Ruling, A Push for Punishment*, N.Y. TIMES, July 2, 2022, at A1.

⁵³⁸ S.C. CODE ANN. § 44-41-20 (2021); NEV. REV. STAT. § 442.250 (2021).

⁵³⁹ See LAURA HUSS ET AL., SELF-CARE, CRIMINALIZED: AUGUST 2022 PRELIMINARY FINDINGS 2 (2022), <https://www.ifwhenhow.org/resources/self-care-criminalized-preliminary-findings> [<https://perma.cc/7L8Y-ZH37>].

⁵⁴⁰ See *Arrests and Prosecutions of Pregnant Women, 1973–2020*, NAT'L ADVOCS. FOR PREGNANT WOMEN (Sept. 18, 2021), <https://www.nationaladvocatesforpregnantwomen.org/arrests-and-prosecutions-of-pregnant-women-1973-2020> [<https://perma.cc/9Q5R-VUDG>].

⁵⁴¹ See *Ferguson v. City of Charleston*, 532 U.S. 67, 70–71 (2001); MICHELE GOODWIN, *POLICING THE WOMB 14* (2020); Lynn M. Paltrow et al., *Beyond Abortion: The Consequences of Overturning Roe*, AM. J. BIOETHICS, June 2022, at 3, 9–10.

⁵⁴² Anna Kirkland, *Physicians as Political Pawns — The Texas Directive on Gender-Affirming Care and Other Moves*, 386 NEW ENG. J. MED. 2161, 2162 (2022).

criminalize or punish women and we stand firmly opposed to includ[ing] such penalties in legislation.”⁵⁴³ Whereas punishing doctors who provide unpopular forms of care might more readily secure a democratic majority, going after patients themselves may be a heavier lift, and exact a political price.

In the abortion context, this strategy cedes the moral high ground that opponents have long sought by arguing that restrictions actually protect women.⁵⁴⁴ Professor Mary Ziegler explains that these claims “resonate politically because they soften the image of pro-lifers and shift blame for difficult pregnancies from women” to others who deceive or coerce them.⁵⁴⁵ The push for “prosecutions of any pregnant woman undermines woman-protective arguments and makes them seem hollow,” casting “abortion opponents as moral absolutists, indifferent to the well-being of women.”⁵⁴⁶

Finally, abortion seekers who draw on their religious faith might have conscience claims of their own.⁵⁴⁷ The Rabbinical Assembly holds that Judaism commands that abortion be available when needed to preserve a woman’s health.⁵⁴⁸ Florida’s Congregation L’Dor Va-Dor challenged the state’s fifteen-week abortion ban on free exercise grounds that it “impose[s a] religious view[] about when life begins.”⁵⁴⁹ The law overrides the Jewish teachings that a woman should “abort the pregnancy and protect herself”⁵⁵⁰ until the point of birth “if a fetus poses a threat to [her] health or emotional well-being.”⁵⁵¹

⁵⁴³ Carol Tobias et al., *An Open Letter to State Lawmakers from America’s Leading Pro-Life Organizations*, NAT’L RIGHT TO LIFE (May 12, 2022), <https://www.nrlc.org/uploads/communications/051222coalitionlettertostates.pdf> [<https://perma.cc/UFK2-34VB>].

⁵⁴⁴ See Reva B. Siegel, *The Right’s Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1687–88 (2008).

⁵⁴⁵ Mary Ziegler, *Some Form of Punishment: Penalizing Women for Abortion*, 26 WM. & MARY BILL RTS. J. 735, 784 (2018).

⁵⁴⁶ *Id.* at 783–84.

⁵⁴⁷ See, e.g., Olivia Roat, *Free-Exercise Arguments for the Right to Abortion: Reimagining the Relationship Between Religion and Reproductive Rights*, 29 UCLA J. GENDER & L. 1, 51–52 (2022); Schragger & Schwartzman, *supra* note 332, at 18. The religious-liberty argument against abortion bans surfaced before *Roe*. See, e.g., Joseph S. Oteri et al., *Abortion and the Religious Liberty Clauses*, 7 HARV. C.R.-C.L. L. REV. 559, 593 (1972). For discussion, see *supra* notes 117–19 and accompanying text.

⁵⁴⁸ See *Resolution on Reproductive Freedom in the United States*, RABBINICAL ASSEMBLY (May 21, 2012), <https://rabbinicalassembly.org/story/resolution-reproductive-freedom-united-states> [<https://perma.cc/53F4-V8GG>]; accord Danny Horwitz, Opinion, *Texas’ Abortion Ban Is Against My Religion. As a Rabbi, I Will Defy It if Necessary.*, RELIGION NEWS SERV. (Sept. 2, 2021), <https://religionnews.com/2021/09/02/texas-abortion-ban-is-against-my-religion-as-a-rabbi-i-will-defy-it-if-necessary> [<https://perma.cc/PD8U-2QXM>].

