UNCLEAR CONSCIENCE: HOW CATHOLIC HOSPITALS AND DOCTORS ARE CLAIMING CONSCIENTIOUS OBJECTIONS TO DENY HEALTHCARE TO TRANSGENDER PATIENTS

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For years, federal and state conscience clauses have given healthcare providers and doctors blanket protections for refusing to treat patients for reproductive health by citing religion. With some states beginning to broaden the scope of conscience clauses to make them applicable to transgender patients, religious providers and doctors are now given the opportunity to cite religion so that they may be excused from treating transgender patients. Many of these patients are now at risk and unable to access healthcare, especially in parts of rural America as mergers with Catholic hospitals continue to rise. These broad conscience clauses put transgender patients at risk by offering an opportunity for doctors and providers to serve their own self-interests and be excused from standards of care set forth by nationally established medical associations, resulting in a lower standard of care for transgender patients.

This Note explores the purpose and development of conscience clauses, their application in the context of reproductive health, the current harms that transgender patients face when refused healthcare (especially in rural America), and the Supreme Court's view on public accommodations law that may guide conscience clauses and transgender healthcare. This Note recommends statutory reform to provide information regarding to whom conscience clauses apply, as well as practical healthcare reform that encourages the system to better educate doctors on transgender health issues in order to reduce the stigma and discrimination transgender patients experience when they visit a healthcare provider.

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I. INTRODUCTION

Imagine yourself in a waiting room at a doctor's office hoping to resolve some medical issue that you are concerned with after being warmly welcomed and having filled out all of your paperwork. But there is one thing you forgot to mention before your visit and include on your paperwork: you are transgender. You realize that this is important information, so you decide to inform the receptionist before seeing the doctor; the information is well-received with a smile and you are finally taken to an examination room, fully expecting to meet your doctor.

A few minutes later, the doctor comes in and tells you that he or she refuses to treat you.

This experience has become far too common for transgender individuals who are denied healthcare because of their gender identities.[1] To make matters worse, these refusals to treat transgender patients are legally protected as long as a healthcare professional or hospital claims that its refusal is based on religious belief or moral grounds.[2] In cases like these, the healthcare worker will sometimes argue that serving these patients makes them complicit in allegedly sinful behavior.[3] While balancing doctors and hospitals' religious rights is important, religious and moral convictions are being used as an excuse for outright discrimination,[4] an experience that too many transgender individuals have experienced.[5]

Religious objections to being made complicit in the allegedly sinful behavior of others are known as complicity-based conscience claims.[6] In the healthcare context, the statutory provisions that allow hospitals and doctors to refuse treatment to patients are known as conscience clauses.[7] These clauses are present at the federal and state level, and the protections they provide to patients vary depending on the state.[8] But the general purpose of each clause is the same: to protect a healthcare professional or hospital that declines to perform certain services—most notably services related to abortion—if they conflict with a religious or moral belief.[9] In early 2018, President Donald Trump created the Conscience and Freedom Division within the Department of Health and Human Services ("Department of Health" or "HHS") to further enforce conscience clauses, meaning that more LGBTQ individuals and their families are at risk of being denied healthcare solely based on their sexual orientation and/or gender identity.[10]

This Note argues that current legislation permitting conscience clauses to apply to transgender individuals provides very few, if any, healthcare options for transgender patients in the event of a refusal, which burdens and puts them in potential danger by not providing equal access to healthcare. Part II reviews the

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1. Laura Arrowsmith, *When Doctors Refuse to See Transgender Patients, the Consequences Can Be Dire*, WASH. POST (Nov. 26, 2017), https://www.washingtonpost.com/national/health-science/when-doctors-refuse-to-see-transgender-patients-the-consequences-can-be-dire/2017/11/24/d063b01c-c960-11e7-8321-481fd63f174d_story.html.

2. *Conscience and Refusal Clauses*, REWIRE.NEWS: LEGIS. TRACKER (Sept. 12, 2018), https://rewire.news/legislative-tracker/law-topic/conscience-and-refusal-clauses/.

3. Douglas NeJaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2516 (2015) [hereinafter NeJaime & Siegel, *Conscience Wars*].

4. *See* Christine Grimaldi, *It's 'Scary,' But Transgender Patients Are Fighting Trump's Health-Care Discrimination Agenda*, REWIRE.NEWS (Mar. 13, 2018, 3:50 PM), https://rewire.news/article/2018/03/13/scary-transgender-patients-fighting-trumps-health-care-discrimination-agenda/.

5. *Id.*

6. NeJaime & Siegel, *Conscience Wars*, *supra* note 3, at 2518–19. For the purpose of this Note, "complicity-based conscience claims" and "conscientious objection" will be used interchangeably.

7. *Conscience and Refusal Clauses*, *supra* note 2.

8. *Id.*

9. *Id.*

10. Alex Barasch, *HHS's New Rule Allows Health Care Workers to Discriminate Against LGBTQ People and Abortion Seekers*, SLATE (Jan. 18, 2018, 6:17 PM), https://slate.com/technology/2018/01/trumps-new-hhs-rule-is-a-license-to-discriminate-against-lgbtq-people-and-abortion-seekers.html.

purpose and development of conscience clauses, their application in the context of reproductive health, and the relationship between these clauses and public accommodations law. Part III analyzes current conscience clause legislation, the effect of recent mergers between secular and religious hospitals, current harms that transgender patients face when refused healthcare (especially in rural America), and the Supreme Court's view on public accommodations law. Part IV recommends statutory reform to provide information regarding to whom conscience clauses apply, as well as practical healthcare reform that encourages the system to better educate doctors on transgender health in order to reduce the stigma and discrimination transgender patients experience when they visit a healthcare provider.

II. BACKGROUND

A. *Constitutional Balancing in Conscience Clauses*

Complicity-based conscience claims contain two important dimensions.[11] The first dimension is the third party's conduct, such as using contraception or making sexual lifestyle decisions.[12] The second dimension is the claimant-objector's relationship to the third party.[13] Complicity-based conscience claims specifically touch upon the issues of how to live in a community with others who do not share the objector's beliefs, and the lawful conduct by the third party that the person of faith believes to be sinful.[14] These claims are explicitly oriented toward third parties and thus present concerns about third-party harm.[15]

Because the conscience clause issue contains these two dimensions, legislation must balance two fundamental American principles found in the Constitution. The first is the free exercise of religion, protected by the Establishment Clause of the First Amendment, which, in relevant part, provides that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."[16] The second principle is equal protection within public accommodations, provided by the Fifth and Fourteenth Amendments, which state that the federal or state governments shall not "deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."[17] This balance—in considering the treatment of objectors while also being cognizant of protections to other citizens who do not share the objectors' beliefs—is known as "pluralism."[18]

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11. NeJaime & Siegel, *Conscience Wars*, *supra* note 3, at 2519.
12. *Id.*
13. *Id.*
14. *Id.*
15. *Id.*
16. U.S. CONST. amend. I.
17. U.S. CONST. amend. V, U.S. CONST. amend. XIV.
18. Douglas NeJaime & Reva Siegel, *Religious Exemptions and Antidiscrimination Law in* Masterpiece Cakeshop, 128 YALE L. J. F. 201, 224 (Sept. 14, 2018), https://www.yalelawjournal.org/forum/religious-exemptions-and-antidiscrimination-law-in-masterpiece-cakeshop [hereinafter NeJaime & Siegel, *Religious Exemptions*].

B. The Evolution of Conscience Clauses in Federal Law

The federal laws discussed in this Section are examples of laws that provide some form of protection to the hospital or healthcare worker through the enforcement of a conscience clause. Again, these clauses generally provide that institutions, healthcare professionals, or insurance providers who refuse to provide a specific healthcare service to a patient will not be discriminated against when being considered for federal funding and will not be held liable for refusal of such services if the refusal is based on a moral or religious objection.[19]

In order to understand conscience clauses as they operate today, it is crucial to understand their origination. While modern conscience clauses encompass issues in the medical field, their original purpose and use were for "conscientious objection to participation in war."[20] But soon after the landmark decision of *Roe v. Wade*,[21] conscientious objections started appearing outside the military context as a response against the pro-choice decision of *Roe*.[22] In 1973, the most notable federal law that followed *Roe* was the Church Amendment, which provides that healthcare institutions receiving federal funds can refuse to provide abortion services if such services are against their religious beliefs.[23]

In 1993, the Religious Freedom Restoration Act ("RFRA") was signed into law by President Bill Clinton, which prohibits the government from substantially burdening religious exercise without compelling justification.[24] RFRA soon became a means for those with religious objections to avoid complying with laws of general applicability by citing their religion.[25]

In 1996, the Public Health Service Act (also known as the "Coats-Snowe Amendment")[26] was passed. This law protects federally funded government entities and doctors who refuse to undergo or provide medical abortion training from being discriminated against when compared to entities and doctors who do

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19. *Conscience and Religious Freedom*, HHS, https://www.hhs.gov/conscience/conscience-protections/index.html (last visited May 27, 2020).

20. Marshall, *The Spread of Conscience Clause Legislation*, 39 ABA HUMAN RIGHTS MAG. (Jan. 1, 2013), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/2013_vol_39/january_2013_no_2_religious_freedom/the_spread_of_conscience_clause_legislation; *see also Origin and Meaning of Conscientious Objection*, CONSCIENTIOUS-OBJECTION, http://www.conscientious-objection.info/origin-meaning-of-conscientious-objection/ (last visited May 27, 2020).

21. 410 U.S. 113 (1973).

22. Marshall, *supra* note 20.

23. 42 U.S.C. § 300a–7(b)(1) (2018) "The receipt of any grant, contract, loan, or loan guarantee [from the federal government] by any individual or entity does not authorize any court or any public official or other public authority to require . . . such individual to perform or assist in the performance of any sterilization procedure or abortion if . . . [it] would be contrary to his religious beliefs or moral convictions."); *Conscience and Refusal Clauses, supra* note 2.

24. Religious Freedom Restoration Act, 42 U.S.C. § 2000bb (2018). A person's right to exercise their religion, however, is not absolute. The Act further provides that the government is excepted from this prohibition and may impose a burden on an individual "if it demonstrates that application of the burden to the person: (1) furthers a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." *Id.*

25. *Conscience and Refusal Clauses, supra* note 2.

26. 42 U.S.C. § 238n (2018).

provide such procedures.[27] The Weldon Amendment[28] provides similar protection. Finally, the Affordable Care Act[29] introduced conscience objections in the context of insurance coverage; the Act allows insurance plans to opt out of providing abortion coverage.[30]

C. *Right of Refusal*

Refusal clauses, also known as a "right of refusal," are related to conscience clauses.[31] Refusal clauses excuse pharmacists from filling certain prescriptions sometimes referred to as "abortifacient" drugs, including birth control and emergency contraception, as long as their reason is related to religious or moral beliefs.[32] While most states limit the right to refuse simply to that—i.e. a right to refuse to dispense drugs for a patient—there are cases in which pharmacists have abused this right and refused to transfer a prescription to another pharmacy, or refused to tell a patient of an alternative pharmacy he or she could use. In one particular case, *Noesen v. Medical Staffing Network, Inc.*,[33] the Seventh Circuit Court of Appeals held that the pharmacist had a right to refuse to provide birth control but had no right to refuse to transfer a valid prescription to another pharmacy.[34] There are currently regulations allowing pharmacists to refuse to fill prescriptions in at least seven states, with an equal number of states that *require* pharmacists to fill prescriptions.[35]

In cases such as *Noesen*, plaintiffs argue that their employer has violated their rights under Title VII of the 1964 Civil Rights Act ("Title VII").[36] Title VII provides protections to employees against discrimination by their employers on the basis of religious beliefs and practices, but also conditions this protection on whether the accommodation will create undue hardship on the employer.[37] If it will create such hardship, the courts will find in favor of the employer despite the alleged discrimination.[38]

In 2012, the Washington State Pharmacy Quality Assurance Commission passed a regulation stating that pharmacies "must stock and dispense emergency

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27. *Id.*

28. Consolidated Appropriations Act of 2009, Pub. L. No. 111-117, §508(d), 123 Stat. 3034 (2009).

29. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 42 U.S.C.).

