

2006

Objections in Conscience to Medical Procedures: Does Religion Make a Difference Lecture?

Kent Greenawalt
Columbia Law School, kgreen@law.columbia.edu

Follow this and additional works at: https://scholarship.law.columbia.edu/faculty_scholarship



Part of the [Medical Jurisprudence Commons](#)

Recommended Citation

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

Available at: https://scholarship.law.columbia.edu/faculty_scholarship/3396

This Article is brought to you for free and open access by the Faculty Publications at Scholarship Archive. It has been accepted for inclusion in Faculty Scholarship by an authorized administrator of Scholarship Archive. For more information, please contact scholarshiparchive@law.columbia.edu, rwitt@law.columbia.edu.

OBJECTIONS IN CONSCIENCE TO MEDICAL PROCEDURES: DOES RELIGION MAKE A DIFFERENCE?[†]

*Kent Greenawalt**

How should the government respond if people refuse standard medical treatment? What should the government do if people refuse medical treatment for their children, and what autonomy should teenagers be given in making such choices? Is religion a proper basis for refusing such medical treatment? Furthermore, should medical practitioners have a privilege not to render services that they object to in conscience? This article analyzes such questions and proposes that the most sensible answers depend on context. Legislatures should sometimes create no exemptions, should sometimes create exemptions based on nonreligious criteria, and should sometimes use criteria framed in terms of religion. As a matter of constitutional law, statutes may often use religion as a criterion for a privilege, but even then, legislatures may choose broader criteria.

I. INTRODUCTION

Many Americans who do not trust standard medical treatment have religious grounds for their distrust. They believe that standard treatment is ineffective or even will lead to damnation. Religious parents want to raise their children according to their religious beliefs. If parents following this course suffer the death of a beloved child, one of the worst events imaginable in our personal lives, they seem very different from ordinary criminals. One wonders what punishing such parents can add to their misery. But can the state stand by while parents let children die? Last June, the press reported a tug of war between Texas child welfare

[†] This article was originally presented on October 5, 2005, as the first 2005–06 lecture of the David C. Baum Memorial Lectures on Civil Rights and Civil Liberties at the University of Illinois College of Law.

^{*} University Professor, Columbia University. His *Does God Belong in Public Schools?* appeared in 2005, and *Religion and the Constitution*, vol. I, *Fairness and Free Exercise* will be published in the summer of 2006. I greatly benefited from discussion of these issues with faculty members and others when I was honored to deliver a Baum Lecture on this topic.

officials and the parents of a child with Hodgkin's disease.¹ There, the impasse was not over religious convictions, but it well could have been. In a recent book, Marci Hamilton tells of a diabetic child who could easily have been saved by insulin, but who died an agonizing death because his Christian Science mother did not take him to the doctor.² As the Supreme Court held many years ago, parents may martyr themselves, but they are not free "to make martyrs of their children."³

When we think about medical treatment for children, we see the parents' claim of civil liberty to practice their religion, a kind of civil right of children to protection and decent medical care, and a broader theoretical question of whether religion is a proper basis of categorization if the government offers some exemption from ordinary requirements. Like many questions of civil liberties and civil rights, these issues involve both legislative choice and constitutional law.

II. DIMENSIONS OF THE INQUIRY

Certain forms of medical treatment are standard. Blood transfusions replace lost blood; doctors set broken bones; diabetics take insulin. How should the government respond if people refuse these forms of treatment, and, most importantly, how should it respond if parents refuse this treatment for their children? That is the major practical problem this essay considers. I shall also ask whether medical practitioners—doctors, nurses, orderlies, and pharmacists—should have a privilege not to render services to which they object in conscience. This issue most commonly arises over abortion, sterilization, "morning-after" pills, and withdrawal of life support.

Perhaps the most basic question about refusing standard medical treatment for children and declining to participate in providing medical services is whether *anyone* should have a legal right to make that choice. Those with religious convictions that a medical procedure violates God's law may seem to have the strongest claim to possess such a right. But is it fair to exempt religious parents and medical practitioners and not to exempt others with similar feelings and attitudes? If religion is *not* to be the crucial criterion for an exemption, what is to stand in its place—conscience, moral judgment, or something else?

What is the right relationship between religion and possible privileges regarding medical treatment? My answer is contextual; it all depends on the exact privilege we are talking about. My position contrasts both with the view that religion is always a good basis for creating exemptions and with the view that religious faith or affiliation should never

1. See Ralph Blumenthal, *Hodgkin's Returns to Girl Whose Parents Fought State*, N.Y. TIMES, June 11, 2005, at A8.

2. MARCI A. HAMILTON, *GOD VS. THE GAVEL* 36–37 (2005).

3. *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

be a crucial criterion for a privilege to deviate from ordinary standards of behavior. (One version of this latter view is that religion should be understood so broadly that it includes all claims of conscience or all matters about which someone feels very deeply.) I shall offer examples of possible exceptions and ask what kind of privilege makes sense, if any does.

The issue about the place of religion for exemptions has important constitutional dimensions. People with strong religious convictions that some medical treatment is wrong will see their refusal to accept it as part of their free exercise of religion. Under the free exercise test that prevailed from 1963 to 1990, parents could claim that state compulsion to accept objectionable treatment for their children was unconstitutional unless the state had a compelling state interest that could not be served by less restrictive means.⁴ In 1990, *Employment Division v. Smith*⁵ wiped out this argument. There is now no federal constitutional right to be exempt from standard legal requirements.⁶ Some states, wisely in my opinion, have retained the compelling interest test as a construction of their own free exercise clauses, but for most medical problems, it does not make much difference. A court will determine that a legislative decision to protect the physical well-being of children does serve a compelling interest.

The question of religion as a standard of classification is more complicated. After first ruling that a conscientious objector need not have a traditional faith in God to establish “belief in relation to a Supreme Being,”⁷ the Supreme Court in 1970 had to rule on the boundaries of the statutory requirement of “religious training and belief.”⁸ In *Welsh v. United States*, Elliott Welsh had written his local draft board of the waste of “the military complex” and the country’s failure to recognize political, social, and economic realities.⁹

The eight justices divided 4-4 over whether Welsh was religious under the statute.¹⁰ A plurality of four said he was, effectively treating any deep objection to participating in war as religious.¹¹ Three justices said that Congress obviously meant to deny C.O. status for men like Welsh, and that given the recognition in the Free Exercise Clause of the place of religion, that was perfectly appropriate.¹² Justice Harlan relied explicitly on a view that probably drove the plurality’s strained exercise in statutory interpretation, namely that it violated the Establishment Clause to

4. See *Sherbert v. Verner*, 374 U.S. 398, 403 (1963).

5. 494 U.S. 872 (1990).

6. *Id.* at 885.

7. *United States v. Seeger*, 380 U.S. 163, 165 (1965).

8. *Welsh v. United States*, 398 U.S. 333, 335 (1970).

9. *Id.* at 342.

10. *Id.* at 333.

11. *Id.* at 343–44.

12. *Id.* at 369–70 (White, J., dissenting).

exempt religious objectors and not to exempt those whose pacifist objections rested on secular beliefs.¹³

Since the *Welsh* case, the Supreme Court has made clear that, at least sometimes, the government may classify in terms of religion when it grants a privilege. When it ruled in *Wisconsin v. Yoder* that the Amish had a constitutional right to withdraw their children from school after the eighth grade, that Court commented that followers of Henry Thoreau would not have a similar right.¹⁴

The Court's most recent encounters with the issue have been in the 2004 and 2005 Terms. With surprising unanimity, the Court ruled in *Cutter v. Wilkinson* that Congress did not violate the Establishment Clause by adopting the Religious Land Use and Institutional Persons Act, which forbids prisons from substantially burdening the free religious exercise of inmates unless the government shows that it has a compelling interest.¹⁵ Justice Ginsburg's opinion for the Court explicitly rejected the argument that privileging religion over other deeply held concerns was unconstitutional.¹⁶ In February of 2006, the Court (again unanimously) applied the Religious Freedom Restorative Act to hold invalid the federal government's employment of the Controlled Substances Act to prevent the importation of a hallucinogenic tea used by a small religious sect in its worship services.¹⁷

As far as prevailing doctrine is concerned, the law definitely can use religion as a criterion for a privilege on some (even many) occasions. Whether that is *always* constitutionally permissible is not certain. I believe Justice Harlan's approach is preferable for certain kinds of exemptions. But whether the answer to the constitutional issue of classification is that government can always, or only often, use a criterion of religion, the legislature definitely has a choice *not* to use religion. It can write a legal exemption in terms of conscience or moral conviction, rather than religion, if it chooses.