⁵⁴⁹ Complaint for Declaratory Relief and for Temporary and Permanent Injunction Declaring House Bill 5 Invalid, Unconstitutional and Unenforceable ¶ 67, Generation to Generation, Inc. v. Florida, No. 2022-CA-000980 (Fla. Cir. Ct. June 10, 2022).

⁵⁵⁰ *Id.* ¶ 75.

⁵⁵¹ *Id.* ¶¶ 63–75.

Devout patients and their faith leaders point to religious-liberty provisions of federal and state constitutions as well as RFRA.⁵⁵² Interestingly, RFRA's bipartisan enactment in the 1990s was actually slowed by staunch resistance from anti-abortion groups, including the Catholic Church, that opposed the bill out of fear that it risked introducing an independent basis for abortion advocates of faith to restore the abortion right in statutory form in the event that *Roe* were ever overturned.⁵⁵³

In 1972, more than two decades before RFRA finally passed, an Ohio minister stood poised to make a First Amendment religious-liberty argument for abortion counseling had *Roe* not rendered moot his case before the Massachusetts high court.⁵⁵⁴ Robert Hare was charged as an accessory to criminal abortion before the fact for having advised one of his Cleveland congregants about how to seek a criminal abortion out of state.⁵⁵⁵ Reverend Hare's church defended the actions that he took in the service of "his ordination vows and the confessional position of this Church."⁵⁵⁶

Hare was one of over a thousand ministers and rabbis who referred women living in states that criminalized abortion for safe procedures with licensed doctors.⁵⁵⁷ Historians estimate that, during its six years of operation between 1967 to 1973, this network helped hundreds of thousands of women get safe abortions.⁵⁵⁸ Now that medication abortion is possible, a modern-day counterpart to that Clergy Consultation

⁵⁵² Some Buddhists deem reproductive rights essential to their spiritual conception of "equal personhood." Sallie Jiko Tisdale, *Is There a Buddhist View on Abortion?*, TRICYCLE (Oct. 8, 2021), <https://tricycle.org/trikedaily/buddhism-abortion> [https://perma.cc/TJ7R-QCK6]. Even with evangelical traditions that formally disfavor abortion, many adherents recognize the procedure as a spiritual imperative "[f]or those whose religion dictates that authentic choice is an ethical necessity." Brief of Amici Curiae Religious Coalition for Reproductive Choice et al. in Support of Respondent at 20, *Stenberg v. Carhart*, 530 U.S. 914 (2000) (No. 99-830); see also Complaint for Declaratory and Injunctive Relief ¶ 112, *Whole Woman's Health v. Jackson*, 556 F. Supp. 3d 595 (W.D. Tex. 2021) (No. 21-cv-00616). Differently protected appeals for Catholics and not Jews might invite an equal protection challenge. To escape rational basis review, however, claimants would have to show that selective protections are a pretext for religious favoritism that disadvantages a certain suspect group of religious clinicians, while privileging others who pray to a different God. See, e.g., Thomas C. Berg, *Minority Religions and the Religion Clauses*, 82 WASH. U. L.Q. 919, 939-41 (2004).

⁵⁵³ See, e.g., Douglas Laycock & Oliver S. Thomas, *Interpreting the Religious Freedom Restoration Act*, 73 TEX. L. REV. 209, 231 (1994); Thomas Scott-Railton, Note, *A Legal Sanctuary: How the Religious Freedom Restoration Act Could Protect Sanctuary Churches*, 128 YALE L.J. 408, 427-28 (2018).

⁵⁵⁴ *Commonwealth v. Hare*, 280 N.E.2d 138 (Mass. 1972).

⁵⁵⁵ See *id.* at 139.

⁵⁵⁶ TOM DAVIS, SACRED WORK: PLANNED PARENTHOOD AND ITS CLERGY ALLIANCES 132 (2005).

⁵⁵⁷ See ARLENE CARMEN & HOWARD MOODY, ABORTION COUNSELING AND SOCIAL CHANGE: FROM ILLEGAL ACT TO MEDICAL PRACTICE 28, 47-51 (1973).

⁵⁵⁸ See DORIS ANDREA DIRKS & PATRICIA A. RELF, TO OFFER COMPASSION: A HISTORY OF THE CLERGY CONSULTATION SERVICE ON ABORTION 5 (2017); Bridgette Dunlap, *How Clergy Set the Standard for Abortion Care*, THE ATLANTIC (May 29, 2016), <https://www.theatlantic.com/politics/archive/2016/05/how-the-clergy-innovated-abortion-services/484517> [https://perma.cc/SCA3-NM8D].