30. *Id.*; *Conscience and Refusal Clauses, supra* note 2.

31. Marshall, *supra* note 20.

32. *Id.*

33. 232 F. App'x 581 (7th Cir. 2007).

34. *Id.* at 585.

35. Kenneth R. Baker, *Refusal to Fill Prescriptions Under Conscience Clauses*, DRUG TOPICS (June 22, 2018), http://www.drugtopics.com/legal-news/refusal-fill-prescriptions-under-conscience-clauses.

36. *See, e.g.*, *Noesen*, 232 F. App'x at 582; *see also* 42 U.S.C. § 2000e-2 (2018).

37. 29 C.F.R. § 1605.2(b)(1) (2019) ("Section 701(j) [of Title VII] makes it an unlawful employment practice under section 703(a)(1) for an employer to fail to reasonably accommodate the religious practices of an employee or prospective employee, unless the employer demonstrates that accommodation would result in undue hardship on the conduct of its business.").

38. *See id.*

contraceptive drugs"[39] regardless of religious reasons. A Ralphs drugstore in Washington challenged this regulation and the district court originally held that it violated the pharmacy owners' religious freedoms.[40] This decision, however, was overturned in a unanimous decision by the Ninth Circuit Court of Appeals, which held the legislation was rationally related to a legitimate purpose under rational basis review.[41]

Protections given to hospitals and healthcare workers vary from state to state, with many governing abortion services and refusal to dispense birth control.[42] But because of the varying degree of protection provided to doctors and hospitals, and the silence on the applicability of conscience clauses to transgender patients, it is currently difficult to say what kinds of service refusals (besides those regarding abortions or birth control) are legal under a given conscience clause for the transgender community.[43]

D. State Conscience Clauses

Many states have also independently adopted laws that govern conscientious objections to medical procedures. As of February 1, 2019, forty-six states "allow some health care providers to refuse to provide abortion services."[44] All forty-six states allow individual providers to refuse to provide abortion services, and forty-four states allow health care institutions to refuse to provide such services.[45] Twelve states allow some providers to refuse to provide contraceptive services,[46] and eighteen states allow providers to refuse to provide sterilization services. In addition, twenty-one states have adopted some form of the RFRA.[47]

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39. Baker, *supra* note 35.

40. Stormans, Inc. v. Selecky, 865 F. Supp. 2d 925, 988–99 (W.D. Wash. 2012).

41. Stormans, Inc. v. Wiesman, 794 F.3d 1064, 1088 (9th Cir. 2015).

42. Marshall, *supra* note 20.

43. For example, some statutes "expand their coverage beyond abortion services to include all medical procedures that conflict with providers' moral or religious beliefs." Melissa Duvall, *Pharmacy Conscience Clause Statutes: Constitutional Religious "Accommodations" or Unconstitutional "Substantial Burdens" on Women?*, 55 AM. U. L. REV. 1485, 1492 (2006); *see, e.g.*, Medicaid Managed Care Balanced Budget Act of 1997, 42 U.S.C. § 1396u-2(b)(3)(B) (2000) (providing that managed care providers are allowed to opt out of providing, reimbursing, or referring Medicaid patients for any services that conflict with the organization's religious or moral beliefs).

44. *Refusing to Provide Health Services*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services (last updated May 1, 2020).

45. *Id.* In addition, thirteen of those states "limit the exemption to private healthcare institutions" and one state only allows "religious health care entities to refuse to provide" the services. *Id.*

46. *Id.* In the context of contraception and prescriptions, these clauses are known as "right of refusal." For more information *see* discussion *supra* Section II.C.

47. *Conscience and Refusal Clauses, supra* note 2. The twenty-one states are: Alabama, Arizona, Arkansas, Connecticut, Florida, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, and Virginia. *State Religious Freedom Restoration Acts*, NAT'L CONF. STATE LEGISLATURES (May 4, 2017), https://www.ncsl.org/research/civil-and-criminal-justice/state-rfra-statutes.aspx.

Because each state has its own conscience clause legislation, protections for patients vary greatly depending on the jurisdiction.[48] Some states, for example, provide no protections to the patient while providing blanket protections for the doctor or pharmacist who chooses to refuse the patient on *any* conscientious ground.[49] In contrast, other states provide that a person may refuse to personally provide services based on religious, moral, or ethical beliefs, but may not interfere with the patient's right to obtain the service or healthcare.[50] Other states give patients further protections by providing that "the pharmacist has a professional obligation to take steps to avoid the possibility of abandoning or neglecting a patient."[51]

E. Conscience Clauses and the Trump Administration

While federal and state medical conscience clauses originated as a response against women's reproductive rights, many doctors and healthcare providers have recently been given implicit permission to use these clauses to deny services to LGBTQ patients based on a "moral or religious opposition to homosexuality[,]"[52] originating from President Donald Trump's recent creation of the Conscience and Freedom Division within the Department of Health.[53] The Division was created in January 2018 to "expand conscience protections" for healthcare workers and hospitals who not only want to deny abortion services to women, but to also deny treatment to LGBTQ patients.[54] The Division's director stated that the purpose of the Division was to "vigorously and effectively enforce existing laws protecting the rights of conscience and religious freedom" for health care workers and entities.[55] The Department of Health also issued a proposed regulation that would reinterpret federal laws to expand the ability of healthcare

48. *See Conscience and Refusal Clauses, supra* note 2.

49. For example, Idaho's conscience clause provides that "[n]o health care professional shall be required to provide any health care service that violates his or her conscience." IDAHO CODE ANN. § 18-611(2) (West 2019).

50. Delaware, for example, allows pharmacists to refuse "to dispense pharmaceuticals based on the[ir] religious, moral, or ethical beliefs," but such procedures "shall include proper supervision of supportive personnel and delegation of authority to another pharmacist when not on duty." 24 DEL. ADMIN. CODE § 2500 (2020).

51. 49 PA. CONS. STAT. § 27.103 (2020).

52. *Conscience and Refusal Clauses*, *supra* note 2.

53. *See* Kevin Clarke, *Catholic Hospitals Will Continue Treating LGBT Patients Under Trump's New Guidelines*, AM. JESUIT REV. (Jan. 19, 2018), https://www.americamagazine.org/politics-society/2018/01/19/catholic-hospitals-will-continue-treating-lgbt-patients-under-trumps.

54. *See* Juliet Eilperin & Ariana Eunjung Cha, *New HHS Civil Rights Division to Shield Health Workers with Moral or Religious Objections*, WASH. POST (Jan. 17, 2018, 7:06 PM), https://www.washingtonpost.com/national/health-science/trump-administration-creating-civil-rights-division-to-shield-health-workers-with-moral-or-religious-objections/2018/01/17/5663d1c0-fbe2-11e7-8f66-2df0b94bb98a_story.html.

55. Dalia Sofer, *HHS Division to Enforce 'Conscience and Religious Freedom'*, AM. J. NURSING (Apr. 2018), https://journals.lww.com/ajnonline/Fulltext/2018/04000/HHS_Division_to_Enforce__Conscience_and_Religious.9.aspx.

providers to deny patients on religious or moral grounds.[56] The proposed regulation seeks to broaden the definition of what it means to "assist in the performance" of an activity to include workers beyond physicians.[57] This would mean that workers such as receptionists or schedulers at a clinic or hospital would be able to assert a new right to refuse when performing their jobs.[58]

Following the Division's creation, Catholic hospitals and spokespeople have reassured that their hospitals will continue to provide services to members of the LGBTQ community,[59] but the community and its advocates are uncertain that this promise will be kept.[60] This is because of Catholic hospitals' contradictory track records of refusing to treat patients who seek routine sterilization surgeries, refusing to provide or continue hormone therapy, or even refusing to treat children of LGBTQ parents.[61] While the Conscience and Freedom Division has not acted yet, LGBTQ individuals worry about their access to healthcare since there is also proposed legislation that would give "authority [to the Division] to initiate compliance reviews, conduct investigation, supervise and coordinate compliance…and use enforcement tools"[62] to reinforce conscience clauses. If this legislation is enacted, transgender patients will have even more difficulty finding hospitals and doctors that will treat them.

F. The Increase of Catholic Hospitals Throughout the Country

In addition to the potential inclusion of transgender patients under the umbrella of people who are denied treatment under conscience clauses, the number of Catholic hospitals throughout the United States that enforce such clauses has also increased. The combination of these factors has, in turn, decreased hospital options for LGBTQ patients.[63] Importantly, one in six hospital patients in the United States is treated in a Catholic facility.[64] In ten states, 30% or more of these hospitals were acute-care hospitals under Catholic ownership in 2016.[65] Catholic hospitals' presence has also been expanding in rural areas, often being the only source for acute care.[66]

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56. MAP & NAT'L CTR. FOR TRANSGENDER EQUAL., RELIGIOUS REFUSALS IN HEALTHCARE: A PRESCRIPTION FOR DISASTER 2 (2018), http://www.lgbtmap.org/file/Healthcare-Religious-Exemptions.pdf [hereinafter RELIGIOUS REFUSALS IN HEALTHCARE].

57. *Id.*

58. *Id.* "In interpreting 'assist in the performance,' the Department seeks to provide broad protection for individuals, consistent with the plain meaning of the statutes. The Department believes that a more narrow definition of...'assist in the performance,' such as a definition restricted to those activities that constitute direct involvement with a procedure...would fall short of implementing the protections Congress provided." Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880 (proposed Jan. 26, 2018) (codified at 45 C.F.R. pt. 88) [hereinafter Protecting Statutory Conscience Rights in Health Care].

59. Katie Hafner, *As Catholic Hospitals Expand, So Do Limits on Some Procedures*, N.Y. TIMES (Aug. 10, 2018), https://www.nytimes.com/2018/08/10/health/catholic-hospitals-procedures.html.

60. RELIGIOUS REFUSALS IN HEALTH CARE, *supra* note 56.

61. *See id.*

62. Sofer, *supra* note 55.

63. *See* Hafner, *supra* note 59.

