New Refusal Clauses Shatter Balance Between Provider 'Conscience,' Patient Needs

By Adam Sonfield

A series of attention-grabbing lawsuits and a crop of new legislation have spotlighted a long-gathering movement to vastly expand the scope of policies allowing health care providers, institutions and payers to refuse to participate in sexual and reproductive health services by claiming a moral or religious objection. In some cases, these radical new policies are intentionally designed to undermine, if not actually eliminate, the ability of governments at all levels, and even private businesses, to balance providers' "conscience" rights with the ability of patients to exercise their own conscience and gain access to health care services that they want and need.

Ever-Expanding Objections

U.S. policymakers first enacted "refusal clauses" in response to the nationwide legalization of abortion in the 1973 *Roe v. Wade* decision. These early policies—adopted by the federal government and all but a handful of states—were designed to allow doctors and other direct providers of health care to refuse to perform or assist in an abortion, and hospitals to refuse to allow abortions on their premises ("Refusing to Participate in Health Care: A Continuing Debate," *TGR,* February 2000, page 8). The federal policy also applies to sterilization, and a minority of states' policies apply to sterilization or contraception more broadly.

Since the 1970s, and especially over the past decade, the refusal clause debate has spread to a larger range of health care activities and participants. Much of the new momentum comes from the advent of technologies and medical practices that some Americans find objectionable. Examples include in vitro fertilization and other assisted reproductive technologies; medical research involving human embryos or fetuses, or embryonic stem cells; and end-of-life practices such as assisted suicide or even adherence to living wills. Refusal clause advocates have used public misgivings about these technologies and practices to push for provisions applying to these activities specifically—or to any activity, without limitation—and for an increasingly wide group of individuals and institutions that they claim are unwilling "participants" in these activities.

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An important example of this tactic capitalizes on public ignorance about emergency contraception, which many antiabortion and other conservative activist groups have tarred as causing abortion, despite broad consensus in the medical community that it prevents an unintended pregnancy. The growing use of emergency contraception has helped bolster a movement to give pharmacists the right to refuse to fill prescriptions, for this drug and for others ("Objections, Confusion Among Pharmacists Threaten Access to Emergency Contraception," *TGR,* June 1999, page 1).

Even for older technologies, however, the refusal clause debate is expanding to implicate new participants and increasingly indirect forms of involvement. Three news stories from one month this year alone illustrate the pattern: In May, an ambulance worker in suburban Chicago sued a company that had purportedly fired her for refusing to transport a patient suffering severe abdominal pain to a clinic for an abortion. Later that month, an Illinois county settled a lawsuit brought by an employee denied a promotion purportedly because she refused to translate into Spanish information for family planning clients on abortion options. Also that month, a Wisconsin pharmacist faced a disciplinary hearing for refusing to even transfer a woman's prescription for oral contraceptives to another pharmacy.

These are not isolated incidents. News reports and court cases from prior years also have highlighted examples of hospital workers refusing to clean surgical instruments or handle paperwork tied to abortion, as well as police officers refusing to protect reproductive health clinics. Furthermore, social conservatives have called over the past decade for the creation of refusal clauses for health care payers, seeking to exempt insurance companies and employers purchasing insurance from laws requiring private-sector coverage of contraception, and to exempt managed care plans from covering reproductive health services under Medicaid.

Avenues for Expansion

Conservative advocates have been working at both the state and the federal levels in their campaign to enact laws to expand the scope of refusal policies. At the state level, the prime example is a law signed in May by Mississippi Gov. Haley Barbour (R)—legislation he campaigned on and extolled as "the single most

expansive conscience exception law in the nation." Individuals and institutional providers and payers of health care may now refuse to be involved in any type of service to which they object on moral, ethical or religious grounds, free from any type of liability, regardless of the effects on patients and employers. The law is as sweeping as it is detailed, covering activities such as counseling, diagnosis and research, as well as dispensing or administering any type of drug, device, surgery, care or treatment. Individuals granted this right of refusal include any employee of a hospital, clinic, nursing home, pharmacy or medical school, along with students, counselors or "any other person who furnishes, or assists in the furnishing of, a health care procedure."

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Expansive refusal legislation was vetoed in April by Wisconsin Gov. Jim Doyle (D). The legislation would have extended the refusal clause currently in state law beyond its focus on performing or assisting in abortion and sterilization. It would have applied to a broader range of activities (including counseling and prescribing drugs) related to reproductive health, embryo research and end-of-life care.

Legislation has also passed the Michigan House and is pending in the state's Senate that would vastly expand refusal provisions for individual and institutional providers and add new provisions for insurers. It would exempt individuals from participating in almost any way in any type of health care service, except for provision of a contraceptive medication "taken or used in advance of sexual intercourse." That language is designed to allow refusal for emergency contraception and such devices as IUDs. Similar exemptions for institutions and insurers do not even include this limited caveat for contraceptive medication.