Service has emerged: “a growing army of community-based distributors” that’s “reaching pregnant women through word of mouth or social media to supply pills for free — though typically without the safeguards of medical oversight.”⁵⁵⁹

CONCLUSION

Conscientious providers are laying their careers and freedom on the line in numbers not seen in half a century.⁵⁶⁰ Doctors have never so roundly condemned a Supreme Court decision like they have *Dobbs*.⁵⁶¹ Almost every major professional organization and public health association has denounced the ruling as “a direct attack on the practice of medicine and the patient-physician relationship.”⁵⁶² At this inflection point, how should society reconcile what the clinical establishment thinks of contested treatments with the views of legislatures that make rules about them?⁵⁶³

The *New England Journal of Medicine* ran an editorial after *Dobbs* encouraging clinicians nationwide to collectively resist state restrictions on “evidence-based medical care, even if doing so means accepting — en masse — fines, suspensions of licensure, and potential imprisonment.”⁵⁶⁴ Institutional leadership and support is critical from accrediting organizations and influential groups like the American Medical Association. But that sacrifice is too much to expect of doctors, standing alone, and even shoulder to shoulder. Also, any doctor who’s preoccupied with trial or sitting in jail is one fewer who’s able to help care for patients. If lawmakers won’t protect conscientious providers, then judges should: a partial excuse to supply medically indicated care.

This affirmative defense betrays a normative tension. It would have the state go easy on clinicians for the very conduct that it criminalizes

⁵⁵⁹ Kitchener, *supra* note 21. For discussion, see also *supra* note 275; *supra* notes 19–21 and accompanying text; and Taladrid, *supra* note 21.

⁵⁶⁰ See, e.g., Dipti Barot, Opinion, *As a Doctor in California, My Life Hasn’t Changed Since the End of Roe. I’m Disgusted by That.*, S.F. CHRON. (Aug. 30, 2022, 8:21 AM), <https://www.sfchronicle.com/opinion/openforum/article/california-abortion-doctor-17405871.php> [https://perma.cc/9ZWH-BFPK]; Morgan Smith, “*We Are Drowning in Despair: How 3 Doctors Are Navigating the Chaos of a Post-Roe America*,” CNBC (Sept. 14, 2022, 11:24 AM), <https://www.cnbc.com/2022/09/14/us-doctors-on-providing-abortion-care-post-ro-its-devastating.html> [https://perma.cc/7KGN-CCU8].

⁵⁶¹ See *supra* notes 17–25 and accompanying text.

⁵⁶² Press Release, Jack Resneck, Jr., President, Am. Med. Ass’n, Ruling an Egregious Allowance of Government Intrusion into Medicine (June 24, 2022), <https://www.ama-assn.org/press-center/press-releases/ruling-egregious-allowance-government-intrusion-medicine> [https://perma.cc/6FJC-F85L]; see also *supra* note 160 and accompanying text (discussing amicus brief filed by twenty-five medical groups in *Dobbs*).

⁵⁶³ See M. Gregg Bloche, *Medicalizing the Constitution?*, 386 NEW ENG. J. MED. 2357, 2359 (2022); Dov Fox, *Interest Creep*, 82 GEO. WASH. L. REV. 273, 279 n.35, 307–08, 348–55 (2014).

⁵⁶⁴ Matthew K. Wynia, *Professional Civil Disobedience — Medical-Society Responsibilities After Dobbs*, 387 NEW ENG. J. MED. 959, 960 (2022).

as child abuse or murder.⁵⁶⁵ This conciliation straddles a precarious moral position if the rules are so riddled with exceptions that they come to be seen as arbitrary or unjust.⁵⁶⁶ And yet some social disagreements are so profound that even the cleverest compromise is bound to be unsatisfying.⁵⁶⁷

In *Death Is that Man Taking Names*, Professor Robert Burt eschewed bright lines in matters like abortion and assisted suicide.⁵⁶⁸ He argued that there was no distinguishing unequivocally good endings-of-life from just-as-categorically bad ones.⁵⁶⁹ In his view, they all involved tough calls, demanding moral tradeoffs that elude any conceptual fix. Burt thought that trying to parse “persons” from “non-persons,” or “killing” from “letting die,” was an illusory exercise in reducing irreducible complexity.⁵⁷⁰ And he worried that suppressing such deeply felt convictions would force them to reemerge elsewhere in more pernicious ways.⁵⁷¹ Burt urged measures to write these competing values into the law, affirming the unshakeable conflict that they express through legislative compromises, administrative incongruities, even judicial contradictions.⁵⁷²

Giving voice to this ambivalence can mediate the thorniest controversies with uneasy fit and uncomfortable candor. It’s not anti-democratic to build principled exceptions into rules that were designed to apply generally.⁵⁷³ Taking the edge off of civil or criminal consequences needn’t defeat the law itself if leniency is limited to harsh penalties.⁵⁷⁴ Nor does this incomplete mitigation fortify a bad law or stifle the impetus to change it.⁵⁷⁵ The point is to bridge a tenuous divide

⁵⁶⁵ See Kathleen M. Sullivan, *The Supreme Court, 1991 Term — Foreword: The Justices of Rules and Standards*, 106 HARV. L. REV. 22, 78 (1992).