64. *Id.*

65. *Id.*

66. *Id.*

The increase of Catholic institutions presents a challenge for transgender patients who do not know that their primary healthcare provider or facility is affiliated with a Catholic institution due to recent mergers between Catholic hospitals and private corporations. Previously, the norm was to have hospital names that indicated the hospital's affiliation with the Catholic Church; names such as Catholic Healthcare West made the hospital's Catholic affiliation clear and put patients on notice of this affiliation.[67] It is far less common today, however, for hospital names or interiors to fully put a patient on notice that the hospital is religiously affiliated.[68] As Catholic hospitals lost patients and required mergers with private corporations, the common practice was for the hospitals to continue as a religiously affiliated church organization in exchange for a common, non-religious name which is generally chosen by the private corporation.[69] Additionally, fewer than 3% of Catholic hospitals in the nation have websites that list services that are not performed at their hospital.[70] All of those that do are located in the state of Washington, where state law requires hospitals to provide this information on their websites.[71]

G. Conscience Clauses and Public Accommodations Laws

Finally, some conservative groups have been anticipating even stronger conscience clause enforcement because of the recent Supreme Court case, *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission*.[72] These groups hope that this case's holding, which protects the cakeshop owner's religious freedoms, will be interpreted as generally supporting conscience clause enforcement.[73] Advocates for LGBTQ groups have responded, countering that the Court's dicta supported the opposite conclusion by upholding past opinions which spoke on public accommodations and anti-discriminatory behavior in the racial context.[74]

Advocates for LGBTQ protections in the healthcare setting have pointed to the federal public accommodations law under Title II of the Civil Rights Act of 1964 ("Title II"), which prohibits establishments affecting commerce from discriminating against "all persons." These advocates have argued that LGBTQ discrimination in the healthcare setting is analogous to racial discrimination under Title II.[75] Title II as it currently stands does not, however, explicitly list LGBTQ

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67. *Id.*
68. *Id.*
69. *See id.*
70. *Id.*
71. *Id.*
72. 138 S. Ct. 1719 (2018).
73. Wesley J. Smith, *Medical Conscience and* Masterpiece Cakeshop, NAT'L R. (Jun. 6, 2018, 6:07 PM), https://www.nationalreview.com/corner/masterpiece-cakeshop-decision-medical-conscience-rights/ (commenting that, although the *Masterpiece Cakeshop* decision does not guarantee medical-conscience rights being upheld, it began to set the legal foundation for such a course).
74. *See* NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 202.
75. *Id.*

persons as a protected class.[76] Title II currently reads that all persons are entitled to full and equal enjoyment of accommodations of any public place without discrimination on the basis of race or religion.[77] In addition, Title II designates specific establishments such as entertainment centers, hotels, and restaurants that are subject to its provisions.[78] But establishments such as governmental buildings and hospitals[79] have also been included under the "operations affecting commerce" clause which states that "'commerce' means travel, trade, traffic, commerce, transportation, or communication among the several States . . . ."[80]

In the past, Title II's enactment prompted some public accommodation owners to argue that they could not practice their religion because the accommodations law was forcing them to serve African Americans against their religious beliefs.[81] On the basis of race, the Supreme Court has held that religious exemptions are not allowed for public accommodation requirements if granting the exemption burdens a compelling governmental reason for the public accommodation law.[82] This same language is found in the RFRA which provides that a government cannot burden a person's exercise of religion unless the government demonstrates a compelling interest.[83] The Supreme Court has held racial equality and equal opportunities to be compelling governmental interests that allow the government to burden an individual's exercise of religion.[84] Thus, the Supreme Court's recent decision in *Masterpiece Cakeshop* rejected the conservative viewpoint, which argued that refusals to treat or serve individuals based on those persons' sexual orientations are analogous to religious exclusions for refusal to participate in abortions.[85] Instead, the Court accepted the public accommodations approach and embraced the general rule that no person should be discriminated against in public establishments.[86] The Court also addressed

76. 42 U.S.C. § 2000(a) (2018).

77. *Id.* ("All persons shall be entitled to the full and equal enjoyment of goods, services, facilities, privileges, advantages, and accommodations of any place of public accommodation…without discrimination or segregation on the ground of race, color, religion, or national origin.").

78. *Id.* § 2000(b).

79. *Know Your Rights: Public Accommodations,* NAT'L CTR. FOR TRANSGENDER EQUAL., https://transequality.org/know-your-rights/public-accommodations (last visited May 27, 2020).

80. 42 U.S.C. § 2000(c) (2018).

81. *See generally* Newman v. Piggie Park Enters., Inc., 390 U.S. 400 (1968).

82. *Id.*

83. 42 U.S.C. § 2000bb-1 (2018). ("Government shall not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability . . . . [unless the government] demonstrates that application of the burden to the person (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest.").

84. *See* Bob Jones Univ. v. United States, 461 U.S. 574, 604 (1983) ("[T]he Government has a fundamental, overriding interest in eradicating racial discrimination in education . . . .").

85. *See* NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 204; Elizabeth Sepper, *Symposium: More at Stake Than Cake—Dignity in Substance and Process*, SCOTUSBLOG (June 5, 2018, 11:23 AM), http://www.scotusblog.com/2018/06/symposium-more-at-stake-than-cake-dignity-in-substance-and-process.

86. Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n, 138 S. Ct. 1719, 1727 (2018) ("[I]t is a general rule that . . . [religious and philosophical] objections to gay marriage do not allow business owners and other actors in the economy and in society to deny protected persons equal access to goods and services under a neutral and generally applicable public accommodations law.").

pluralism concerns regarding services to LGBTQ individuals.[87] Thus, *Masterpiece Cakeshop* provided some guidance toward public accommodation issues that are applicable in the healthcare context, but these ideals from the Court's opinion have yet to be embraced by the healthcare community.[88]

III. Analysis

Because conscience clause legislation is so varied and broad throughout the country, the first part of this Section will focus on the actual intent and purpose of conscience clauses and why they should not be applicable to transgender patients. Second, this Section will look at the current healthcare system and address the potential dangers transgender patients will face if conscience clauses are enforced against them. Finally, this Section will discuss the relevance and distinction of *Masterpiece Cakeshop* as well as how conscience clauses relate to public accommodation laws.

A. Declaring Conscientious Objections in Healthcare

Declaring conscientious objections can be analogized to a scene from the American hit TV-show *The Office*, in which Michael Scott faces financial trouble and is advised by one of his co-workers to declare bankruptcy.[89] A few moments later, Michael announces and shouts loudly to his office staff, "I declare bankruptcy!"[90] In the following scene, one of Michael's employees, Oscar, comes into Michael's office and tells him "I just wanted you to know that you can't just say the word bankruptcy and expect anything to happen," to which Michael replies "I didn't say it. I declared it."[91] The same situation arises in the context of religious and moral objections in healthcare. Physicians and providers, believing that their religious beliefs relieve them of their duties simply declare a conscientious objection, to which the law would reply in a similar manner as Oscar to Michael—merely stating a conscientious objection does not mean you can expect anything to happen.[92] In response, physicians and providers, not understanding the limits to their religious rights, say "I didn't say it, I declared it."[93]

Private hospitals and healthcare professionals are indeed entitled to religious rights.[94] But there is a difference between protecting an individual or institution's religious rights and using said protections as an excuse to discriminate against a group of people and putting that group in danger by refusing medical

87. *Id.*

88. NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 204.

89. *The Office: Money* (NBC television broadcast Oct. 18, 2007) (transcript on file with the *University of Illinois Law Review*).

90. *Id.*

91. *Id.*

92. *See, e.g.*, Noesen v. Med. Staffing Network, Inc., 232 F. App'x 581, 584 (7th Cir. 2007).

93. *Cf. id.*

94. See U.S. Const. amend. I; *see generally* Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 Yale J.L. & Feminism 135, 137–38 (2003).

treatment. Current interpretations and applications of conscience clauses are incorrect because conscience clauses have deviated from their original intent and purpose. These incorrect interpretations allow doctors and hospitals to claim conscientious objections in ways that lead to applications of these clauses that were not originally intended by their enactment.

1. Evolution of Conscientious Claims from the Military to Healthcare

As previously mentioned, the original purpose of conscience clauses was to address and protect men who objected to military services based on religious beliefs.[95] It was from this concept of religious objection that the Church Amendments were created to address abortion policies, relieving doctors and healthcare providers from the duty to perform abortions as set forth in *Roe*.[96] In addition to the federal Church Amendments, forty-seven states, including the District of Columbia, have enacted some form of conscience clause regulation surrounding contraceptives and abortions, many of which were immediately enacted in response to *Roe*.[97]

If conscience clauses related to abortion and reproductive rights are one degree of separation away from the original military purpose of conscience clauses, LGBTQ treatment refusals are two degrees of separation away from conscience clauses' original purpose. The Supreme Court decision of *Obergefell v. Hodges*[98] came after years of legal scholars discussing implications of conscience clauses for women's rights and healthcare.[99] *Obergefell* secured marriage rights for the LGBTQ community.[100] After this decision, conservative groups in opposition to LGBTQ rights again claimed religious and conscientious protections in the healthcare context, citing to anti-abortion conscience clauses in support of their position.[101] But if abortion-conscience clauses were abstracted from military conscience clauses,[102] and religious-exemption clauses "are an idea from abortion-conscience clauses,"[103] then religious-exemption clauses are laws that are implementing protections that are outside the scope of the original military purpose.

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95. *Id.*

96. *Id.*

97. *Id.*

98. *See generally* 135 S. Ct. 2584 (2015).

99. *See, e.g.*, William W. Bassett, *Private Religious Hospitals: Limitations Upon Autonomous Moral Choices in Reproductive Medicine,* 17 J. CONTEMP. HEALTH L. & POL'Y 455, 456 (2001); Courtney Miller, *Reflections on Protecting Conscience for Health Care Providers: A Call for More Inclusive Statutory Protection in Light of Constitutional Considerations*, 15 S. CAL. REV. L. & SOC. JUST. 327 (2006).

100. *Obergefell*, 135 S. Ct. at 2608.

101. *See* Louise Melling, *Will* Obergefell *Be the New* Roe?, SLATE (June 5, 2018, 1:41 PM), https://slate.com/news-and-politics/2018/06/the-masterpiece-cakeshop-decision-will-not-deter-opponents-of-lgbt-equality.html.

102. Marshall, *supra* note 20.

103. 42 U.S.C. § 18116 (2018); Emma Green, *When Doctors Refuse to Treat LGBT Patients*, ATLANTIC (Apr. 19, 2016), https://www.theatlantic.com/health/archive/2016/04/medical-religious-exemptions-doctors-therapists-mississippi-tennessee/478797/.

The bulk of current federal legislation pertaining to conscience clauses addresses women's reproductive rights and the appropriate refusal in regard to abortions and birth control. The federal government gives protections to doctors and hospitals through Section 245 of the Public Health Service Act of 1996, more commonly known as the Coats-Snowe Amendment.[104] This Act prohibits the federal government and any state or local government from discriminating against any hospital on the basis that the hospital refuses to require, partake, or provide abortion training.[105] While this particular Act focuses on protecting entities and physicians who oppose abortions, it is an example of how the government provides protections for healthcare workers' and providers' religious beliefs outside the scope of military protections.

In 2005, the Weldon Amendment was enacted and offered additional protection to healthcare entities by prohibiting federal agencies or programs as well as states or local governments from discriminating against healthcare entities that "do[] not provide, pay for, provide coverage of, or refer for abortions."[106] The term "health care entity" is broadly defined and may include a physician, a health care professional, or hospital, among others.[107]

In 2010, the Affordable Care Act ("ACA") provided protection for hospitals in the insurance context, preventing discrimination against entities within the health insurance Exchange program.[108] Section 1303(b)(4) of the ACA provides that insurance providers, when offering their plans on a market (generally online), may not discriminate against entities which refuse abortion services to its patients.[109]

While the ACA provided hospitals more protection from being discriminated against within the insurance context, it interestingly provided a section that prohibited any healthcare programs receiving federal funds from discriminating and refusing care on the basis of "race, color, national origin, sex, age, or disability."[110] In fact, the U.S. Department of Health and Human Services issued regulations explaining that this prohibition extends to claims based on gender

104. 42 U.S.C. § 238n (2018).