At the federal level, most of the debate in recent years has centered on the Abortion Non-Discrimination Act (ANDA), which passed the House of Representatives in 2002. A provision with similar effects was inserted by the House Appropriations Committee into the bill that provides FY 2005 funding for the Department of Health and Human Services. If enacted, the provision essentially would forbid any federal, state or local government from requiring any individual or institutional provider or payer to perform, provide, refer for or pay for an abortion. Such a policy would effectively negate the federal requirement that all clinics supported by Title X family planning funds provide abortion referrals upon specific request, in the form of a simple list of providers, as part of counseling clients about their full range of pregnancy options. It also would limit states' ability to enforce the federal Medicaid requirement that indigent women have access to Medicaid-funded abortions in situations of life endangerment, rape and incest, since states no longer could require managed care plans with which they contract to provide abortions to their enrollees in these circumstances. And it might even be used in an attempt to override state laws requiring hospitals to provide emergency contraception to rape victims, under the pretext that the drugs are abortifacients.

Another effort has occurred under a broader canopy of religious rights. Title VII of the federal Civil Rights Act protects workers from discrimination on the basis of religion, but many religious rights advocates assert that courts have interpreted this protection too narrowly. Bipartisan legislation under consideration in Congress—the Workplace Religious Freedom Act—would amend Title VII to redefine when and how employers must accommodate an employee's religious practices. Most supporters of the measure, including a wide array of religious groups, say the legislation is needed to accommodate such things as religious apparel and scheduling for religious observances. The Family Research Council, however, cites cases of pharmacists' refusal to provide contraception as a reason to enact this legislation.

Loss of Balance

This campaign to expand refusal rights threatens the ability of governments, communities and private organizations to protect patients' access to information and care. Health care provider groups, for example, generally support a balance between respecting providers' moral and religious beliefs and protecting the ability of patients to give informed consent and gain access to the health care they need. The American Nurses Association, for instance, asserts that although nurses have a right to refuse to participate in particular cases, a provider has an obligation "to share with the client all relevant information about health choices that are legal." The American Pharmacists Association adopted a policy in 1998 attempting to counterbalance pharmacists' right of refusal with "the establishment of systems to ensure patient access to legally prescribed therapy."

Much of the most recent wave of legislation appears to have been tailored specifically to eliminate this balance, in effect asserting that patients have no real rights to care or even information—or that repro-

ductive health care is not really health care at all. In his veto message, Wisconsin's governor noted that under the legislation, "there are no requirements that the health care professionals advise patients of their treatment options, provide a referral to the patient, transfer certain patients, or render care if the patients' health or life is threatened." He also stressed its potential harm to patients with a limited choice of providers, such as those in rural areas. He could have added that the legislation allowed individuals to ignore essential functions of their job, meaning, for example, that an abortion clinic could not fire a worker who refused to participate in abortion.

The Mississippi legislation includes all of these flaws and more. For instance, its definition of what is considered illegal "discrimination" against a provider, institution or payer asserting a religious or moral objection would prohibit many actions that a government or private entity could take to protect individuals' access to health care. This includes reassigning a worker to a different shift, a standard way of accommodating such an objection. This same language, as well as ANDA and the appropriations language currently pending before Congress, would also block efforts by policymakers, communities and advocates to preserve access to reproductive health services in the face of plans by religious institutions to affiliate or merge with secular ones or to assert control over what doctors do in their private practices.

Another concern is that these increasingly broad refusal clauses will allow individuals and institutional providers and payers to deny services for any reason—even prejudice. Most existing laws have few if any restrictions as to why an entity may object to a service and

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few requirements for anyone to actually provide care, except perhaps in emergencies. Indeed, only in the latest crop of legislation—the Mississippi law and the bills pending in Michigan—have lawmakers prohibited providers from refusing to participate in a service based on specific patient characteristics, such as race, ethnicity or religion. In both cases, however, the breadth of these lists of protected characteristics can been questioned. In Michigan, opponents of the legislation have noted that the list (a part of the state's civil rights law) does not include sexual orientation and have argued that the legislation would give providers license to refuse care to homosexuals. The Mississippi law's list of protected characteristics includes sexual orientation but does not include marital status, implying that providers or payers could discriminate against single people, for example by refusing to provide contraceptives to unmarried women.

All hope for balancing the rights of providers and patients is not lost, however. State legislators crafting requirements that insurance coverage of contraceptives be on par with other prescription drugs, for example, have intensely debated the breadth and effects of exemptions from these requirements ("Contraceptive Coverage: A 10-Year Retrospective," *TGR,* June 2004, page 6). In March 2004, California's top court upheld a religious exemption in the state's contraceptive coverage law, noting that it was narrowly tailored to serve the state's compelling interest in eliminating gender discrimination in health care. In addition, a handful of states have enacted mechanisms designed to ensure patients' access to care despite the objections of religious employers or insurers; Hawaii, Missouri and New York, for example, enable employees to purchase contraceptive coverage directly from an insurer if their employer refuses to provide coverage. One can hope that all of these actions may light the way for future attempts at balance, in contraceptive coverage laws and beyond. ⊕

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