III. REFUSALS TO RECEIVE TREATMENT

When we think about refusals to receive treatment, we need to recognize that some religious persons who decline ordinary medical assistance believe that an alternative form of treatment, say faith healing or meditation, will actually be more effective in curing their illnesses.¹⁸

13. *Id.* at 356 (Harlan, J., concurring).

14. 406 U.S. 205, 247–48 (1972).

15. 544 U.S. 709, 718–19 (2005).

16. *Id.* at 723–25; *see also* *Employment Div. v. Smith*, 494 U.S. 872, 890 (1990) (expressing acceptance of legislative exemptions cast in terms of religion); *Corp. of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327, 339 (1987) (approving Title VII exemption for religious discrimination by religious organizations).

17. *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 126 S. Ct. 1211 (2006).

18. Indeed, they typically believe that the alternative treatment alone would be at least as effective as the alternative treatment *plus* standard medical treatment.

Christian Scientists, for example, do not *believe in* much standard medicine, because they conceive physical “illness” as based on a kind of mental illness or misperception.¹⁹ Jehovah’s Witnesses, on the other hand, recognize that blood transfusions may be needed for physical recovery, but they believe that God’s will is that they not accept transfers of blood.²⁰

The law may “intervene” in decisions about medical treatment in either of two ways. Officials may directly authorize treatment, overriding the judgment of the person who would typically choose, or the law may impose penalties for failures to obtain needed medical assistance. Determinations of child neglect have aspects of both approaches: they are based on past behavior, but may lead to a loss of custody or restrictions on parental choice.

The relation between free exercise claims and general principles of autonomy is very important for this topic. People have a wide range of choices in deciding when to seek medical treatment and what form of treatment to accept. To judge whether religious claimants should have any special privileges, we need a sense of the choices everyone does, and should, possess. Because adults now have virtually unfettered discretion to decline forms of medical treatment for themselves, the crucial practical questions about possible religious exemptions involve decisions about children.

IV. ADULTS CHOOSING FOR THEMSELVES

Under the common law and as a matter of constitutional right, adults—not parents of a small child—can refuse to seek any medical treatment at all or decline to accept measures doctors recommend.²¹ Does this wide power to decide make good sense? Because punishment after the fact is not at issue here,²² the serious question is whether the state should ever compel treatment that the individual refuses.

19. See Nathan A. Talbot, *The Position of the Christian Science Church*, 309 *NEW ENG. J. MED.* 1641 (1983); Jennifer L. Hartsell, *Mother May I . . . Live? Parental Refusal of Life-Sustaining Medical Treatment for Children Based on Religious Objections*, 66 *TENN. L. REV.* 499, 503–06 (1999).

20. Literature of the Jehovah’s Witnesses suggests many of the dangers of blood transfusions; but it implicitly acknowledges that, on occasion, transfusions have a greater promise of saving lives than alternatives. *Genesis* 9:4, *Leviticus* 17:14, and *Acts* 15:19–20 are taken as the basis for the proposition that even in these situations, no one should accept a transfusion because doing so violates God’s will and threatens one’s eternal soul.

21. See *Schloendorff v. Soc’y of New York Hosp.*, 105 *N.E.* 92, 93 (N.Y. 1914) (common law); *Cruzan v. Div. Mo. Dep’t of Health*, 497 *U.S.* 261, 269–70 (1990).

22. If an adult dies because he has failed to receive treatment, he is not available to be punished. An adult could be punished for “harming himself” by refusing to get medical treatment, but no one has proposed this as a form of criminal liability. However, it can be criminal to injure oneself to avoid military duty. See *Bowe, Confusion About Malingering and Attempted Suicide: A Self-Inflicted Wound*, *ARMY LAW.*, June 1992, at 38. A failure to obtain standard medical treatment in order to remain incapacitated may count as an act of injuring oneself.

A wide range of choices about medicine is now regarded as reasonable. Doctors often disagree about helpful treatments or the desirability of risking harmful side effects to achieve likely benefits. Having evolved from a culture in which doctors often made such decisions themselves, our ideal now is that patients choose after receiving full (enough) information from their doctors. The only conceivable situations in which the law might intervene are when a person's choice is unreasonable from a medical point of view or her motivation is inappropriate.

Although a legal focus on motivation might initially seem attractive, it would not provide a workable legal approach. A person's medical choice is ordinarily based on an assessment of likely benefit, harmful side effects, and suffering. Because of the last two components, someone may choose against a treatment that best promises to preserve her life for the longest time. A patient with incurable cancer may decide in favor of a better quality of life for the time that remains instead of accepting further radical interventions that will prolong life but cause excruciating pain and debilitation. But suppose a patient refuses medical treatment because she wants to die? If people are not legally free to commit suicide, perhaps they should not be able to bring about their deaths by refusing treatment.²³

The ethics of declining treatment in order to die are arguable. One might think that actively committing suicide is morally wrong, but that allowing illness or injury to take its natural course without medical intervention is morally permissible, even if a person's motivation is to die.²⁴ Or, one might think that a motivation to die makes a choice to decline treatment immoral.²⁵

We need not resolve the morality of declining treatment in order to die, because that is not a standard that the law could comfortably adopt. Imagine that patients *A* and *B* are offered a painful course of medical treatment that will almost surely prolong their lives. Both decline the treatment. *A* does not want to suffer the pain; *B* actually desires to die and would refuse the treatment even if it was painless. We cannot expect doctors, hospital administrators, and courts reviewing applications to make deference to a patient's choice turn solely on whether a patient wishes to die. Such a practice would simply encourage patients to be less than honest about why they decline treatment.

23. Although suicide is no longer a crime, it is not legally permitted. State authorities will intervene to stop a person attempting to kill herself if they are able. (I put aside here Oregon's law permitting terminally ill persons, with various constraints, to choose to die.) Assisting suicide remains criminal in virtually every state.

24. Of course, if one believes active suicide is itself morally acceptable, one will think that a refusal of medical treatment in similar circumstances is also acceptable.

25. See John Finnis, *A Philosophical Case Against Euthanasia*, in *EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES* 23, 28 (John Keown ed., 1995).

A more plausible possibility would be to order medical treatment if its refusal was grossly unreasonable.²⁶ It is hard to determine whether a citizen's autonomy should extend to refusing medical treatment where the highly probable consequence of doing so is avoidable death or serious bodily harm. The argument for intervention is that people's lives and bodies should be protected against their own rashness and stupidity. One argument for freedom of choice, even unreasonable choice, is that the making of such choices should be an aspect of liberty in a free society. People who are allowed to do all sorts of dangerous things—climb high mountains, swim in shark-infested waters, bungee jump, skydive, etc.—should be allowed to refuse medical interventions on their own bodies, even when the refusal is highly dangerous. A second argument for freedom focuses on institutional decisions. The vast majority of people, advised by doctors, make reasonable medical decisions. Diluting the legal right of choice so it does not cover the infrequent instances of very foolish decisions would open up too many debates about the boundaries of reasonable choice and would leave uncertain the status of too many patient wishes. It is better to have an absolute right, even if the result is to give effect to a few stupid choices that, looked at in isolation, the state might override. Whether people should be able to make very foolish medical decisions as a matter of principle, giving them an absolute choice to decline treatment is the proper legal approach.²⁷

This privilege of absolute choice does not address respective rights and duties when a provider of medical services declares he will not provide service at all unless it includes a form of treatment.²⁸ Suppose a doctor says a transfusion will be necessary to keep a patient's blood supply at a minimal level during an operation; otherwise, the patient's chances of survival will be slight. I do not assume that a patient should have a legal right to compel treatment on the exact terms he wants, only that he cannot be forced to accept treatment that he does not want.

If adult citizens should not be forced to accept medical treatment they do not want, adults with religious reasons to decline medical treatment need no special privilege.²⁹

26. We need not pause to consider exactly what the standard should be, but, roughly, if a competent doctor or a reasonable person would definitely choose medical treatment, medical personnel, backed by legal authorities, could impose the treatment against the patient's wishes. Thus, if someone refused to have a broken bone set, or to take an antidote to a poison, or to receive a life saving blood transfusion, the treatment would be imposed.

27. However, absolute choice is for competent adults, not for those who are senile or suffer serious mental illness. If people are incapable of making a thoughtful choice, close relatives or medical personnel must choose for them. (I do *not* assume that everyone who makes an unreasonable choice is incompetent. Some competent people may have strong aversions to forms of medical treatment or be highly resistant to sound medical advice.)