105. *Id.*

106. Consolidated Appropriations Act of 2005, Pub. L. No. 447, tit. V, § 508, 118 Stat. 2809 (2004).

107. *Id.* (defining a health care entity as including "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.").

108. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 42 U.S.C.).

109. *Id.* (providing that "[n]o qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions."). The Affordable Care Act also introduced conscience protections against assisted suicide, illustrating another way it has expanded conscientious protections. *Id.*

110. P. L. 111–148, title I, § 1557, codified as 42 U.S.C. § 18116 (2018); *Section 1557: Frequently Asked Questions*, HHS, https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html (last visited May 27, 2020) ("The final rule is consistent with existing, well-established Federal civil rights laws and clarifies the standards HHS will apply in implementing Section 1557 of the ACA. These standards provide that individuals cannot be denied access to health care or health coverage or otherwise be subject to discrimination because of race, color, national origin, sex, age, or disability.").

identity and sex stereotyping.[111] All other statutes discussed above never explicitly provide patients protection from sexual orientation or gender identity discrimination.

So far, federal conscience clauses have been limited to the context of contraceptives and abortion. The problem arises at the state level, where protections vary greatly from state to state leading to a disarray of patient protections depending on the state they are in.[112] For example, Mississippi's exemption law allows a doctor to refuse to provide any form of care to a transgender patient, including routine check-ups,[113] whereas Pennsylvania's conscience clause provides that "the pharmacist has a professional obligation to take steps to avoid the possibility of abandoning or neglecting a patient."[114]

While the application of conscience clauses in military and healthcare contexts still involves protecting those with a religious or moral objection, the context and the outcomes are drastically different. In the military, conscience protections required those who objected on the basis of conscience to fulfill their civic duties through other means.[115] Nevertheless, if a doctor or hospital refuses to serve an LGBTQ patient based on religious or moral objection, they are simply released from their professional duty to care for patients. In the context of rural communities, discussed later below, this can become very dangerous as Catholic hospitals are commonly the sole provider for rural communities,[116] leaving transgender patients with no other immediate option in the surrounding area. This release from duty can also have consequential effects on employers, especially in the pharmacy context, in which case the release of duty for a conscientious objector means additional work for another pharmacist or a team member to incur on behalf of the objector.[117] The following Section will illustrate that, in contexts such as the one just described, a court has rightly denied an objector from claiming conscientious protection on the grounds that, after attempting to reasonably accommodate the objector, the employer would undertake undue hardship to accommodate even further.[118]

2. *Free to be You and Me (Until You Cause Undue Hardship on Others)*

While individuals are free to practice their religion in this country, not all of those freedoms carry into the workplace. Title VII of the Civil Rights Act of

111. Protecting Statutory Conscience Rights in Health Care, *supra* note 58; Final Rule, 81 Fed. Reg. 31,376, 31,387 (May 18, 2016) (codified at 45 C.F.R. pt. 92) ("We proposed that the term 'on the basis of sex' includes, but is not limited to, discrimination on the basis of . . . sex stereotyping, and gender identity.").

112. *See Conscience and Refusal Clauses, supra* note 2.

113. *Id.*

114. 49 PA. CODE § 27.103 (2007).

115. Even today, conscientious objectors to military service are still required to register in the system with two options: "alternative service" (for those completely objecting to "participation in war in any form" or to serve in the Armed Forces without using any military weapons. *See Alternative Service Program*, SELECTIVE SERVICE SYSTEM, https://www.sss.gov/register/alternative-service/ (last visited May 27, 2020).

116. Hafner, *supra* note 59.

117. *See generally* Noesen v. Med. Staffing Network, Inc., 232 F. App'x 581, 585 (7th Cir. 2007).

118. *Id.*

1964 provides protections to employees against discrimination by their employers on the basis of religious beliefs and practices.[119] But this protection is provided upon the condition that accommodations made by the employer for the employee's religious beliefs will not cause undue hardship on the employer.[120] The court's holding and reasoning in *Noesen v. Medical Staffing*[121] illustrates this law.

Neil Noesen was a pharmacist in Wisconsin looking for some extra work.[122] During his job search, he disclosed to a temporary staffing company that he refused to fill prescriptions for birth control medications.[123] Noesen had a complaint previously filed against him for his refusals to fill prescriptions, which was why he was required by the state board of pharmacy to provide written notice to his future employers.[124]

A Wal-Mart pharmacy in Wisconsin required pharmacists and pharmacy technicians to share in customer-service duties, including counseling walk-in patients and answering phone calls from patients, physicians, hospitals, clinics, insurance companies, and other pharmacies.[125] The pharmacists were to check all prescriptions and labels and hand the medication to patients; approximately 10% of this Wal-Mart pharmacy's customer volume was related to contraception prescriptions and inquiries.[126]

Noesen was recommended to this pharmacy by the staffing company and was subsequently hired.[127] Upon employment, Noesen immediately disclosed to his supervisor that he would not fill prescriptions for birth control.[128] The supervisor understood and accommodated this limitation by relieving Noesen from "filling prescriptions for birth control, taking orders for birth control from customers or physicians, handling customer's birth control medication, and performing checks on birth control orders."[129] The supervisor also sorted birth control prescriptions in a separate basket so that Noesen would not have to fill them.[130]

Despite these accommodations, Noesen was still not satisfied and the supervisor soon found that, when phone calls would come in for refills on prescription contraceptives, Noesen would put the caller on hold and not notify another pharmacist of the caller.[131] Noesen would also ignore patients at the counter after

119. 42 U.S.C. § 2000e-2 (2018).
120. *Id.*
121. *Noesen*, 232 F. App'x at 585.
122. *Id.* at 583.
123. *Id*.
124. *Id.*
125. *Id.*
126. *Id.*
127. *Id*.
128. *Id.*
129. *Id.*
130. *Id.*
131. *Id.*

learning they were in need of a refill or in need of counsel for birth control products without notifying another pharmacist of the patient.[132] The supervisor tried to accommodate even further to ensure Noesen would not have to talk to any walk-in patients but, as a compromise, Noesen would have to continue answering phone calls and refer the objectionable calls to someone else.[133]

By the fifth day, the supervisor terminated Noesen's employment because Noesen would not accept the accommodations.[134] After being notified of his termination, Noesen refused to leave the store and began to publicly state that he was being discriminated against for his religious beliefs.[135] Noesen soon brought an action against the staffing agency and Wal-Mart for violating his religious freedoms established by Title VII, and against the state of Wisconsin for refusing to adopt a conscience clause that would protect him.[136] The case was quickly dismissed by the trial judge after finding that Noesen did not have jurisdiction to bring an action against the state of Wisconsin and that Wal-Mart acted reasonably by offering extensive accommodations.[137]

Dissatisfied, Noesen appealed to the Seventh Circuit Court of Appeals.[138] The Court of Appeals affirmed the district court's holding by acknowledging that, although Title VII requires employers to make reasonable accommodations for employees' religious beliefs,[139] the law does not require employers to make accommodations that would create an undue hardship on the employer.[140] The court stated that an accommodation that would require other employees to assume a disproportionate workload or divert them from their regular work was an undue hardship as a matter of law.[141] Relieving Noesen from his counter and telephone duties would have resulted in substantial costs and would have shifted responsibilities to other employees who already had a full workload.[142] The court also dismissed the claims against the staffing agency because the organization merely placed Noesen at the Wal-Mart and did nothing more in relation to his discrimination claims.[143]

As for the claim that the state of Wisconsin discriminated against Noesen by not adopting a conscience clause, the Court held that the state was immune to these claims pursuant to the 11th Amendment of the Constitution.[144] The only exceptions to the immunity are when the state is the employer of the employee

132. *Id.*
133. *Id.*
134. *Id.*
135. *Id.*
136. *Id.*
137. *Id.*
138. *Id.*
139. 42 U.S.C. § 2000e(j) (2018) ("The term 'religion' includes all aspects of religious observance and practice...unless an employer demonstrates that he is unable to reasonably accommodate to an employee's or prospective employee's religious observance or practice without undue hardship on the conduct of the employer's business.").
140. *Id.*; *Noesen*, 232 F. App'x at 584.
141. *Noesen*, 232 F. App'x at 585.
142. *Id.*
143. *Id.*
144. *Id.*

making the discrimination claim or when the state voluntarily consents to the jurisdiction;[145] since neither exception applied, the state was dismissed from the suit.[146] While *Noesen* did not involve a conscience clause, the decision most likely would have come out the same even if a conscience clause were present.[147] This is because Wal-Mart made reasonable accommodations and accommodating further would have caused undue hardship, in which case Title VII protects the employer from refusing to further accommodate an individual's religious beliefs.[148]

In another case, *Stormans v. Wiesman*,[149] the Ninth Circuit Court of Appeals upheld the Washington State Pharmacy Quality Assurance Commission's regulation stating that pharmacies "must stock and dispense emergency contraceptive drugs."[150] The Commission's rules provided that an objecting pharmacist was allowed to deny delivery of prescription drugs as long as another pharmacist working for the pharmacy provided timely delivery of the drug.[151] The rules also required that a pharmacy deliver all prescriptions, even if the pharmacy owner religiously objected.[152] In *Stormans*, the owners of a Ralphs drugstore objected to delivering emergency contraceptives and challenged the Commission's rules under the First Amendment's Free Exercise Clause.[153] While the district court held that the rules violated the owners' free exercise of religion,[154] the court of appeals reversed and held that the rules were "neutral and generally applicable and that the rules rationally further[ed] the State's interest in patient safety,"[155] and therefore limited the applicability of the Free Exercise.[156]

Noesen and *Stormans* illustrate that the common layperson understanding of "religious freedom"—that the right to exercise religion or raise objections based on religion without limits—is a misconception. In the context of Title VII and *Noesen*, religious exercise is allowed and accommodated by the employer *to the extent* that it does not cause undue hardship on the employer.[157] In the general context of free exercise of religion raised in *Stormans*, the court held that the regulation was rationally related to a legitimate purpose, with the state's interest *outweighing* any individual religious objection to a valid and neutral law.[158] It is also appropriate to note here that, even with the RFRA, the government is pro-

145. *Id.*
146. *Id.*
147. Jesse C. Vivian, *The Crossroads Between Law and Science: Conscience Clauses*, U.S. PHARMACIST (Aug. 20, 2007), https://www.uspharmacist.com/article/the-crossroads-between-law-and-ethics-conscience-clauses.
148. *Id.*
149. 794 F.3d. 1064, 1064 (9th Cir. 2015).
150. Baker, *supra* note 35.
151. *Stormans*, 794 F.3d at 1071.
152. *Id.*
153. *Id.*
154. *Id.*
155. *Id.*
156. *Id.* at 1077.
157 *Noesen*, 232 F. App'x 581 at 584.
158. *Stormans*, 794 F.3d. at 1084.

hibited from burdening a person's exercise of religion *unless* imposing the burden would be for a compelling governmental interest and is done in the most limiting fashion.[159] So, while individuals and entities are entitled to the fundamental right to freely exercise whatever religious beliefs they have, they must realize that "free" does not mean "unlimited[,]" and that these beliefs are subject to properly imposed governmental limitations to serve the government's legitimate purposes.[160]

While *Noesen* and *Stormans* illustrated refusal rights' impact on the relationship between women seeking to obtain contraceptives and pharmacists (or pharmacy owners), two important issues found in the transgender religious healthcare context were not addressed (particularly in *Noesen*) because 1) the law in question affected women and not the transgender community, and 2) the employer in question was not a religiously exempt employer (which was why the *Noesen* court used Title VII's undue hardship clause to easily hold against the employee). Because these two issues were not addressed by *Noesen* and are not addressed in existing legislation, it still leaves room for doctors and hospitals to incorrectly claim religious freedom via conscience clauses to refuse treatment to transgender patients, especially in the states that allow refusal to anyone on any moral or religious ground. The current composition, structure, and administration of the healthcare system in the United States further facilitates the abuse, and thus, a closer look at the dangers of the current healthcare system must be analyzed in order to reveal the potential harm to transgender patients if no change is made.

