Health Care Providers’ Right to Refuse to Treat Patients

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The Texas Legislature is considering Senate Bill No. 10161 (SB 1016), a “conscience-clause” bill that would allow health care providers, health care facilities and health insurers to refuse to participate in certain procedures.

Since the 1973 decision in Roe v. Wade, 47 states have passed limited laws allowing physicians to refuse to perform abortions or sterilization procedures.2 The American Medical Association and other physician’s groups have historically supported conscience clause laws, but states are now considering greatly expanded versions of such laws that may be objectionable to physicians.3 SB1016 would allow (with some exceptions) most health care facilities and providers to refuse to provide a health care service (as defined in § 172.001 (1) “on ethical, moral or religious grounds.” For example, SB1016 could allow a physician or hospital to refuse to honor a patient’s advance directives. It would clearly allow a pharmacist to refuse to dispense contraceptives without risk of disciplinary action by the pharmacy board or the pharmacist’s employer.

Health Care Providers

SB 1016 provides that a health care provider may as a matter of conscience object to providing or participating in the provision of a health care service on ethical, moral, or religious grounds. The objection may be asserted:

(1) at the time the provider is offered employment;
(2) at the time the health care provider adopts an ethical, moral, or religious belief system that conflicts with providing or participating in the provision of a health care service; or
(3) not later than 24 hours after receiving notice that the provider is scheduled to participate in a health care service to which the provider objects on ethical, moral, or religious grounds.4

SB 1016 provides that a health care provider’s employment can be terminated only if he or she asserts an objection to provide or participate in a health care service that

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3 Id.
4 S.B. 1016 § 172.151.
constitutes 50 percent or more of the health care provider’s daily or weekly hours of duty.5

The recent public debate over conscience clauses has involved pharmacists’ refusal to fill prescriptions for emergency and other contraception.6 A recent article in the New England Journal of Medicine lists the arguments in favor of a pharmacist’s right to object as: “pharmacists can and should exercise independent judgment; professionals should not forsake their morals as a condition of employment; [and] conscientious objection is integral to democracy.”7 However, the arguments against a pharmacist’s right to object are also significant. The authors argue that “pharmacists are bound by fiduciary duties; pharmacists’ objections significantly affect patients’ health; [and] refusal has great potential for abuse and discrimination.”8 The authors conclude that pharmacists should not have a legal duty to dispense emergency contraception, but should be required to promptly refer patients elsewhere.9

The Washington Post has published a number of articles regarding the pharmacy issue. Pharmacists have refused to fill prescriptions for contraceptives in California, Washington, Georgia, Illinois, Louisiana, Massachusetts, Texas, New Hampshire, Ohio and North Carolina.10 One pharmacist in Wisconsin may be disciplined for refusing to fill a birth control prescription for a college student. The state pharmacy board is deciding whether to impose a penalty in the case.11 The advocacy group Pharmacists For Life is supporting legislation that would not only allow pharmacists to refuse to fill prescriptions but would also require them to refer patients elsewhere.12 The Post reports that at least 11 states are considering laws that would protect pharmacists who refuse to fill prescriptions based on their beliefs; four states currently have laws “that specifically allow pharmacists to refuse to fill prescriptions that violate their beliefs;” but “at least four states are considering laws that would explicitly require pharmacists to fill all prescriptions.”13

The American Pharmacists Association (APhA) “recognizes the individual pharmacist’s right to exercise conscientious refusal and supports the establishment of systems to ensure patient’s access to legally prescribed therapy without compromising the pharmacist’s right of conscientious refusal.”14 APhA says that “[w]hen the profession’s

5 S.B. 1016 § 172.158.
7 Id. at 2008-2009.
8 Id. at 2009-10.
9 Id at 2011.
11 Id.
12 Id.
13 Id.
policy is implemented correctly--and proactively--it is seamless to the patient, and the patient is not aware that the pharmacist is stepping away from the situation."\textsuperscript{15} APhA envisions a process where either another pharmacist on duty completes the prescription or where patients are “proactively directed to pharmacies where certain therapy is available. . .”\textsuperscript{16} In a properly structured system “the patient gets the medication, and the pharmacist steps away from that activity--with no intersection between the two.\textsuperscript{17}

Illinois Governor Rod R. Blagojevich issued an emergency rule April 1, 2005, requiring pharmacies to fill contraceptive prescriptions without delay. The rule provides as follows:

\begin{quote}
\textbf{j) Duty of Division I Pharmacy to Dispense Contraceptives}
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1) Upon receipt of a valid, lawful prescription for a contraceptive, a pharmacy must dispense the contraceptive, or a suitable alternative permitted by the prescriber, to the patient or the patient’s agent without delay. If the contraceptive, or a suitable alternative, is not in stock, the pharmacy must obtain the contraceptive under the pharmacy's standard procedures for ordering contraceptive drugs not in stock, including the procedures of any entity that is affiliated with, owns, or franchises the pharmacy. However, if the patient prefers, the prescription must either be transferred to a local pharmacy of the patient’s choice or returned to the patient, as the patient directs.