28. Whether providers should be able to refuse to afford certain forms of ordinary treatment is taken up in the latter part of this essay.

29. The issue about such an exemption would arise if treatment were sometimes forced on others. A choice to refuse a blood transfusion necessary to save life that would be grossly unreasonable

Certain forms of medical intervention, such as vaccinations to prevent serious illnesses and blood tests administered prior to marriage or to determine paternity, benefit others as well as those who are the object of the intervention. People may reasonably be required to submit to such health measures. But what if they have religious reasons to refuse? Having been married twice, once in Croatia (then a part of Yugoslavia) and once in New Jersey, without undergoing a premarital blood test, I am skeptical about its necessity,³⁰ but a court facing the issue decided that a state did have a compelling interest in imposing these tests and that it need not make any exceptions.³¹ Courts have also judged the state's interest in determining paternity to be compelling.³²

Because most vaccination requirements apply to children, we shall look at the possibility of a religious exemption in that context.

V. ADULTS WITH SMALL CHILDREN

It is a serious question whether adults with small children should have the same range of choices as other adults.³³ Perhaps they should not be able to make choices that will lead almost certainly to their own deaths, especially if no close relatives can care for their children. Courts have divided over whether mothers with very young children should be able, based on religious objections, to refuse treatment necessary to keep them alive.³⁴

As a general matter, parents with small children are allowed to choose activities as dangerous as those in which other adults may engage, but that does not settle whether the state should intervene if a parent makes a choice virtually certain to result in death, and the state can approve treatment that will prevent that from happening.

If we put aside religious reasons, why might a person refuse treatment necessary to save her life? Ignorance, fear of pain, or a wish to die are possible explanations. Viewed in isolation, the state's interest in pre-

by ordinary standards might not seem grossly unreasonable if it was a response to a perceived prohibition issued by God.

30. Because some states require such a test and others do not, and many foreign countries do not, any state will have living within its boundaries many married couples who have not undergone such tests. Nonetheless, a state might say that such a test is required to protect each member of a couple from being deceived about the health of the other.

31. *In re Kilpatrick*, 375 S.E. 2d 794, 797-98 (W. Va. 1988). Of course, under *Employment Division v. Smith*, a legislative decision to require tests generally would be conclusive. 494 U.S. 872, 890 (1990).

32. *State v. Meacham*, 612 P.2d 795, 797 (Wash. 1980); *Essex County Div. of Welfare v. Harris*, 460 A.2d 713, 714 (N.J. Super. Ct. App. Div. 1983).

33. Kristin M. Loumond, *An Adult Patient's Right to Refuse Medical Treatment for Religious Reasons: The Limitations Imposed by Parenthood*, 31 LOUISVILLE J. FAM. L. 665, 675 (1992/1993).

34. *Compare* *Mercy Hosp., Inc. v. Jackson*, 489 A.2d 1130, 1134 (Md. Ct. Spec. App. 1985) (parent can refuse if doing so does not threaten physical harm to child), *with* *Application of the President and Dirs. of Georgetown Coll., Inc.*, 331 F.2d 1000, 1008 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964) (parent could be compelled to take blood transfusion rather than "abandoning" small child).

serving the best possible environment for a child might well override the parent's claim to make an autonomous choice about medical treatment.³⁵ The parent's claim seems decidedly stronger if she feels she has a religious obligation not to receive treatment. One might conclude that for parents with small children, religious claims to decline treatment should succeed, even though claims of autonomy should not.³⁶ However, considering the freedom parents generally have to create various living arrangements for their children and to put children up for adoption, they should also be granted a freedom, as broad as that of other adults, to make decisions about their own medical treatment.

VI. CHOICES FOR CHILDREN

The difficult issues about refusing medical treatment involve parents making decisions for children. Should the state compel treatment, if it has the opportunity? Should it punish parents who fail to seek treatment or deprive them of custody? For these questions, the possibility of a religious exemption figures importantly.

A. *Compelling Treatment*

What should the law do if parents refuse treatment for a minor child, when, from an ordinary medical perspective, the *only* reasonable choice is accepting the treatment? A striking example would be a parental decision to refuse a blood transfusion for a six-year-old girl that is necessary to save her life.

The right course is easy if the parents' choice is based simply on bad judgment, say, a belief that, despite what doctors tell them, virtually all blood used for transfusions carries H.I.V. (the virus that causes AIDS). The same conclusion follows if the parents have a perverse attitude about child development—that any child who cannot survive without a transfusion does not deserve to live. No one argues that for these matters, parental autonomy in respect to children should be absolute. The state should not allow a child to die just because parents have exercised a patently indefensible judgment about medical needs.³⁷ As with many

35. Barring terminal illness, a parent's wish to die would probably be regarded as a symptom of mental illness. If the parent has a terminal illness, forcing treatment would not save the parent for very long to nurture her child.

36. However, hospital officials and judges *might* determine that the parent feels that she cannot consent to treatment, but that no spiritual harm will be done if it is imposed against her will. Perhaps treatment then should be compelled; *but* doctors and judges should not assume the parent has this attitude unless she or a loved one makes clear that she does.

37. The state's interest is sometimes put as one of its own survival, given its dependency on healthy young people. See David E. Steinberg, *Children and Spiritual Healing: Having Faith in Free Exercise*, 76 NOTRE DAME L. REV. 180, 182, 196–99 (2000). Given the infrequency in which parents, by choice or through ignorance, jeopardize the lives of their children by failing to get necessary treatment, and the ample number of citizens reaching adulthood here or immigrating to the United States,

other aspects of child welfare,³⁸ the state constrains the choices of parents to some degree; all states have laws requiring parents to assure medical treatment for their children.

What the state should do is somewhat more debatable if the parents' reason for refusal is religious—if, for example, they believe that their souls and the souls of their children will be jeopardized if the children receive a transfusion. Someone might argue that the state should defer to the parents, because no one knows what acts will endanger souls. Certainly it is better to lose one's life on this earth than to suffer eternal damnation, *if* that is the alternative. But this notion that the state should abstain from interfering with parental judgments about eternal welfare has a serious flaw. Were that line of argument accepted, it would open the door to the state's accepting every form of behavior judged by participants to be good eternally for all concerned. Suppose members of a religion practicing child sacrifice were certain that every child sacrificed was assured of eternal happiness. The state cannot abandon its determination about secular welfare in the face of such beliefs, and it should require medical treatment that is essential for life, even if parents claim that the treatment is harmful religiously. When this particular conflict reaches courts, judges have not hesitated to order treatment over the parents' wishes.³⁹

Analysis becomes more difficult if a parent's refusal of medical treatment does not threaten a child's life or basic health, or the advantages of treatment are more arguable, but the treatment would definitely be desired by the great majority of people. Suppose doctors propose to close a cleft palate or to treat a broken leg so that a child will not limp for the rest of his life. Or doctors recommend a highly invasive, very painful course of chemotherapy that could itself cause death and that promises only a forty percent chance of survival.⁴⁰ The parents refuse. Should parents be able to make a final decision, and should it matter if their reasons are religious?

I am inclined to think that when a child's life is definitely at stake, courts should feel free to intervene, even when the parents' choice to decline treatment could receive some defense apart from religion,⁴¹ but that parents should have authority about medical measures when life and basic health are not threatened.

we need to see the state's main interest as preserving the lives and health of individual children, not as maintaining a sufficient number of healthy citizens.

38. Parents cannot, for example, choose to put their young children to work. *See* *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

39. *See, e.g., In re Hamilton*, 657 S.W. 2d 425, 429 (Tenn. Ct. App. 1983); *Custody of a Minor*, 393 N.E.2d 836, 846 (Mass. 1979).

40. *Newmark v. Williams*, 588 A.2d 1108, 1118–19 (Del. 1991).

41. I see *Newmark* as such an example. One can understand a parental choice against a painful treatment not likely to save a child, but almost all doctors and parents would choose a forty percent chance of survival against virtually certain death.