B. Where is the "Care" in "Healthcare"?

Statistics show that transgender patients currently face discrimination in the healthcare context ranging from doctors refusing to treat them, to abuse and embarrassment in the examination room.[161] The growing presence of Catholic hospitals does not help their situation because of the conservative culture and religious restrictions set by these hospitals.[162] The increase in Catholic hospitals is due to recent mergers of secular and religious hospitals. If conscience clauses exempt healthcare workers from treating transgender patients, it poses a danger to transgender patients in three ways. First, in many merger cases, the old religious-sounding hospital name is abandoned and is replaced with a generic hospital name, providing a lack of notice to the patient of the hospital's religious affiliation.[163] Second, the number of rural areas where Catholic hospitals are the

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159. 42 U.S.C. § 2000bb-1 (2018).

160. *Stormans*, 794 F.3d at 1075 ("The right to exercise one's religion freely, however, 'does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religious prescribes (or proscribes).'").

161. Shawn Markus Crincoli, *Transgender Health Care & Religious Exemptions in Post-*Hobby Lobby *America*, SLIDESHARE (July 13, 2017), https://www.slideshare.net/petrieflom/shawn-markus-crincoli-transgender-health-care-religious-exemptions-in-posthobby-lobby-america.

162. *Religious Restrictions: Health Care for Lesbian, Gay, Bisexual and Transgender Persons*, MERGERWATCH, http://www.mergerwatch.org/lgbt-health-care/ (last visited May 27, 2020).

163. Hafner, *supra* note 59.

sole healthcare provider has also increased, putting patients in those areas more at risk of being denied treatment.[164] And third, transgender patients ultimately receive a lower standard of care when Catholic hospitals and doctors claim conscientious objections for their own self-interests rather than acting in the patient's best interest.[165] But before analyzing these three harms that would occur if conscience clauses are broadened to include transgender patients, it is important to note the current harms that transgender patients face.

1. *Current Harms that Transgender Patients Face*

Transgender patients are especially threatened when it comes to conscience clauses because they are at risk for being denied the most basic healthcare attention due to their transgender status. President Trump's recent introduction of the Conscience and Freedom Division in the Department of Health and Human Services ("HHS"), to enforce conscience clauses to the maximum extent possible poses a further threat to these patients.[166] Regarding President Trump's Division of Conscience and Freedom in HHS, Professor Steve Sanders, an associate professor at Indiana University Maurer School of Law, observes the following:

> Transgender people get colds, backaches, and cancer like everyone else. Will [the Conscience and Freedom Division's] new policy be so broadly written that a nurse might believe they can refuse to administer chemotherapy drugs to a patient who happens to be trans? Even if that is not the policy's intent, it is foreseeable that such humiliating incidents could occur.[167]

Even without the HHS's new policy in place, a survey showed that 28% of transgender patients postponed medical care when sick or injured because of discrimination,[168] 28% were subjected to harassment, and 2% were victims of violence in medical settings or doctors' offices.[169] If postponing medical care or incidents of harassment are not enough to illustrate the dangers that conscience clauses would increasingly impose on transgender patients, the survey indicated that 41% had attempted suicide because of transgender discrimination in the healthcare setting.[170] If these are the numbers that illustrate the discrimination that transgender patients already face without an extra enforcement from the government, the numbers can only be expected to grow higher if conscience clauses legally allow doctors to refuse treatment to transgender patients.

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164. Anna Maria Barry-Jester & Amelia Thomson-DeVeaux, *How Catholic Bishops are Shaping Health in Rural America*, FIVETHIRTYEIGHT (July 25, 2018), https://fivethirtyeight.com/features/how-catholic-bishops-are-shaping-health-care-in-rural-america/.

165. *See id.* ("In rural communities served by a dwindling number of hospitals, [religious] exceptions can mean that certain types of standard care aren't available at all.").

166. *See* RELIGIOUS REFUSALS IN HEALTHCARE, *supra* note 56.

167. Steve Sanders, *Commentary: 'Religious Liberty' Is Not an Excuse to Deny Transgender People Medical Care*, FORTUNE (Jan. 18, 2018, 2:38 PM), http://fortune.com/2018/01/18/transgender-health-medical-care-discrimination-religious-refused/.

168. Crincoli, *supra* note 161.

169. *Id.*

170. *Id.*

Much of the discrimination includes not only outright refusal of healthcare, but also instances wherein the doctor is uneducated about transgender health. In a 2015 U.S. Transgender Survey, 33% of respondents reported that they had experienced "being refused treatment, verbal harassment, physical or sexual assault, or having to teach providers how to give appropriate care."[171] In a separate survey conducted by the National Center for Transgender Equality and the National Gay and Lesbian Task Force, 50% of respondents reported that they had to teach their doctors about transgender identity.[172] This lack of knowledge stems from medical schools limiting the discussion of LGBTQ health to approximately five hours, with almost zero hours allocated during clinical training, inevitably leading to ignorance and harassment in the healthcare setting.[173]

In 2012, 138 Liaison Committees on Medical Education, accredited U.S. academic faculty practices, were invited to participate in a survey related to LGBTQ competency in hospitals and medical schools.[174] The survey response rate was 50%, and of the participants, only 9% had existing procedures or policies, such as online directories of self-identified LGBTQ-competent physicians, in place to identify these physicians.[175] Moreover, only three institutions reported having an explicit policy as well as a procedure to identify LGBTQ-competent healthcare physicians that were associated with their medical groups.[176] Finally, only 16% of participants reported to have a comprehensive LGBTQ-competency training and 52% reported having no training at all; 80% of participants, however, indicated interest to address these issues in the healthcare system.[177]

Given that a proposed solution to combat stigma of transgender patients is increased education on the issue,[178] a law allowing conscience clauses to extend to an already vulnerable population would have increased negative effects. Allowing conscience clauses to affect transgender patients would worsen the stigma that currently exists and would lower the standard of care even further. This is because the exemption would prevent hospitals and physicians from becoming educated on transgender healthcare since they would simply refuse to treat these patients instead. Allowing religion to intervene to deny patients healthcare is thus not only discriminatory but puts patients at a major health risk

171. Susmita Baral, *What It's Like Being Transgender in the Emergency Room*, NAT'L GEOGRAPHIC (Mar. 19, 2018), https://news.nationalgeographic.com/2018/03/transgender-health-emergency-rooms-training-hospitals-science/.

172. Sonya Vatomsky, *Why It's So Hard for Doctors to Learn About Transgender Health Issues*, CUT (Oct. 30, 2017), https://www.thecut.com/2017/10/why-its-so-hard-for-doctors-to-learn-about-trans-health.html.

173. Anna Goshua, *Medical Schools Aren't Preparing Doctors to Serve Trans and Non-Binary People*, BMJ OPINION (Nov. 23, 2018), https://blogs.bmj.com/bmj/2018/11/23/anna-goshua-medical-schools-arent-preparing-doctors-to-serve-trans-and-non-binary-people/.

174. Joshua Khalili et al., *Finding the Perfect Doctor: Identifying Lesbian, Gay, Bisexual, and Transgender-Competent Physicians*, 105 AM. J. PUB. HEALTH 1114, 1114. (2015).

175. *Id.*

176. *Id.* at 1118.

177. *Id.* at 1114.

178. Goshua, *supra* note 173.

by providing them with a lower standard of care.[179] Recent mergers of religious and secular hospitals further facilitate this harm.

2. *No More Notice of Religious Affiliation for Most Catholic Hospitals to Patients*

Recent mergers of Catholic and secular hospitals facilitate harm by not providing notice to patients of their religious affiliation. Mergers between Catholic and secular hospitals often result in the previously Catholic or religious-sounding hospital name to be abandoned and replaced by a secular, generic name.[180] While the hospital's name changes, the religious affiliation remains intact.[181] This results in patients in the community believing that the hospital closest to them is not religiously affiliated, causing them to make an appointment at the doctor's office in hopes of having a procedure done[182] only to be rejected by the physician on religious grounds.[183]

While it may be easy to access information about a hospital's services in today's day and age, hospitals have yet to provide information about their religious affiliation on their websites[184] or about the procedures that they specifically do not perform.[185] Hospitals are generally not required to inform patients of what services they do not provide.[186] In fact, only the state of Washington has a law that requires hospitals to provide information about what procedures are not performed at their hospital, and of all the hospitals in America, the only ones that provide this information are in Washington.[187]

So, while a reasonable patient would be expected to research their hospital and/or physician, it is still nearly impossible to know whether a patient will be denied healthcare because of a hospital's religious affiliation.[188] Furthermore, the fact that Catholic doctrine is interpreted by bishops on a case-by-case basis,

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179. Roughly 0.6 to 0.7% of the American population identifies themselves as transgender, and the rate of illness and death within this population is disproportionately high because of a reluctance to seek out emergency treatments and routine checkups over concerns about the quality of care they will receive. Baral, *supra* note 171.

180. Jocelyn M. Wascher et al., *Do Women Know Whether Their Hospital is Catholic? Results from a National Survey*, 98 CONTRACEPTION, 498, 498 (2018); Hafner, *supra* note 59.

181. Hafner, *supra* note 59.

182. *Id.* ("Many patients across the country are unaware that a hospital is Catholic to begin with. In a study published last year in the journal Contraception, researchers surveyed 1,430 women, and of those whose primary hospital was Catholic, 37% were not aware of the religious affiliation.").

183. *Id.* For example, "Angela Valavanis, 45, . . . was denied a tubal ligation following an emergency cesarean section at a Catholic hospital in Evanston, Ill." *Id.*

184. *See id. The New York Times* analyzed websites of 652 Catholic hospitals gathered from a list maintained by the Catholic Health Association; on nearly two-thirds of those websites, it took more than three clicks from the website's home page to determine whether the hospital was Catholic-affiliated. *Id.*

185. *See id.*

186. Barry-Jester & Thomson-DeVeaux, *supra* note 164.

187. Hafner, *supra* note 59 ("Under the Washington State law health systems must post their policies on reproductive and end-of-life care on their websites 'where it is readily accessible to the public, without requiring a login or other restriction.'").