2) For the purposes of this subsection (j), the term “contraceptive” shall refer to all FDA-approved drugs or devices that prevent pregnancy.\textsuperscript{18}

In 2004, Mississippi enacted the Mississippi Health Care Rights of Conscience Act.\textsuperscript{19} Governor Haley Barbor called the law “the single most expansive conscience exception law in the nation.”\textsuperscript{20} The law provides that a health care provider shall not be required to participate in any health care service that violates his or her conscience. The law also provides that a health care institution or health care payer shall not be required to participate in any health care service that violates its conscience. Providers, payers and

\begin{footnotesize}
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\item Susan C. Winckler, Letter to the Editor submitted by APhA to \textit{Prevention} magazine, (July 1, 2004) available at \url{http://www.aphanet.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=2689}.
\item \textit{Id.}
\item \textit{Id.}
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insurers who refuse to provide services for reasons of conscience are granted immunity from liability resulting from such refusal.\textsuperscript{21}

\textbf{Health Care Insurers}

SB 1016 allows a health insurer to refuse to offer or provide a benefit “on ethical, moral, or religious grounds as provided the insurer’s articles of incorporation, bylaws, or an adopted mission statement”\textsuperscript{22} unless the benefit is specifically provided under the insurance policy or “required to be provided by the insurer under the Insurance Code.”\textsuperscript{23}

The public debate surrounding the issue addressed by this provision is whether health plans offered by religious organizations must offer prescription drug coverage for contraceptives. In 2004, the California Supreme Court rejected Catholic Charities constitutional challenges to the California Women’s Contraception Equity Act (WCEA), which required certain health insurance plans to cover prescription contraceptives.\textsuperscript{24} Catholic Charities opposes contraceptives on religious grounds, and argued that WCEA violates the establishment and free exercise clauses of the United States and California Constitutions.\textsuperscript{25} California enacted WCEA in 1999 “to eliminate gender discrimination in health care benefits and to improve access to prescription contraceptives.”\textsuperscript{26} WCEA contains an exception that permits a “religious employer” to offer prescription drug coverage that excludes coverage for contraceptives that are contrary to the religious employer’s beliefs. However, the court held Catholic Charities is not a “religious employer” for purposes of WCEA since it offers a wide variety of health and social services to individuals who are not Catholic and since its corporate purpose is not to directly evangelize.\textsuperscript{27} In addition, most of Catholic Charities’ 183 employees are not Catholic. Rejecting Catholic Charities’ constitutional challenges, the court said:

This case does not implicate internal church governance; it implicates the relationship between a nonprofit public benefit corporation and its employees, most of whom do not belong to the Catholic Church. Only those who join a church impliedly consent to its religious governance on matters of faith and discipline.\textsuperscript{28}

SB 1016 does not allow insurers to refuse to provide coverage required to be provided by the insurer under the Insurance Code.\textsuperscript{29}

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\item \textsuperscript{21} S.B. 2619.
\item \textsuperscript{22} S.B. 1016 §172.001.
\item \textsuperscript{23} Id.
\item \textsuperscript{24} Catholic Charities of Sacramento, Inc. v. Superior Court, 85 P.3d 67 (Calif. 2004).
\item \textsuperscript{25} Id. at 73.
\item \textsuperscript{26} Id. at 74.
\item \textsuperscript{27} Id. at 75.
\item \textsuperscript{28} Id. at 77.
\item \textsuperscript{29} S.B. 1016 §172.001.
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Health Care Facilities

SB 1016 also permits a health care facility (broadly defined in § 172.001) to withdraw from providing a service or to refuse to provide a service on ethical, moral, or religious grounds.30 The bill provides that the facilities’ right to object does not apply during emergencies including public health emergencies.31 An example of the issues raised by this provision is whether Catholic hospitals should be required to provide emergency contraceptives to rape victims.

Critics of health care facility refusal laws see such laws as a threat to reproductive rights, particularly for rape victims. One author noted as follows:

> Sexual assault survivors face . . . obstructions to access to emergency contraception in hospital emergency rooms. An estimated 25,000 unintended pregnancies each year are a result of sexual assault. Approximately 22,000 of these pregnancies could be prevented if all women who were raped were provided with EC (Stewart & Trussell, 2000). Surprisingly, many hospitals overlook their responsibility to offer EC to sexual assault survivors.

A study of sexual assault survivors who were treated in emergency rooms found that fewer than half of the women who were at risk of pregnancy received EC (Amey & Bishai, 2002). Another study found that as many as 1,000 sexual assault survivors per year left New York State emergency rooms without having received EC (FPANYS, 2003).32

The author concludes that “[w]omen's access to reproductive health care diminishes as an increasing number of non-religiously affiliated hospitals are merging with Catholic hospitals”33 based on the following:

> In June of 2000, it was found that 10 of the 20 largest not-for-profit U.S. hospital systems were operated by Catholic entities (Pawelko & Krishnamurthy, 2001).34

> In the U.S., 13 percent of all hospitals with emergency rooms are Catholic. In many states, 30-40 percent of people who need emergency care visit a Catholic hospital (CFFC, 2002).35

In 2001, The City of Austin was forced to renegotiate its contract that allowed the Catholic Seton Healthcare Network to operate Brackenridge Hospital. Catholic officials

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30 Id. § 172.051
31 Id. § 172.052.
33 Id.
34 Id.
35 Id.
objected to the provision of reproductive services, and the city eventually agreed to operate the maternity ward as “hospital within a hospital” on the fifth floor of the hospital. It is unclear whether SB 1016 would affect this or similar future agreements.

Conclusion

Refusal clauses are being hotly debated in newspaper editorial pages. For example, two columns were published in the Houston Chronicle on April 10, 2005. One columnist supported a pharmacist’s right to refuse to fill prescriptions that violate his or her conscience while another author concluded that “the drugstore is not an alter. . .[and] the pharmacist’s license [does] not include the right to dispense morality.”

Critics of broad conscience clause exceptions are concerned that the “campaign to expand refusal rights threatens the ability of governments, communities and private organizations to protect patients’ access to information and care.” Opponents of broad refusal rights point out that “[h]ealth care provider groups. . . 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.”

38 Ellen Goodman, Birth Control to Ritalin, Whose Right is it to Judge?, HOUSTON CHRONICLE, Apr. 10, 2005, at E3.
39 Adam Sonfield, supra.
40 Id.