However, one might believe parents should not be able to make unreasonable decisions about a child's welfare. In one New York case, the court authorized a dangerous operation to partially correct the massive, "grotesque and repulsive" deformity on a boy's face caused by neurofibromatosis; and it directed that blood transfusions be given during the operation, over the objections of his mother, a Jehovah's Witness.⁴² It declined to wait until the boy could make a decision for himself at the age of twenty-one, because of the physical and psychological damage caused by his disease. Were the courts to override parental choices more frequently, perhaps parents acting on religious reasons should be afforded a greater range of choices, including being able to decline treatment they believe is opposed to God's will.⁴³

Vaccinations raise a special problem. A vaccination protects the person who receives it, but it also protects others against the spread of disease. Some people suffer adverse effects from vaccinations. Very few people in the United States will ever acquire diseases against which the vast majority of citizens have been vaccinated. An individual making a purely selfish choice might reasonably conclude that he would risk more by being vaccinated than by refusing. Yet the effectiveness of the vaccination program may depend on near universality. Parents could oppose vaccination for their children because of a rational calculation of what is best for them, because of nonreligious beliefs about physical and psychological health, or because of peculiar religious objections. States with requirements that children be vaccinated before entering public school have understandably not chosen to exempt all children whose parents object to their being vaccinated. But some state legislatures have created an exemption for parents with religious objections. In New York, for example, standard requirements do not apply to children whose parents "hold genuine and sincere religious beliefs" against vaccination.⁴⁴ In applying this law, courts have not required typical theist beliefs,⁴⁵ but they have insisted that the objection be more than "medical or purely

42. *In re Sampson*, 317 N.Y.S.2d 641, 643 (Fam. Ct. 1970), *aff'd*, 323 N.Y.S.2d 253 (App. Div. 1971), *aff'd*, 278 N.E.2d 918 (N.Y. 1972). The American Academy of Pediatrics has recommended that parents' objections be overridden "when . . . treatment is likely to prevent substantial harm or suffering or death." Committee on Bioethics, American Academy of Pediatrics, *Religious Objections to Medical Care*, 99 PEDIATRICS 279, 279 (1997).

43. But see *Sampson*, 317 N.Y.S.2d at 653, which does not extend such a privilege when the mother's objection to treatment was based on her religion. Were a privilege given to theists, I assume it would also go to other religious persons with a powerful objection to treatment. But the typical objection would be of the sort I discuss. Conceivably any privilege to decline treatment should depend on parents acting for the welfare of the child, not authorizing parents to satisfy their own spiritual welfare, as they see it, at the expense of a child; but such a limit probably does not make sense, in part because almost every parent will think a child will be better off if the parent follows God's will. Thus, parents who refuse an operation because God must have intended their child to have a cleft palate would think it better for the child to "submit" to this misfortune than to have it altered.

44. N.Y. PUB. HEALTH LAW § 2164(9) (McKinney 2002).

45. See *Sherr v. Northport-E. Northport Union Free Sch. Dist.*, 672 F. Supp. 81, 93-94 (E.D.N.Y. 1987).

moral,”⁴⁶ and one court, after examining the parents’ testimony very carefully, concluded that their references to standard biblical sources did not reflect the true health-related and moral grounds of their objection to vaccination.⁴⁷ Because an exemption that is broader opens up the possibility of parents refusing vaccinations because they believe their children will be better off without them, this strikes me as one area in which a limitation cast in terms of religion makes good sense.

There are two arguments against judges singling out religious claims as bases parents may use to refuse various forms of medical treatment. One is that, according to the spirit of *Employment Division v. Smith*, judges should avoid any distinctive favoring of religious grounds that is not specified by a legislature.⁴⁸ A second argument, applicable to legislatures as well as judges, is that when parents have peculiar religious grounds to oppose medical treatment, there is even less basis to suppose that their decision could be defended as reasonable according to ordinary secular criteria than when parents offer nonreligious grounds for judgment.

By and large, the best strategy for judicial deference to parental choice about medical procedures for their children concentrates on the kind of procedure involved, not the exact grounds of parental judgment, but it may be that in some instances the special strength of religious claims against treatment should make a difference.

B. *Medical Choices and Teenagers*

Questions about how far the judgments of older (mature) children will count can be especially acute when medical treatment is involved. A teenager may want treatment that the parents wish to decline, or may want to refuse treatment that the parents wish her to have, or may agree with her parents in declining treatment.⁴⁹ Of course, “teenager” is a broad category—let us focus on a minor who is sixteen or seventeen, not old enough to vote or sign contracts but approaching that age, and past the age when she would become a full member of a Christian or Jewish congregation.

The simplest situation is when the teenager seeks to decline ordinary medical treatment that the parents want—want even after they realize their daughter’s wishes and have tried unsuccessfully to resolve the

46. *Id.* at 92; *Farina v. Bd. of Educ.*, 116 F. Supp. 2d 503, 507 (S.D.N.Y. 2000); *see also* *Friedman v. S. Cal. Permanente Med. Group*, 125 Cal. Rptr. 2d 663, 685–86 (Cal. Ct. App. 2002) (rejecting a claim of employment discrimination based on refusal to hire plaintiff who, as a vegan, was unwilling to be vaccinated for mumps (the vaccine was grown in chicken embryos)). The court concluded that veganism was a moral code, not a religious set of beliefs.

47. *Farina*, 116 F. Supp. 2d at 506, 512–13.

48. 494 U.S. 872 (1990). That case does not bar individualized judicial determinations about medical treatments, based as they are on common law and statutory powers.

49. Yet another variation is when the parents themselves have opposing views.

disagreement.⁵⁰ The state should support the parents. A teenager should not be able to refuse treatment that any doctor would recommend and that the parents want for her. Certainly a child should not be able to refuse life-saving treatment that the parents wish her to have; a sixteen-year-old has not reached a level of maturity that should permit her to make an unreasonable medical decision that will probably result in her death. Instances of future disfigurement or modest physical incapacity, such as a limp, are more troublesome,⁵¹ but probably the parents together should have final authority to decide on medical treatment, *if* their daughter's wish, religious or not, is unreasonable according to ordinary medical standards.

How should courts react if the situation is reversed—the teenager wants treatment that doctors strongly recommend, but the parents wish to decline it? Needless to say, the treatment should be given to the teenager if the state would override the parents' wishes to refuse it for a very small child; but what if the parents' wishes would control were the child small? I have suggested that parents should have authority to decline an operation that will correct a cleft palate or prevent a future limp. As to such matters of appearance or physical capacity, a teenager who wants treatment that virtually all doctors would strongly recommend should be able to determine her own future.

A counterargument against this position is that because teenagers can exert great influence and make life miserable for parents, and few parents will withstand the combined force of medical recommendations and teenage insistence, it makes sense to stick with a legal rule that parents can make final decisions about medical treatment for all minor children. However, this counterargument faces two powerful objections. First, given that parents almost always want the physical health and well-being of their children, they will be likely to refuse operations that will prevent disfigurement or incapacity only if they possess strong religious convictions that the operations are wrong. With such convictions, they may not accede to what they see as their disagreeing child's erring ways. Second, most religions recognize by their age of confirmation that teenagers are old enough to make their own religious choices. If the child wants treatment any doctor would recommend, the parents should not be able to prevent it because they have religious values that the child now rejects.⁵²

50. I am not addressing commitment to a psychiatric facility. The wisdom of commitment is often arguable, and parents may have important interests, most notably relief from strife and acute frustration, that may not correspond with what is best for the child. *See, e.g., Parham v. J.R.*, 442 U.S. 584, 604 (1979); Lois A. Weithorn, *Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates*, 40 *STAN. L. REV.* 773, 780 (1988).

51. They are more troublesome because one might think a teenager is old enough to opt for these consequences if she chooses.

52. It does not follow that parents should have to pay for the treatment; their objection to it should probably be sufficient for them to avoid paying.

The Supreme Court's approach to abortion, which takes final decision-making power away from parents and gives it to pregnant teenagers and their doctors, has relevance here. Laws that would prevent minors from having abortions without parental consent are unconstitutional.⁵³ A young woman's right to choose whether to have an abortion has implications for ordinary medical procedures. Although one might conceive of abortion as special because the alternative is having one's body bear a fetus and then giving birth to a child, disfigurement and irreversible incapacity can involve the teenager's body for the rest of her life. If she can choose to terminate the life of the fetus, she should be able to choose to prevent long-term harm to her body, as well.

A range of delicate questions arise if child and parents disagree, and each choice is reasonable according to ordinary medical standards. One can imagine a variety of possible approaches.⁵⁴ I shall suggest that the kind of medical procedure and motivations should make a difference, but without defending that approach against various alternatives and without discussing whether courts should evaluate the maturity of individual teenagers.