188. *See* Wascher et al., *supra* note 180. Respondents were asked in the survey to identify whether their hospital was Catholic; two thirds of women misidentified their hospital as secular, and 48% of that group felt sure or very sure of their incorrect response. *Id.* at 498.

which ultimately influences what procedures can and cannot be performed at each hospital, makes it even harder for patients to know what services are not provided.[189] And while this may not be a great concern for patients living in large, metropolitan areas where non-religiously affiliated providers are likely to exist, the real danger lies in rural areas where there is only one hospital for that area and where patients do not have the option to access a hospital that will treat them.[190]

3. Nowhere to Go with No Options—Substantial Burdens Imposed on Transgender Patients in Rural America

With a vast number of rural hospitals being religiously affiliated and serving more people, tied together with rural areas being generally more conservative,[191] the combination of a rural area and a religiously affiliated hospital can be life-threatening to transgender patients and cause undue economic burdens if they are refused.

Recent data show that, while the number of Catholic hospitals has risen by 22% from 2001 to 2016, the actual total number of hospitals across the United States has decreased.[192] In the context of rural healthcare, many independent hospitals have faced financial difficulty,[193] leading to 130 rural hospitals closing from January 2010 to the present.[194] A community, rural hospital is defined as "any short-term, general acute, non-federal hospital that is . . . not located in a metropolitan county."[195] In 2011, twenty-nine rural communities had Catholic hospitals that solely served the area.[196] By 2016, forty-five communities relied solely on Catholic healthcare.[197] Out of all the *sole* hospitals that served the community in 2016 (459 hospitals), 10%, then, were religiously affiliated, and it is estimated that as of 2016 about one in four rural hospitals were religiously affiliated.[198]

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189. Barry-Jester & DeVeaux, *supra* note 164.

190. *Id*.

191. *See* Kim Parker et al., *Urban, Suburban and Rural Residents' Views on Key Social and Political Issues*, PEW RES. CTR. (May 22, 2018), http://www.pewsocialtrends.org/2018/05/22/urban-suburban-and-rural-residents-views-on-key-social-and-political-issues/.

192. Barry-Jester & Thomson-DeVeaux, *supra* note 164; Julia Kaye et al., *Health Care Denied*, AM. C. L. UNION 22 (May 2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

193. Barry-Jester & Thomson-DeVeaux, *supra* note 164.

194. *172 Rural Hospital Closures: January 2005 –Present (130 Since 2010)*, U. N.C. CECIL G. SHEPS CTR. FOR HEALTH SERVICES RES., http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (last visited May 27, 2020).

195. *Id.*

196. Barry-Jester & Thomson-DeVeaux, *supra* note 166. Another statistic from 2011 indicated that more than one-third of Catholic hospitals served in rural or underserved areas. Marcy Doderer, *Catholic Hospitals and the Safety Net*, AMA J. ETHICS (Aug. 2011), https://journalofethics.ama-assn.org/article/catholic-hospitals-and-safety-net/2011-08 (noting that many of those hospitals often provided a higher percentage of public health services such as dental care, crisis prevention, and cancer screening).

197. Barry-Jester & Thomson-DeVeaux, *supra* note 164.

198. *Id.*

In the context of abortion, the Supreme Court has upheld statutes that seem to put a burden on women, such as 24-hour waiting periods[199] or a state ban on abortions at public institutions,[200] stating that these statutes do not pose an undue burden on women and their ability to make reproductive decisions[201] or to receive abortions from a private institution.[202] According to the Supreme Court, "[a] burden may be 'undue' either because the burden is too severe or because it lacks a legitimate, rational justification."[203] Such decisions by the Supreme Court have made it difficult to present the "increased cost and potential delays" argument when challenging due process for conscience clause legislation related to abortions.[204]

In the context of pharmaceutical conscience clauses, however, it has been proposed that due process challenges could be more successful depending on the approach the Supreme Court will take in the future when measuring the burden placed on women in rural areas who are denied contraceptive drugs.[205] The first approach the Court may adopt is a more lenient "substantial burden" test, with courts interpreting this term as the affected party accruing "more than *de minimis* cost";[206] the second approach is a more stringent "significant difficulty or expense" standard.[207]

If the Supreme Court adopts the "substantial burden" test, lower courts will easily find most pharmacy conscience clauses unconstitutional because women will likely face increased costs because of pharmacist refusals.[208] Furthermore, women in rural areas will likely have increased expenses because of having to travel to another town to get their prescriptions filled, and even women in urban areas will have to spend additional time and money to find pharmacies to fill their prescriptions.[209]

The more stringent "significant difficulty or expense" standard may allow courts to find fewer pharmacy conscience clauses unconstitutional and only on a case-by-case basis.[210] But even then, scholars suggest that women in rural areas could argue that they face a "significant difficulty and expense" because they are forced to find pharmacists outside of their area.[211] Moreover, the women in these communities require public assistance to meet their prescription needs, which

199. *See*, *e.g.*, Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 886–87 (1992) (finding that even though a twenty-four hour waiting period would be "particularly burdensome" on women who had to explain where they were or did not have the resources to travel, the "increased costs and potential delays [did not] amount to substantial obstacles.").

200. Webster v. Reproductive Health Services, 492 U.S. 490, 512 (1989).

201. Duvall, *supra* note 43, at 1497.

202. *Webster*, 492 U.S. at 512.

203. *Planned Parenthood of Southeastern Pennsylvania*, 505 U.S. at 920.

204. Duvall, *supra* note 43, at 1497.

205. *Id.*

206. *Id.* at 1513.

207. *Id.* at 1514.

208. *Id.*

209. *Id.*

210. *Id.* at 1515.

211. *Id.* For example, in South Dakota, the population is 9.9 persons per square mile and many communities only have a single pharmacy. *Id.*

suggests that traveling to another town would impose even greater burdens.[212] And in the context of prescriptions, women face health risks from not receiving their prescription medications and prolonged medical care could further increase financial burdens.[213]

Given these two possible tests, if healthcare conscience clauses apply to transgender patients and if the Supreme Court were to decide on the constitutionality of such conscience clauses, transgender patients in rural areas would definitely meet the lenient "substantial burden" test for the same reasons that women in rural areas would meet this standard for prescription medication—traveling to another city to find another doctor would accrue "more than a *de minimis* cost." And if the Supreme Court were to adopt the more stringent "significant difficulty or expense" test, transgender patients will also likely meet that standard because refusing care to transgender patients would result in similar health burdens as denying women their prescribed medication. The increased number of Catholic-affiliated hospitals in rural areas makes it more likely that patients will be denied. Transgender patients would then incur increased expenses from having to travel to another town for treatment, and prolonged medical care could add more expense for these patients who may become more ill from not receiving preventative or necessary care—ultimately imposing an undue hardship on this population—and would render such conscience clauses unconstitutional. As a result, these hardships lower the standard of care offered to transgender patients since the quality of care they receive is not the same as what a cisgender patient would receive.

4. *The Result of Serving the Provider's Self-Interests over the Best Interests of the Patient*

Conscience clauses and religious exemptions often directly contradict with medical guidelines set forth by medical associations such as the American Public Health Association and the American Medical Association ("AMA") and prevent medical professionals from doing their jobs if objections are enforced by the employer.[214] Acting in "the best interests of the patient" is a commonly used phrase among the medical community.[215] But allowing conscience clauses to include transgender patients would mean that many doctors employed at Catholic hospitals, who individually have no moral objection to treating transgender patients, would make decisions against their personal judgment, thereby not acting in the best interests of the patient because of the institutions' own self-interest, and will be forced to provide a lower standard of care than usual.[216]

212. *Id.* at 1515–16.

213. *Id.* at 1516; *see also* NAT'L WOMEN'S L. CTR., *Combating Pharmacist Refusal Bills: Messaging*, Mar. 4, 2005 (showing that pharmacy refusals create more than an inconvenience on women but also create health implications that can be serious if emergency contraceptive prescriptions are not filled within seventy-two hours.).

214. *See* Barry-Jester & Thomson-DeVeaux, *supra* note 164.

215. *See, e.g.*, Norma J. Hirsch, *In the Patient's Best Interests—A Call to Action, A Call to Balance*, 18 BIOETHICS F. 24 (2002), https://practicalbioethics.org/files/members/documents/Hirsch_18_1_2.pdf.

216. *See* Barry-Jester & Thomson-DeVeaux, *supra* note 164.

Organizations such as the AMA have voiced their concerns regarding the recent mergers of hospitals, their affiliations with religion, and how they present obstacles to a patient's health options.[217] While there are many instances where doctors personally object to a certain procedure because of religious beliefs, many doctors are on the opposite end of the spectrum: they want to provide care to their patients but must refuse to give the best care possible because the hospital they work for is religiously affiliated.[218]

While current laws protect doctors and hospitals from objecting to a certain procedure on religious grounds and those protections are "enshrined in law[,]. . . the right to standard medical care is not."[219] Susan Berke Fogel, a director at the National Health Law Program, believes that religious exemptions are merely exceptions to standards that were set by the medical profession, and those standards exist to ensure that doctors give patients the best possible care.[220] She states that "[w]hat [religious hospitals] are getting is permission not to meet those standards."[221]

Again, the best examples of the standard of care being lowered in the religious healthcare context has been observed with women and reproductive care.[222] Numerous cases exist where women have been denied tubal ligations and C-sections during labor and emergency situations because the hospital had a policy against such procedures.[223] In some instances, women were subjected to prolonged miscarriages at Catholic hospitals because they were not informed of other safer alternatives.[224] In other instances, abortions were not allowed even if it meant that the fetus was no longer viable and put the mother at a major health risk.[225]

Religious objections in the healthcare context lower the standard of care by not considering the effect of third-party harm when a doctor raises a conscientious objection. Douglas NeJaime and Reva Siegel note that "complicity-based conscience claims differ in *form* . . . from the claims featured in the free exercise cases RFRA invokes."[226] They recognize that these complicity-based conscience claims made by objectors may be just as authentic as any other claim of faith protected by the RFRA, but the differences in form and logic are significant because "they amplify the material and dignitary harms that accommodation of the claims can inflict on other citizens."[227] Complicity-based claims differ in form

217. Susan Berke Fogel & Lourdes A. Rivera, *Religious Beliefs and Healthcare Necessities: Can They Coexist?*, ABA (Apr. 1, 2003), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/human_rights_vol30_2003/spring2003/hr_spring03_religiousbeliefs/.

218. Barry-Jester & Thomson-DeVeaux, *supra* note 164.

219. *Id.*

220. *Id.*

221. *Id.*

222. *See id.*; Fogel & Rivera, *supra* note 217.