⁵⁶⁶ In the Native American peyote case, Justice Scalia opposed judicially sanctioned religious exemptions from the criminal laws for fear of “courting anarchy.” *Emp. Div. v. Smith*, 494 U.S. 872, 888 (1990). Court-made carve-outs would in his view “permit every citizen to become a law unto himself.” *Id.* at 879 (quoting *Reynolds v. United States*, 98 U.S. 145, 167 (1879)). “Conscientious scruples have not,” in the domain of religion at any rate, “relieved the individual from obedience to a general law not aimed at the promotion or restriction of religious beliefs.” *Id.* (quoting *Minersville Sch. Dist. v. Gobitis*, 310 U.S. 586, 594 (1940)). Justice Scalia’s real problem with anarchy was with unelected judges deciding such policy tradeoffs and not legislators: “it is horrible to contemplate that federal judges will regularly balance against the importance of general laws the significance of religious practice.” *Id.* at 889 n.5.

⁵⁶⁷ See Joseph William Singer, *The Player and the Cards: Nihilism and Legal Theory*, 94 YALE L.J. 1, 12–13 (1984).

⁵⁶⁸ See ROBERT A. BURT, *DEATH IS THAT MAN TAKING NAMES* 157–59, 163 (2002).

⁵⁶⁹ See *id.* at 157–58.

⁵⁷⁰ See *id.* at 157–59.

⁵⁷¹ See *id.* at 22.

⁵⁷² See *id.* at 159.

⁵⁷³ See *supra* notes 317–18 and accompanying text.

⁵⁷⁴ See *supra* notes 347–48 and accompanying text.

⁵⁷⁵ See *supra* notes 104, 315 and accompanying text.

between enacting the democratic will of today and enabling the worthy reforms of tomorrow.⁵⁷⁶

“Abortionists” is how the *Dobbs* majority referred to those medical professionals whose practice includes abortion — not as “nurses” or “doctors,” but “abortionists.”⁵⁷⁷ Most practitioners who supply abortion recoil from this reductionist label, not just because it neglects so many other ways in which they care for people in need.⁵⁷⁸ The term is meant to conjure up the craven quack or back-alley butcher.⁵⁷⁹ But some providers have begun to embrace that designation to reject that pejorative and reclaim its meaning to capture the moral significance of “ending potential human life” to honor the patient before them.⁵⁸⁰ Clinicians should be able to carry out this conscientious work without the looming threat of punitive sanctions.⁵⁸¹

Writing in 1959, Packer and Gampell reflected on the “significant disparity between what the law commands” and what reputable doctors do.⁵⁸² They resolved that the legal system “ought to be brought into greater conformity with” how medicine operates at its best to promote health and relieve suffering.⁵⁸³ The conscience clauses enacted in *Roe*’s wake made carve-outs for refusers a permanent feature of America’s legal and medical landscape. The fallout from *Dobbs* underscores why conscientious providers should get a break too. Not only to sustain their moral integrity by tending to the sick and the vulnerable. But also to shore up the relationship between the practice of medicine and the rule of law that’s never felt so fragile.

⁵⁷⁶ See *supra* notes 96–97 and accompanying text.

⁵⁷⁷ *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2236, 2250, 2254 (2022).

⁵⁷⁸ See, e.g., No, We Aren’t “Murderers” — We Are Your Doctors, DR. GABRIELLE GOODRICK (Mar. 7, 2019), <https://drgabriellegoodrick.com/2019/03/07/no-we-arent-murderers-we-are-your-doctors> [<https://perma.cc/P2HT-LHB2>] (“I am not a murder[er], or a monster. I am a doctor. I once delivered your babies and still do your paps, IUD’s, physical exams and STI checks, and yes, I terminate pregnancies, too.”).

⁵⁷⁹ See RICKIE SOLINGER, *THE ABORTIONIST* xiii (2019).

⁵⁸⁰ Marc Heller, *Being an Abortionist*, in *ABORTION CARE AS MORAL WORK*, *supra* note 524, at 37; see also Lisa A. Martin et al., *Dangertalk: Voices of Abortion Providers*, in *ABORTION CARE AS MORAL WORK*, *supra* note 524, at 127–28 (arguing that clinicians should give public voice to the moral tensions reflected in the complex realities of abortion).

⁵⁸¹ See *supra* note 495 and accompanying text.

⁵⁸² Packer & Gampell, *supra* note 471, at 417.

⁵⁸³ *Id.* at 449.