If a treatment involves imposing on the patient's body, as by an operation or painful course of chemotherapy, it should not be forced on an older teenager whose reasonable decision is that she does not want it. In the reverse situation, when the teenager wants treatment that the parents have decided is ill advised, the outcome should depend on the parents' reasons. If parents and the child both rely on ordinary criteria for their decisions, and the parents conclude that a treatment is too risky, although the teenager is willing to undertake it, doctors and the state should not overcome the force of reasonable parental judgment. Matters look different if quality of life is at stake. Doctors, parents, and child agree on the likely benefits and harms of treatment. Parents think the treatment will be too painful, but the teenager wants to undertake it. Here, her choice should have more force; after all, it is her life that is at issue. A similar conclusion holds if the disagreement is over religious values. The parents' choice, one that is reasonable according to ordinary medical standards, is based on religious convictions that the child now rejects. The teenager has reached a stage at which her religious sense should not be overridden by that of her parents.⁵⁵ My overall conclusion

53. See *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976); *Bellotti v. Baird*, 443 U.S. 622, 651 (1979). See *infra* note 56, for the proposition that this analysis does not depend on acceptance of the view that anyone should have a constitutional right to have an abortion.

54. Parental or teenager choice could control in all circumstances, or the balance might be struck against treatment, or the nature of the medical procedure and motivations could matter. Courts could or could not evaluate the maturity of individual teenagers. Whatever standards are adopted need to be administrable, as well as yielding appropriate outcomes in theory.

55. However, if the treatment would generally be classified as "optional," such as ordinary plastic surgery, it is more doubtful whether doctors should proceed if the parents object. They should not be forced to pay, and perhaps for such elective measures, a child should need the consent of her par-

is that treatment should not be undertaken if either a parent or a teenager makes a reasonable choice to refuse it, *unless* the parent's choice relies on values that the teenager should, at this stage of her life, have the autonomy to reject.⁵⁶ An interesting implication of this approach is that within the range of reasonable choices, parental decisions based on religious premises will carry less weight than their ordinary risk assessments. The logic is not a general downgrading of religious convictions, but rather a conclusion that as to religion, parents should not be able to dictate to older teenage children.⁵⁷

One might object that an approach that privileges teenage judgments and distinguishes risk assessment from quality of life will set members of families in opposition to each other and will require courts to make judgments that are too difficult. In answer, parents, teenagers, and doctors will almost always reach agreement; the law will rarely intervene. Although the line between risk assessment and quality of life is difficult, it best captures the domains where a parental choice to decline treatment should or should not control.

The starkest issue about the state and older children arises when a teenager joins parents in wanting to decline treatment, such as a blood transfusion, that parents could not decline for a small child. The child has now reached an age when her own religious convictions carry weight, and she makes a choice, supported by parents, that an adult could make for herself. It is one thing to conclude that a child's religious convictions should count heavily if they line up in favor of a reasonable course of medical treatment; it is quite another to say that the convictions can support what would otherwise be an unreasonable choice, especially about treatment necessary to save life. Although in past eras, teenagers may generally have accepted parental values, or at least not have explicitly rejected them, perhaps now it is fairer to assume that a sixteen-year-old who subscribes to her parents' religion has made a serious, independent

ents or wait until she is an adult. It may be relevant that the state will not supply such treatment to indigents.

56. The law of abortion provides support for aspects of this approach. The choice about abortion concerns quality of life and ethical responsibility, not ordinary risk assessment. If the teenager can choose abortion, she should probably be able to make other medical choices for which values are central.

Readers who reject the whole notion of a liberal abortion law may suspect any analogies that draw from it. But the force of the analogy does not depend on the fundamental right to abort. The main objection to permissive abortion laws is that the fetus deserves the state's protection, even if a pregnant teenager *and* her parents choose abortion. The crucial question about reasonable medical treatment is who can make a choice that parents and child can undoubtedly make together. Some reasons why the teenager's choice in respect to abortion should prevail over the parents' may have broader applicability, *even if* the underlying premise that anyone can choose abortion in ordinary circumstances (not involving rape, incest, or risk of death) is itself misconceived.

57. Parents might substitute grounds of risk assessment to cover their religious reasons, and indeed those reasons may influence their honest risk assessments (Jehovah's Witnesses are particularly likely to think blood transfusions are dangerous); but many religious people will not wish to conceal their religious opposition.

choice to do so.⁵⁸ With hesitation, I take to the view that a teenager who is sixteen or older who wants to decline even life-saving treatment for religious reasons, and is supported by her parents, should be free to do so.⁵⁹

This privilege should not extend to a foolish choice that is not made from deep conviction. Suppose parents have ill-formed ideas about medical practice; they believe that blood transfusions usually carry H.I.V., despite assurances by doctors to the contrary, and they have persuaded their sixteen-year-old to their view. Although an otherwise competent adult with that opinion should be able to decline medical treatment, even life-saving treatment, doctors, with the state's support, should be able to say that such a view is mistaken, and it should impose the transfusion over the nonreligious objections of the parents and the teenager.

C. *Judgments of Neglect and Punishment*

Often, neither doctors nor officials learn of the need for medical treatment until it is too late. The child dies or suffers harm before outsiders learn of his condition. Should the law treat parents as neglectful or abusive? As guilty of negligent homicide if the child dies?

1. *Neglect.* A judgment of neglect could be the basis for criminal punishment or for a determination that a child is not safe in his parents' custody. If a judgment about custody exclusively concerns a child's safety, it should matter whether a particular incident teaches anything new about the child or his parents. If the great majority of Christian Scientists will not seek medical care if their children have very high fevers, two Christian Scientist parents have relied only on prayer when their child has suffered a very high fever, and the child has survived, officials have learned nothing new about the parents.⁶⁰ Unless the illness suggests a higher probability of similar illness in the future than apparently existed before the incident, removal of custody cannot be based on a sense that the danger to the child is greater than it seemed in the past.⁶¹

2. *Punishment.* Is punishment warranted for acts, or failures to act, that would constitute serious neglect by ordinary parents? This question poses issues about religion more sharply than does state intervention to compel treatment. The reason is this: with decisions about whether to

58. However, the critical question is not really about most teenagers, but about teenagers whose parents are in groups that have unusual views about medical treatment.

One possibility is an individualized inquiry to see if the teenager is mature enough to have made an independent judgment, but such an inquiry would be fraught with a potential for a doctor or official to conclude that no one would independently accept some "bizarre" religion.

59. A case that reaches this conclusion about a seventeen-year-old Jehovah's Witness who objected to a blood transfusion is *In re E.G.*, 549 N.E.2d 322 (Ill. 1989).

60. Except that they do not fall within the class of Christian Scientists who would seek medical help in a serious emergency.

61. However, one might defend a general presumption that the law does not intervene against parents based on propensities; it waits for manifestations of danger.

decline treatment, parents have a wide range of autonomy, but it is limited. Ordinarily, parents with religious reasons to decline treatment for their children should not be treated differently from parents with other reasons to decline treatment. Thus, the range of parental autonomy depends little on whether reasons are religious or not.

The argument that religion should matter is more powerful in respect to punishment. If criminal punishment is appropriate for parental neglect of children, liability should not depend on whether parents are careless, ignorant, or pigheaded. Parents *A* do not realize their child is developing a very high fever. Parents *B* are ignorant about what doctors can do to help people with high fevers. Parents *C* distrust doctors and refuse to use them. By failing to consult doctors, all three sets of parents have failed to exercise reasonable care for children.⁶² If the children die, all three sets of parents are guilty of negligent homicide. Parents have no general right of autonomy to risk their children's well-being by failing to get medical treatment.

But what should be done about parents *D* who have strong religious reasons not to seek treatment? Should these parents escape liability if other parents do not? A simple argument against their liability is that criminal sanctions are futile, that these parents will follow their deepest religious convictions to benefit the physical and religious health of their children. Such parents will not be deterred by the state's threat of harm if things go badly. As far as blame is concerned, parents who seek the best for their children in light of the spiritual principles in which they believe are not to be condemned. Neither deterrence nor retribution is served by imposing criminal penalties on conscientious parents who already suffer greatly if their children have died.

This forceful argument is attractively neat, but it is in fact a bit too neat. Many parents who are attached to religions that disparage ordinary medical treatments do agonize over what they should do; some may be pushed over the line to consult a doctor by knowing that criminal penalties could follow a failure to do so. Further, people deciding whether to align themselves with a religion whose practices risk physical harm to children may be affected by a highly publicized criminal conviction that follows a child's death. Such criminal punishment may not be wholly ineffective to affect the behavior of others.

Still, punishing those who have used their best judgment to serve the welfare of their children is a large price to pay. Most states, acting originally on an understanding of what they needed to do to receive federal funds,⁶³ have adopted statutes that exempt parents from judgments of neglect or abuse when their failure to seek medical treatment involves

62. No doubt, one might judge these sets of parents more or less harshly as individual details of the children's illnesses and the parents' own backgrounds are filled in.