223. Barry-Jester & Thomson-DeVeaux, *supra* note 164.

224. *See id.*

225. *Id.* In a specific case, a nun was excommunicated after allowing an abortion for a woman who, according to her physicians, had a "close to 100 percent" chance of dying. *Id.*

226. NeJaime & Siegal, *Conscience Wars*, *supra* note 3, at 2520 (emphasis added).

227. *Id.* at 2519–20.

from the original general religious objections made under the RFRA because those claims were by religious minorities who sought exemptions for unconventional beliefs unknown to lawmakers when the challenged laws were adopted, and the costs of accommodating such claims were minimal and widely shared.[228] Claiming a simple religious objection is not as clear in the healthcare setting when it involves third parties and not just the religious rights of the claimant-objector.[229] Yet, the law continues to protect the doctors who refuse transgender patients without considering the harms imposed on transgender patients and providing no protection to them for such harms.[230] Thus, legally allowing conscience clauses to include transgender patients means that they will easily be denied the normal standard of care that other cisgender patients otherwise receive.[231]

Despite the vast array of problems that encompass reproductive care, transgender patients are still a distinct category. Professor Sanders believes that "religious exemption[s] for participating in an abortion is more understandable, given that an employee could be forced into performing a procedure that they see as the taking of a life."[232] Nevertheless, he states, "it is unclear what legitimate objection a health care worker could have to treating a transgender person."[233] As Professor Sanders discussed the potential impact of the Trump administration's new Conscience and Freedom Division under the HHS, he indicated that there can be no clear way of proving whether one's religious beliefs provide an objection to treat a transgender person or whether one simply has a phobia toward transgender people.[234]

While personal and religious beliefs of institutions and individuals are important, medical ethics indicate that doctors should serve the best interests of the patient,[235] and the laws for providing healthcare should be reflective of those standards. The Supreme Court's recent decision in *Masterpiece Cakeshop v. Colorado Civil Rights Commission* provides some general rules and insight as to

228. *Id.* at 2520.

229. *See id.*

230. *Id.* at 2535.

231. Sanders*, supra* note 167.

232. *Id.*

233. *Id.*

234. *Id.*

235. *AMA Code of Medical Ethics: AMA Principles of Medical Ethics*, AM. MED. ASS'N (June 2001), available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf. The preamble of the AMA Code of Medical Ethics provides that "[a] physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights" and that "[a] physician shall respect the law and *also recognize a responsibility to seek changes* in those requirements *which are contrary to the best interests of the patient.*" (emphasis added). *Id.* An AMA Council on Ethical and Judicial Affairs opinion states that a physician is ethically allowed to refuse to enter into a physician-patient relationship when "a specific treatment sought by an individual is incompatible with the physician's personal, religious or moral beliefs." Kevin B. O'Reilly, *Broader Conscience Clauses Would Expand Physicians' Right of Refusal*, AM. MED. NEWS (Mar. 6, 2006), https://amednews.com/article/20060306/profession/303069967/2/. The problem with current conscience and refusal laws is that doctors are allowed to refuse without referring the patient to another hospital or physician and are not required to provide information on alternative sources, leaving tension between the duty to provide competent medical care and the right to refuse. *See* NeJaime & Siegel, *Conscience Wars*, *supra* note 3, at 2566–67. This discussion is elaborated at *infra* Part III.C.

how the issue of gender identity and sexual orientation discrimination could be approached in public accommodation settings such as hospitals.

*C. Accommodate Through Cake—*Masterpiece Cakeshop*'s Guidance on LGBTQ Public Accommodations*

The Supreme Court's decision in *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission*[236] was only a small victory for conservative citizens who oppose gay marriage and the advancement of LGBTQ rights. While the holding in favor of the cakeshop owner whose religious beliefs prompted him to deny a cake to a gay couple seems to sway toward protecting religious beliefs and conscientious objections, it is important to note at the outset that the decision of the Court was not about the Colorado Civil Rights Commission granting religious exemptions to a cakeshop owner.[237] Rather, its holding was on the narrow issue of the Commission's failure to consider and review the cakeshop owner's claim in a neutral and respectful manner.[238] A true understanding of the Court's opinion would acknowledge the Court's guidance as to how future disputes about LGBTQ rights and religion should be handled,[239] and that overly expansive exemption rights are not likely to be well-received.

Long before *Masterpiece Cakeshop*, advocates for religious exemptions tried to distinguish exemptions for laws that prohibit discrimination based on sexual orientation from exemptions for laws that prohibit racial discrimination.[240]

Advocates of this position have tried to create this distinction by attempting to analogize exemptions for LGBTQ discrimination to exemptions for performing abortions[241] since that would mean the objectors would legally be excused from a law that prohibits discrimination against the LGBTQ community by citing religion.[242] LGBTQ advocates, however, have attempted to argue that LGBTQ discrimination is analogous to racial discrimination, which has been prohibited in public accommodations through Title II.[243] The Supreme Court rejected the LGBTQ-abortion analogy in *Masterpiece Cakeshop* by stating that the "general rule" is that religious objections "do not allow business owners and other actors in the economy and in society to deny protected persons equal access to goods and services under a neutral and generally applicable public accommodations

236. 138 S. Ct. 1719 (2018).
237. NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 201.
238. *Id.* at 202.
239. *Id.* at 210.
240. *Id.* at 205.
241. *Id.* at 206.
242. *See id.*
243. *See id.* at 205.

law."[244] By doing so, the Court seems to have been more accepting of the argument that LGBTQ discrimination is more analogous to racial discrimination in public accommodations and should thus be prohibited.[245]

By rejecting the LGBTQ-abortion analogy, the Supreme Court has adopted a single public accommodations framework where the government "can protect gay persons, just as it can protect other classes of individuals, in acquiring whatever products and services they choose on the same terms and conditions as are offered to other members of the public."[246] The Court has decided to treat "lesbian and gay individuals as full members of the national community deserving of equal protection from discrimination,"[247] even though federal law technically does not prohibit discrimination based on sex or gender identity in the public accommodations context.[248]

More importantly, the Court did not view the issue in *Masterpiece Cakeshop* as one that must support either a pro-gay or anti-gay view, but rather approached the issue in light of pluralism by balancing the views between the party who objects to gay rights and the party who does not share the objectors' beliefs.[249] In its closing passage, the Court embraced and addressed the concerns of pluralism by advising to resolve future disputes "without undue disrespect to sincere religious beliefs, and without subjecting gay persons to indignities when they seek goods and services in an open market."[250]

In *Masterpiece Cakeshop*, the Court recognized and reinforced that the government has compelling interests in enforcing antidiscrimination law;[251] these compelling interests include "integrating marginalized groups and protecting them against stereotypes and stigma."[252] Furthermore, the Court recognized that these government interests include protecting marginalized groups from stigma resulting from refusals.[253] This government interest offers a reason to "confine" exemptions to prevent "a community-wide stigma inconsistent with the history and dynamics of civil rights laws that ensure equal access to goods, services, and public accommodations."[254]

After *Masterpiece Cakeshop*, tension exists between this antidiscrimination regime adopted by the Court regarding sexual orientation and LGBTQ rights in

244. Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n, 138 S. Ct. 1719, 1727 (2018); *see also* NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 208.

245. *See* NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 208.

246. *Masterpiece Cakeshop*, 138 S. Ct. at 1728.

247. NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 208.

248. *Know Your Rights, supra* note 79.

249. NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 224.

250. *Masterpiece Cakeshop*, 138 S. Ct. at 1732.

251. NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 214.

252. *Id.*

253. *Id.*

254. *Masterpiece Cakeshop*, 138 S. Ct. at 1727; *see also NeJaime & Siegel, Religious Exemptions*, *supra* note 18, at 215.

the healthcare context.[255] In *Masterpiece Cakeshop*, the Court focused on "material and dignitary harms" to third parties which the antidiscrimination tradition is used to limit,[256] echoing the concerns made in *Burwell v. Hobby Lobby Stores* and *Zubik v. Burwell* about the impact of religious accommodations on other citizens protected by the law who did not share the objector's beliefs.[257] Both *Hobby Lobby* and *Zubik* involved employers who refused to provide employees with insurance coverage that included contraception and who sought exemptions under the RFRA.[258] Notably, in *Zubik*, the Supreme Court issued a *per curiam* order and remanded the case with instructions, stating that the parties should have "an opportunity to arrive at an approach going forward that accommodates petitioners' religious exercise while at the same time ensuring that women covered by petitioners' health plans receive full and equal health coverage, including contraceptive coverage."[259]

By emphasizing such harms to third parties, the *Masterpiece Cakeshop* Court recognized the government's potential interest in *preventing* exemption laws that would undermine these objectives.[260] But in healthcare refusal and conscience clause laws, the government *authorizes* hospitals and doctors to refuse care without any consideration of harm to third parties.[261] Conscience clauses and healthcare refusals do not consider the balance discussed in *Masterpiece Cakeshop* between respecting religious liberty and ensuring appropriate limitations to prevent material and dignitary harm on third parties.[262] Although religious exemptions in the healthcare context were discussed before the Court in *Hobby Lobby* and *Zubik* several years prior to *Masterpiece Cakeshop*, laws have yet to reflect the Court's guidance.[263]

Given that the Supreme Court has taken the view that public accommodation law is to provide equal access while balancing the religious accommodation and appropriate limitations to prevent material and dignitary harm on a third party, conscience clauses and refusal laws should not be applicable to the LGBTQ community. Legislators, hospitals, and doctors should follow the Supreme Court's guidance to provide the same healthcare services to all members of the community and to ensure equal access to all patients.

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255. NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 208 (recognizing that "[t]he antidiscrimination regime into which the Court assimilates sexual orientation stands in stark contrast to the healthcare refusal statutes regulating abortion and contraception that few courts have reviewed.").

256. *Id.; see also Masterpiece Cakeshop*, 138 S. Ct. at 1727. *See generally* NeJaime & Siegel, *Conscience Wars*, *supra* note 3, at 2516.

257. Zubik v. Burwell, 136 S. Ct. 1557, 1560 (2016); Burwell v. Hobby Lobby Stores, 573 U.S. 682, 735–36 (2014); *see* NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 216; NeJaime & Siegel, *Conscience Wars*, supra note 3, at 2529–30

258. 136 S. Ct. 1557 (2016); 573 U.S. 682 (2014).

259. 136 S. Ct. at 1560.

260. *See generally* NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 203.

261. *Id. See also* NeJaime & Siegel, *Conscience Wars*, *supra* note 3, at 2566–67 (discussing that some refusal laws do not require a doctor or nurse to treat a patient even in an emergency situation, and other refusal laws allow healthcare institutions and workers to refuse to provide referrals, counseling, or other alternative care information).

262. NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 217.

263. *Id.*

IV. Recommendation

Two general categories of recommendations are presented in this Section. First, statutory reform is necessary at both the federal and state levels. These reforms should include an explicit list of services and groups of people that can be refused by hospitals, or at least provide access to information and referrals to patients who are refused treatment. The second recommendation addresses the healthcare system by proposing educational programs within hospitals for doctors and nurses to lessen the stigma and discrimination surrounding transgender patients, and to hopefully provide transgender patients the same standard of care provided to cisgender patients.

A. Statutory Reforms

Because of the varying degree of protections in conscience clauses between states, statutory reform at the federal level is necessary to provide transgender patients equal access to healthcare so that states have a uniform, baseline standard they can adopt. As the Supreme Court indicated in *Masterpiece Cakeshop*, issues of public accommodation and religious rights must be balanced**,** and anti-discrimination issues such as these should be addressed at the federal level to ensure equal access to healthcare for all persons in the United States regardless of the state they reside in.