63. See HAMILTON, *supra* note 2, at 31.

a practice of their religious beliefs.⁶⁴ These laws typically do not preclude a court's ordering needed medical treatments for a child. And, as far as I am aware, no state legislature has explicitly created an exemption from the application of homicide laws.

Critics have objected to any exemption from criminal liability on the ground that it gives too little protection to children at risk,⁶⁵ but so long as courts can order necessary medical intervention, these children receive some degree of protection.⁶⁶ Another complaint is that religious motivations should not be singled out specifically for an exemption.⁶⁷ I believe that here, as in some other instances, an exemption restricted to religious claims is appropriate, although formulations should not be limited to particular named religions or favor some religious understandings and practices over others.⁶⁸

Harder questions are raised by legislatures adopting exemptions that reach minor criminal charges and do not include manslaughter or negligent homicide. Legislators understandably do not want to appear to countenance unnecessary deaths of innocent children. But, as far as individual parents are concerned, minor penalties for failures to get medical help for children who survive might be effective in changing parental behavior. Serious punishment after a child dies is too late to help that child. Moreover, punishing as serious criminals parents whose failure to get medical help has already brought them the worst misfortune most parents imagine, is to inflict further pain on people who are already suffering terribly. Still, insofar as criminal penalties can affect the behavior of other parents, highly publicized instances of prosecutions for homicide may be more likely to be productive than minor penalties for neglect.

In states with religious exemptions from determinations of neglect for parents who decline medical help in favor of spiritual healing, parents

64. See generally Jennifer Stanfield, *Faith Healing and Religious Treatment Exemptions to Child Endangerment Laws: Should Parents Be Allowed to Refuse Necessary Medical Treatment for Their Children Based on Their Religious Beliefs?*, 22 *HAMLIN J. OF PUB. L. & POL'Y* 45 (2000); Eric W. Treene, Note, *Prayer-Treatment Exemptions to Child Abuse and Neglect Statutes, Manslaughter Prosecutions and Due Process of Law*, 30 *HARV. J. ON LEGIS.* 135 (1993). The initial impetus for such laws was The Federal Child Abuse Prevention and Treatment Act of 1974.

65. E.g., Ivy B. Dodes, Note, "*Suffer the Little Children . . .*": *Toward a Judicial Recognition of a Duty of Reasonable Care Owed Children by Religious Faith Healers*, 16 *HOFSTRA L. REV.* 165, 183 (1987).

66. That is reduced if the law is taken to preclude a shift of custody even if parental inaction reveals a serious future danger for a child.

67. See, e.g., James G. Dwyer, *The Children We Abandon: Religious Exemptions to Child Welfare and Education Laws as Denials of Equal Protection to Children of Religious Objectors*, 74 *N.C. L. REV.* 1321, 1326-28 (1996); Ann MacLean Massie, *The Religion Clauses and Parental Health Care Decisionmaking for Children: Suggestions for a New Approach*, 21 *HASTINGS CONST. L.Q.* 725, 775 (1994); Anne D. Lederman, Note, *Understanding Faith: When Religious Parents Decline Conventional Medical Treatment for Their Children*, 45 *CASE W. RES. L. REV.* 891, 926 (1995).

68. For exemptions that are too limited, see *ARIZ. REV. STAT. ANN.* § 8-201.01 (1989) (covers "child who in good faith is being furnished Christian Science treatment by a duly accredited practitioner"); *GA. CODE ANN.* § 15-11-2(8) (1989) (covers children given spiritual treatment according to the tenets of a recognized church by an accredited practitioner). It is all right to name some particular religious groups so long as others are not excluded.

do have available a twofold argument that (1) the law implicitly authorizes, and renders unpunishable, the behavior that leads to their child's death, and (2) they have not had fair warning that their behavior was criminal. The argument that the neglect provision insulates against a prosecution for homicide has proved unavailing,⁶⁹ but some courts have been persuaded that the statutory scheme has failed to provide parents the adequate notice that due process requires.⁷⁰ In one of these cases, the court explicitly resolved that the neglect exemption did not itself insulate parents against a manslaughter prosecution, before proceeding to find notice inadequate; it did not indicate whether its opinion on the issue of coverage would provide adequate notice for parents in the future.⁷¹

I believe there is a strong argument that parents who have conscientiously done the best they can for their children's welfare, according to their religious beliefs, should not be punished as criminals; but a final judgment on that score must depend on a careful evaluation of the possible benefits of criminal sanctions. At a minimum, a prosecutor should exercise her discretion sensibly, not pursuing parents who have conscientiously and thoughtfully sought what they regarded as the best treatment for their child,⁷² unless persuaded that criminal punishment can accomplish something more than satisfying the sentiments of those outraged by the child's death.

A judgment that people who act on their religious convictions when they fail to seek ordinary medical treatment for their children should usually not be punished does not settle whether, in jurisdictions that retain a compelling interest standard for judging claims of free exercise, parents should enjoy a free exercise right to escape criminal punishment.⁷³ I think not. The parents have failed to seek medical treatment that the state could have compelled if a welfare worker had become aware of the child's condition, and the state's interest in preserving the lives and health of children is very important. If the state can require treatment, the parents have no right to avoid it. A state's decision to

69. See, e.g., *Walker v. Superior Court*, 763 P.2d 852 (Cal. 1988), *cert. denied*, 491 U.S. 905 (1989). One way of viewing the situation is that the parents' behavior is permissible until it becomes extremely dangerous to the child's life. Another perspective, persuasive, I think, so long as the state can directly override the parents' choice and compel treatment, is that the exemption is better seen as an excuse than a privilege not to seek medical treatment. The excuse would not reach the penalties for homicide.

70. *Hermanson v. State*, 604 So.2d 775, 782 (Fla. 1992); *State v. McKown*, 475 N.W.2d 63, 68 (Minn. 1991), *cert. denied*, 502 U.S. 1036 (1992).

71. See *McKown*, 475 N.W.2d at 67-68.

72. A skeptic might say no one can thoughtfully reject standard medical treatment, but we know that otherwise thoughtful and intelligent people are Christian Scientists and do reject medical treatment, and the numbers and social status of Christian Scientists testify that this is not a religion chosen by the indifferent and irresponsible.

73. The free exercise claim could arise under a state constitution or a state Religious Freedom Restoration Act (RFRA).

punish parents for not seeking treatment is a judgment about means within the range of what the state may do to pursue its legitimate ends.⁷⁴

This conclusion faces a possible objection based on ideas about the least restrictive means: if the state can compel treatment, it does not need to punish parents criminally, so punishment is unnecessary and, therefore, unconstitutional. This objection suffers the double flaw that officials commonly do not know about the need for treatment at the outset and that the alternative to criminal punishment might be much more extensive intrusions into the homes of members of groups that disparage medical treatment. From one standpoint, rare criminal punishment may seem a *less* restrictive means than constant home visits by welfare workers.

Although parents should rarely be prosecuted for secular medical harms that befall children because of religiously grounded failures to seek treatment, a right to this effect should not be accorded under state constitutions and Religious Freedom Restoration Acts (RFRAs).

VII. REFUSALS TO PARTICIPATE IN MEDICAL PROCEDURES

Issues of religious conscience can arise for people who provide medical services, as well as for parents and children who stand to benefit from them. Doctors, nurses, orderlies, pharmacists, hospitals, and HMOs may be so opposed to a particular medical procedure that they cannot comfortably participate in providing it.⁷⁵ Among the services to which health care providers may object are abortion, sterilization, artificial insemination, medical experimentation, withdrawal of life support, withdrawal of nutrition and hydration, organ transplants, autopsies, blood transfusions, and the provision of “morning after” pills and contraceptives. Should providers be given a legal privilege to refuse to participate in some or all of these services, and, if so, how broadly should the privilege extend?

A privilege might be limited to excusing a provider from legal consequences that would otherwise arise; it might also protect an individual from consequences that normally follow if he refuses to do what his employer tells him to do. Federal and state statutes and regulations set

74. One possible counterargument to this analysis is that the parents have a right not to be enlisted in treatment. Therefore, the state cannot punish them for failing to seek treatment. This argument is mistaken. Parents have custody. If the state can compel an operation, it can order parents to produce the child for an operation. One should not view the parents as possessing some absolute privilege not to assist in any way.

75. See Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 HOUS. L. REV. 1429, 1446–76 (1995); Bryan A. Dykes, *Proposed Rights of Conscience Legislation: Expanding to Include Pharmacists and Other Health Care Providers*, 36 GA. L. REV. 565, 566–69 (2002); Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177, 177–78 (1993).

some medical standards;⁷⁶ others are established by semipublic bodies⁷⁷ or accepted norms of the medical profession,⁷⁸ with failures to perform adequately potentially constituting a basis to conclude that a doctor or hospital has been negligent. Lurking in the background is possible criminal liability. Thus, if a patient dies because a doctor in an emergency room fails to authorize a blood transfusion, the doctor could be charged with negligent, or even reckless, homicide.⁷⁹

In other instances, the question is not one of legal liability, but whether a hospital, doctor, or drugstore can require employees to participate in services to which they object, on pain of being disciplined or dismissed.

We need to understand that general legal norms about freedom of religion provide some protection. Under Title VII, an employer might have to “accommodate” the religious refusal of an employee to participate in a particular medical service. Under the constitutional law of free exercise that survives *Employment Division v. Smith*, were an employee to lose his job because he could not conscientiously participate, he would be eligible for unemployment compensation.⁸⁰ And when states have RFRA, or constitutions that courts have interpreted to retain a requirement that the government not impinge on religious exercise without very strong interests in doing so, providers might be protected against some legal consequences or dismissal from a government-run hospital.⁸¹ But the accommodation requirement of Title VII has been construed to demand very little of employers.⁸² Short of a specific “right of con-

76. See, e.g., Katherine A. White, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights*, 51 STAN. L. REV. 1703, 1704 (1999). In many instances, individual health care professionals have no legal obligation to render service, but residents, interns, nurses, and orderlies may be so obligated because they are employees of hospitals. (Most physicians are independent business people allowed to practice in hospitals.)

I do not discuss the interplay of federal and state power. The main trigger for federal regulation here is federal funding, for which the government can attach conditions. State legislatures have broad authority to promote the general welfare, so long as they do not violate constitutional rights or standards set by organs of the federal government.

77. For example, the Accreditation Council for Graduate Medical Education has required that obstetrical and gynecological residents who do not object to performing abortions receive training in performing them. The Council's earlier withdrawal of accreditation partly for a failure to provide such training was upheld in *St. Agnes Hospital of Baltimore, Inc. v. Riddick*, 748 F. Supp. 319, 342–43 (D. Md. 1990). The court discussed whether actions of the Council amounted to state action.

Another example of semipublic regulatory bodies is state pharmacy boards, which oversee the work of pharmacies around the country.

78. Coverage by HMO's and insurance companies also influences what treatments are provided.

79. Recklessness requires that the actor be aware of an unreasonable risk, whereas negligence requires only that the risk be unreasonable. For criminal liability, behavior must be grossly unreasonable.

80. *Thomas v. Review Bd.*, 450 U.S. 707, 719 (1981).

81. Federal hospitals are subject to the federal Religious Freedom Restoration Act. *O'Bryan v. Bureau of Prisons*, 349 F.3d 399, 401 (7th Cir. 2003) (holding that the RFRA applies to federal governmental bodies).

82. See *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 81–85 (1977).

science” provision, workers have little protection against being dismissed by employers in the private sector.

A possible argument against any such protection is that no one need be a doctor, nurse, orderly, or pharmacist. If a person chooses to enter one of these vocations, the government and employers can set conditions on how she exercises it. No conflict of conscience arises because a person can always pursue a different vocation. The flaw in this argument, however, is evident. There is a powerful reason not to force people to choose between offending their consciences and foregoing a major vocational option. When the rules of appropriate behavior change radically, as with the status of most abortions, one especially cannot expect people to abandon a vocation with the onset of a novel conflict between ordinary practice and individual moral standards. Further, ministering to the sick has been a traditional religious vocation; the government should not create conditions that force individuals and organizations long committed to that task to give it up.⁸³

Standards authorizing refusals vary in the attitude they require of those who are to qualify. Although statutes authorizing refusals are commonly referred to as “conscience clauses,”⁸⁴ some laws simply provide that no one may be required to participate in a covered medical procedure.⁸⁵ Such a law would protect one whose refusal to participate was based on unpleasant memories or aesthetic distaste, rather than moral or religious conviction.⁸⁶ Other clauses protect refusals by those whose basis is moral or religious, those who want to avoid an act against conscience, or those who have a conscientious objection.⁸⁷ These variations in phraseology, as well as others, may carry little practical significance, but they have subtly different connotations.

83. See Angela C. Carmella, *The Religion Clauses and Acculturated Religious Conduct: Boundaries for the Regulation of Religion*, in *THE ROLE OF GOVERNMENT IN MONITORING AND REGULATING RELIGION IN PUBLIC LIFE* 21, 30 (James E. Woods & Derek Davids eds., 1993); Boozang, *supra* note 75, at 1475–79 (1995).

84. Various standards and citations to provisions containing them are contained in Wardle, *supra* note 75, at 179–202. See also White, *supra* note 76, at 1709 nn.31–32. If the law sets limiting criteria for protected refusals, and an intern, nurse, or orderly gives appropriate notification that she is not bound to participate, hospital officials will initially have to decide whether she has adequate grounds to refuse. Were they to decide that her claim is not sufficient, a court might have to resolve the question. When a hospital itself claims an exemption against a patient or doctor who wants a procedure the hospital refuses to allow, courts must also be ready to pass on the grounds for the hospital’s stance.

85. Professor Wardle, *supra* note 75, at 197, suggests that these laws presume that refusals to participate in abortions are based on a conscientious objection, but it may well be that state legislators unsympathetic with the Supreme Court’s decisions about abortion want to maximize possibilities for refusal.

86. However, I assume such laws would be interpreted to demand at least a consistent refusal to engage in a particular procedure; it would not be enough that one wished to be elsewhere for a single occasion.

87. What is commonly referred to as the “Church Amendment” (after its sponsor), which was adopted by Congress in 1973, granted an exemption from participating in sterilizations and abortions based on “religious beliefs or moral convictions.” See White, *supra* note 76, at 1707–08.

“Moral grounds” is a broader category than “conscientious objection”; the notion of not committing an act against conscience probably lies closer to “conscientious objection” on this spectrum of possibilities. Consider a nurse who is convinced that elective plastic surgery represents the worst of a materialist, superficial culture, perpetuates unhealthy denials of aging, and wastes resources. She may have moral reasons not to help in such operations, but the reasons do not amount to a conscientious objection, and they might not render her assistance an act against conscience. Sincerely held reasons that do not amount to a conscientious objection can be religious as well as nonreligious. If our nurse conceived attempts to reverse the aging process as a sin against God’s creation, she might have a religious basis not to assist elective plastic surgery that was less than a conscientious objection.

Standards for exemptions raise the question of just why any refusal of conscience should be allowed. Facing this question leaves little doubt why so many exemptions focus on abortion. A legislator might think that protecting conscience is so important that persons should not be made to act against conscience, however odd the basis for their judgments. But a legislator who believes that a particular procedure is seriously wrongful, and should be performed as little as possible, might approve a right of refusal independent of any special sensitivity about the conscience of those who refuse.⁸⁸

Without doubt, legislatures can, in principle, extend a right of refusal to all those who have a conscientious claim to refuse, to all those with moral grounds to refuse, to all those who wish to refuse, or to those refusers who fit within some other categorization that either makes no reference to religion or treats religious and nonreligious claims in the same way. The serious constitutional issues are whether an exemption can be given only to religious claimants and whether an exemption amounts to an excessive imposition on other people.

The answer about impositions is fairly straightforward. Exemptions can be undesirable, or even unconstitutional, if they impose restraints that are too severe on private actors. When Connecticut tried to guarantee that all workers would be given their Sabbath off, the Supreme Court, by a wide margin, held that this amounted to an establishment of religion because the law imposed too great a burden in its restrictions on employers.⁸⁹ This case has potential implications for victims who suffer deprivations because others refuse to participate in ordinary medical treatment.⁹⁰ The “victims” might be individual health care providers, hospitals, or people seeking medical services.

88. An intermediate position could be that a right of conscience should be recognized whenever society is sharply divided about the acceptability of a procedure.

89. *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 710–11 (1985).

90. The claim of right made by the “victim,” whether the victim is a patient or someone who provides medical services, need not have an independent constitutional status. *Caldor* did not claim

Some Catholic hospitals have a requirement that their doctors not perform abortions on their premises or on any others. If a law provides that such an institutional requirement is exempted from any negative legal consequences, a doctor could complain that her actions are excessively restricted, as were the actions of the Connecticut employer, Caldor, Inc. (However, unlike Caldor, the doctor is originally restricted by a private actor's conditions.)

A closer analogy to the Connecticut law actually involves the reverse situation. A nurse or resident relies on a conscience clause to refuse to participate in a procedure that a hospital provides. The hospital complains that the exemption imposes too severely on it. In an actual case, a nurse-anesthetist relied on a conscience statute to refuse to participate in a sterilization.⁹¹ The court found that the nearest substitute nurse-anesthetist was fifty-five miles away and that continual arrangement for substitutes was costly and detrimental to patients because it created scheduling difficulties and uncertainties about when sterilizations could be performed. Although the hospital raised no constitutional argument, its complaint about impracticality was very much like Caldor's, which asserted that giving its employee his day of worship off would be expensive and would impose on other workers.

Yet a third possible victim is the private individual who fails to receive a form of medical treatment. Let us suppose that a refusal provision leaves a woman who has been raped without the possibility of getting a "morning-after" pill that would prevent or terminate a pregnancy.⁹² She asks for a pill in the only emergency room in her area and is refused. (Her physical injuries are so severe that she cannot leave the hospital for three days.) Her conscience draws the line between taking such a pill, which she accepts, and having a standard abortion, which she regards as murder. She becomes pregnant. Thus, the hospital's refusal to provide the pill has led her to sustain an unwanted pregnancy. Although she was not restricted in the manner of the doctor in the Catholic hospital or the hospital that was told it cannot fire a refuser, she can argue that the state has tipped the balance too far toward acceding to religious conscience and away from safeguarding her bodily health and

that a state could never impose such onerous restrictions on it; it successfully asserted that the state's preference for religious interests violated the Establishment Clause. *See id.*

91. *Swanson v. St. John's Lutheran Hosp.*, 597 P.2d 702 (Mont. 1979).

92. As Boozang explains, *supra* note 75, at 1447-48, the pill may prevent fertilization or inhibit implantation on the uterine wall. According to the official Roman Catholic view, the latter is a form of abortion. White, *supra* note 76, at 1715-16, indicates that some rape victims live in communities in which the only local hospitals are Catholic ones, most of which will not supply a morning-after pill. For a case in which a court denied recovery to a woman who did not become pregnant and suggested that a rape victim might recover if she becomes pregnant after being denied information about and access to a morning-after pill, see *Brownfield v. Daniel Freeman Marina Hospital*. 256 Cal. Rptr. 240, 245 (Ct. App. 1989).

physical integrity according to ordinary medical standards.⁹³ A similar argument could be made by someone whose prescription is not filled by the only pharmacy in her area, if all the pharmacists on site refuse to provide her with morning-after pills because they are protected by a refusal statute.⁹⁴

Because those people who can get treatment or drugs elsewhere and have adequate information about alternative possibilities have a much less powerful claim that refusal impinges on them to an impermissible degree, the challenge to excessiveness might be viewed as to particular, atypical applications of a refusal statute, rather than to the law as a whole.

Concerns about impositions on innocent victims are clearly worthy of legislative attention, and they might recommend withdrawal of any refusal right for emergency situations. Excessive imposition might also violate the Establishment Clause. An exemption cast directly in religious terms is most clearly vulnerable in this respect. Were a law to justify all refusals, or all refusals based on conscience, those who benefit might contend that the statute cannot be establishing religion because religion receives no preference. The answer is that laws mainly designed to protect religious conscience may establish religion by an excessive imposition, even if the laws also benefit some persons with nonreligious grounds. Of course, a law that privileges less behavior, and imposes less on others, is less subject to challenge on this ground than a law that might deprive patients and doctors of important benefits or impose substantial costs on health care facilities.

Most existing refusal statutes apply only to abortion; fewer reach sterilization or contraception.⁹⁵ Most statutes do not require religious grounds for objection, but that may be partly because many of those who have legislated exemptions from participation in abortions are opposed to free choice about abortion. Among the critical questions about a privilege to refuse are whether it should be extended to many other medical procedures and what attitude potential refusers should need in order to qualify.

There is a strong argument for extension. In principle, people should not have to render services that they believe are forbidden di-

93. If we imagine the totally unrealistic example of a law authorizing human sacrifice of unwilling victims, performed out of religious conscience, the victim's claim that the law impermissibly established religion would be very powerful (even assuming the law placed no requirement on the victim to submit). To descend to the slightly more plausible, suppose that a refusal statute justified not giving blood transfusions, that the only hospital close enough to save a victim of an auto accident treated him but refused to give a transfusion as a matter of religious conscience, that the victim died, and that virtually all doctors would agree that a transfusion would have saved him. The claim that the state's authorization of the refusal was excessive and amounted to an establishment of religion would be strong.

94. A number of state legislatures have recently been considering refusal statutes for pharmacists. Among these are New Jersey Senate Bill 2178 and Assembly Bill 3772. S.B. 2178, 211th Leg., 2d Reg. Sess. (N.J. 2005); A.B. 3772, 211th Leg., 2d Reg. Sess. (N.J. 2005).

95. See Wardle, *supra* note 75, at 179–80.

rectly by God or are deeply immoral. However, any privilege to refuse needs to be compatible with individuals being informed about and being able to acquire standard medical services and drugs, and with health care institutions and pharmacies not having to turn handsprings to have personnel on hand to provide what is needed. It is debatable whether a legislature should expand protection procedure by procedure, after careful study of potential claims to refuse and likely imposition on victims if a privilege is granted, *or* should cast an extension in more general terms with measured qualifications for situations in which recognizing the privilege would interfere too greatly with the provision of health services.

However broad a privilege is in terms of procedures covered, the question arises whether it should be limited to religious conscience. In regard to individuals, a more inclusive approach is both intrinsically preferable, and more sensible politically, winning allies and softening potential opposition. If in actual administration, most medical personnel are effectively allowed to refuse on their own say so, it probably makes sense to extend the privilege to anyone who wishes to refuse.

Whether nonreligious refusals in conscience are at all frequent must depend on the particular medical procedure. Some nonreligious individuals are convinced by natural law arguments that a human life with full value begins at the moment of conception; some strongly resist any measures taken for the purpose of ending life. It is harder to imagine nonreligious objections in conscience to blood transfusions or advice about contraceptives.

Because the great majority of existing refusal laws do not single out religious conscience, because a broader law is less vulnerable to challenge, and because some nonreligious persons will have strong moral reasons not to participate in certain medical procedures, general privileges to refuse should not be limited to religious claimants.

The issue is harder with respect to institutions. Although it is somewhat difficult to say what gives a collective entity an objection in conscience, we do understand that a hospital that is run by a religious group has a powerful reason not to allow actions on its premises that the religion regards as murder or as another serious moral wrong. Although a hospital run by a nonreligious entity could be dedicated to ideas of "holistic medicine" that condemn certain standard forms of medical treatment, my decidedly nonexpert sense is that there are now few, if any, such hospitals. But there certainly are nonreligious hospitals—public and private—in areas where many people condemn abortion. The directors of such hospitals might wish not to have abortions performed there for moral or political reasons, and their moral reasons might be religiously informed. They might wish to have hospital policy reflect their sense of what is morally acceptable practice. An extensive right of refusal based on moral grounds could reach some of these circumstances, if not all.

My view is that no special right of conscience should protect hospitals whose individual directors happen to feel strong disquiet about procedures on moral or religious grounds. (This is not to say the hospitals necessarily have to perform the procedures; there is a degree of flexibility of choice that does not depend on a specific legal right of refusal.) If this conclusion is sound, limiting institutional exemptions to religious organizations makes sense.⁹⁶ An Alaska case provides modest support for this course. Interpreting a state refusal law that applied to hospitals declining to offer abortions, the state supreme court ruled that the law was invalid unless limited to sectarian facilities, because the general interest in protecting conscience did not outweigh the constitutional right to abortion.⁹⁷ Even if this decision is mistaken in suggesting that a refusal law for abortions *must* be so limited, it offers grounds for thinking that a law *may* be so limited.

In summary, I have argued that whether addressing individual choices about receiving medical services or provider choices about participating, legislatures should sometimes create no exemptions, should sometimes create exemptions based on nonreligious criteria, and should sometimes use criteria framed in terms of religion. As far as constitutional law is concerned, legislative use of religious criteria is sometimes, but not always, consonant with the demands of the Establishment Clause.

96. See Boozang, *supra* note 75, at 1505–08.

97. Valley Hosp. Assoc. v. Mat-Su Coalition for Choice, 948 P.2d 963 (Alaska 1997); *see also* Doe v. Bridgeton Hosp. Assoc., 366 A.2d 641 (N.J. 1976).