1. Federal Statutory Reform Explicitly Prohibiting Healthcare Providers and Physicians from Discriminating Based on Sexual Orientation and Gender Identity

As stated before, conscience and refusal clauses were first used in the healthcare context regarding healthcare workers who had religious objections to abortions and providing contraceptives for women.[264] The reason why conscience clause enforcements are now expanding to transgender patients is because of broadened protections at the state level.[265] Most of the conscience clause legislation at the state level is based on federal legislation addressing abortion and reproductive health services.[266] This has led to a disarray in conscience clause legislation throughout the country where some states have decided to allow refusal on any ground for any service, resulting in zero uniformity or assurance that patients have access to the same quality of healthcare.[267]

To ensure uniformity among the states, a generally applicable federal law prohibiting healthcare providers and physicians from discriminating on the basis of gender identity and sexual orientation should be passed. As seen with the ACA, this is not a difficult task to accomplish; the ACA explicitly prohibits any sex

264. Marshall, *supra* note 20.
265. *See supra* Section III.A.1.
266. *See supra* Section III.A.1.
267. *See supra* Section III.A.1.

discrimination in a hospital or health program that receives federal funds.[268] And in such cases, the U.S. Department of Health and Human Services issued regulations explaining that this prohibition on sex discrimination extends to claims based on gender identity and sex stereotyping.[269] The problem with the ACA's provision is that it only applies to healthcare programs or hospitals that receive federal funding, leaving many private healthcare providers, and thus Catholic hospitals, free to discriminate without violating the ACA.[270] By having no conditions and a generally applicable rule to serve the population, transgender patients throughout the country will have at least the same basic level of care provided to them regardless of the state they reside in.

While states may argue that this raises federalism concerns and prohibits them from creating laws to govern their own jurisdictions, this would not be the first time that federal law has intervened to provide equal protections in the context of public accommodations. Title II of the Civil Rights Act was passed in response to the issue of discrimination based on race in public accommodations.[271] Further, *Masterpiece Cakeshop* encouraged a generally neutral public accommodations law which does not discriminate based on gender identity or sexual orientation.[272] States can, and should, modify the legislation implemented by the government to provide more protections if they so desire, but the new federal legislation should at least set the floor for what the protections should be.

Individual physicians and hospitals may argue that their ability to freely exercise their religious beliefs no longer exist under such a proposed law. These arguments, however, are likely to hold no merit. Under the RFRA, the government is prohibited from interfering with an individual's exercise of religion unless the government demonstrates a compelling interest.[273] Equal access has been held to be a compelling governmental interest in the past. Furthermore, the issue of supposedly not being able to freely exercise one's religion has already been addressed in the healthcare context in *Hobby Lobby* and *Zubik*, in which the Supreme Court emphasized that religious objections should be accommodated without causing third party harm.[274] In all cases of refusing to treat transgender patients, there is third party harm.

2. *Alternative Federal Law Allowing Individual Physician Refusal as Long as Another Willing Physician is Present to Provide Care*

In the event that the first proposed reform is too radical for hospitals and physicians to accept, another approach is to pass a similar law as the regulation

268. 42 U.S.C. § 18116 (2018).

269. Protecting Statutory Conscience Rights in Health Care, *supra* note 58.

270. 42 U.S.C. § 18116(a) (2018).

271. *Title II of the Civil Rights Act (Public Accommodations)*, DEPT. JUST. (Aug. 6, 2015), https://www.justice.gov/crt-22.

272. Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n, 138 S. Ct. 1719, 1727 (2018).

273. Religious Freedom Restoration Act of 1993, 42 U.S.C. § 2000bb(a)(3) (2018).

274. NeJaime & Siegel, *Religious Exemptions*, *supra* note 18, at 204.

in Washington which requires all pharmacies to dispense emergency contraceptives regardless of the pharmacy owners' religious or moral beliefs. *Stormans Inc. v. Wiesman*[275] illustrates that a balance between equal protection and religious rights is possible, and this idea was further emphasized in *Masterpiece Cakeshop*.[276] While the regulation in *Stormans* was directed toward pharmacies,[277] similar legislation could be written in the context of hospitals that requires them, despite their religious affiliation, to treat all patients.[278] The law can provide that hospitals must not discriminate on the basis of gender identity, but doctors may refuse to provide treatment as long as there is one doctor that is willing to provide treatment.

This approach, of course, would require hospitals to check and ensure that there is at least one person in each department willing to provide care at any given time of the day. This solution may create more work for hospitals to implement this system and hospitals may claim that this accommodation presents an undue hardship. But hospitals are in a better position to take on the burden because of their access to information; surveys may be conducted asking which employees feel comfortable providing care to transgender patients, and future employees may be asked through the interview process. By doing so, transgender patients are ensured that at least one person in a hospital is willing to attend to them without burdening the patient with having to frantically choose a different hospital. Additionally, as the 2012 Liaison Survey[279] indicated, some hospitals have already begun to implement a self-identifying LGBTQ-competent physician directory on their websites, demonstrating that gathering and providing this information is not a difficult task. Finally, this approach also embraces the Supreme Court's dicta from *Masterpiece Cakeshop* by abiding by the "general rule" that religious objections do not allow businesses and other actors in the economy to discriminate under a general public accommodations law.[280]

3. *Introduce Federal Law that Prompts Religiously Affiliated Hospitals to Clearly Provide Service Information on Websites and Other Informative Media*

The likely problem with the first and second recommendations is that both would require a bipartisan approach in the House and Senate on an issue that is admittedly politically divisive. This can be very difficult to achieve, and thus, while the first recommendation is the easiest way to solve the issue at-large, and the second recommendation is the most ideal, both may be difficult to implement because it requires political agreement to not include transgender patients under the umbrella of conscience clause enforcement or to systemically require all entities to provide healthcare.

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275. 794 F.3d. 1064 (9th Cir. 2015).
276. 138 S. Ct. at 1732.
277. 794 F.3d. at 1071.
278. *See id.*
279. *See supra* Section III.B.1.
280. Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n, 138 S. Ct. 1719, 1727 (2018).

Thus, another solution would be to introduce legislation to encourage healthcare entities to provide accessible information to the public on what services are or are not provided and to require hospitals, or to require doctors who do refuse patients to at least refer them to another source or provide information on alternative treatment. This solution may be a compromise to members of Congress who do not want to explicitly exclude transgender patients from conscience clause enforcement as it would leave current conscience and refusal clauses as-is, allowing healthcare entities and doctors to exercise their religious liberty and refuse patients, but would require these entities to at least provide clear notice on their websites about their services, and referrals or alternative care options in the case of a refusal.

By doing so, this solution takes into consideration the material and dignitary harms of the third party that the Supreme Court emphasized in *Hobby Lobby, Zubik*, and *Masterpiece Cakeshop*.[281] The solution would mitigate the harm of patients who do not know what services are not provided at the hospital and reduce the chance of being rejected after seeking out services.[282]

As stated before, 3% of Catholic hospitals provide information on what procedures are prohibited at their hospital, and all of those hospitals are located in Washington because of state legislation that requires the state to do so.[283] State governments should also prompt hospitals to provide such information so that patients are better informed overall about where to go in case they are in need of healthcare.

The weakness of this recommendation, however, is that it does not address the ever-growing problem of Catholic hospitals being the sole community health provider in rural areas, meaning that transgender patients in these areas still face the burden of finding another hospital. But the implementation and enforcement of such a law will at least ensure that transgender patients in rural areas with only one Catholic hospital will be informed and have a reference to where to go for alternative treatment. Also, making this information accessible online provides a chance for the patient to plan ahead and know which hospital to go to if it requires commuting to a different town or city instead of facing the uncertainty of potentially being rejected from hospital to hospital during a time when he or she needs care.

B. Encouraging and Promoting Transgender Health Education in the Healthcare System

Statutory reform merely calling for doctors and hospitals to accept these patients is not enough. A doctor or hospital could say they are complying with newly reformed legislation by simply admitting the patient without providing the

281. *See generally id.* at 1719; Zubik v. Burwell, 136 S. Ct. 1557 (2016); Burwell v. Hobby Lobby Stores, 573 U.S. 682 (2014).

282. *See* Hafner, *supra* note 59 (describing a woman who was informed too late after being admitted to the hospital and hooked up to an intravenous magnesium sulfate that the doctor could not provide a tubal ligation).

283. *Id.*

same level of care or attention as they would to a cisgender patient. Thus, a cultural change within the healthcare community is also necessary to ensure transgender patients receive the same standard of care as cisgender patients.

In the Liaison Survey mentioned above, the survey directors discuss that "[e]ffective training of physicians is a key component of cultural competency," and that healthcare provider competency changes physician behavior, which in turn leads to better patient outcomes.[284] Thus, reform should start from the very beginning of a doctor's education in medical school. Schools should re-evaluate their curricula to devote more time to educating doctors on the intricacies of transgender health and how to establish a comfortable and safe doctor-patient relationship in order to decrease the stigma surrounding transgender patients.

Informing doctors of their legal rights and the rights of their patients may also combat stigma. As part of this curriculum change, schools can invite guest law lecturers to better inform students and current doctors on their legal rights and the potential consequences of refusing patients. As seen in *Noesen*, the common understanding of conscience clauses by medical professionals is that they can claim religious objection to any duty at any time.[285] Implementing legal awareness on this issue will lead doctors to understand that refusing to treat a patient based on religious or moral grounds does not just involve their own rights but also affects the rights of a third party. While this solution would not force doctors to change their religious or moral beliefs, the hope is that a legal seminar or lecture in which doctors are encouraged to think about the rights of others will prevent discriminatory behavior by training them to appropriately and respectfully object on conscientious grounds.

For healthcare workers already in practice, hospitals should also implement training for doctors and staff to help them become more competent on LGBTQ health related issues. This training should be provided to all hospital doctors, nurses, and physicians, to educate them on respectful ways to direct patients to other doctors or staff who do not have conscientious objections to treating transgender patients. While this approach is not, on its face, a full legal solution to solving the issue of transgender discrimination in the healthcare setting, it may be the most effective solution to change policy in the long run. While changes may take a long time to implement and adopt because they require an industry to shift from the current norm to an unfamiliar culture, given that 16% of hospitals have implemented LGBTQ-trainings within their institutions in 2012,[286] and that hospitals since then have been encouraged to implement such trainings, change is happening. The goal with this approach is not necessarily to change the law per se but to develop a positive and consistent healthcare provider culture where transgender patients will not be discriminated against. By doing so, this solution addresses the *Masterpiece Cakeshop* Court's view to prevent "a community-

284. Khalili et al., *supra* note 174, at 1118.

285. *See generally* Noesen v. Med. Staffing Network, Inc., 232 F. App'x 581 (7th Cir. 2007).

286. Khalili et al., *supra* note 174, at 1118.

wide stigma inconsistent with the history and dynamics of civil rights laws that ensure equal access to goods, services, and public accommodations."[287]

If, however, a legislative change is needed, a growing cultural change within the medical community may potentially influence the American Medical Association—which is deeply involved in national advocacy and influencing healthcare legislation[288]—to push for a legal standard in the healthcare context which would encourage hospitals and medical schools to implement a substantive curriculum on transgender health education and training. A unified call from a reputable organization consisting of doctors from all over the country would hopefully influence the industry by prompting and encouraging all hospitals and doctors to provide the same standard of care to ensure equal access to all groups of people.

V. CONCLUSION

For years, federal conscience clauses have given healthcare providers and doctors blanket protections for refusing to treat patients for reproductive health by citing religion. These provisions, however, are conscience clauses designed to protect healthcare workers and hospitals from those explicit procedures. With some states beginning to broaden the scope of conscience clauses to make them applicable to transgender patients, religious providers and doctors are now given the opportunity to mindlessly cite religion so that they may be excused from treating transgender patients. Many of these patients are now at risk and out of accessible healthcare, especially in parts of rural America as mergers with Catholic hospitals continue to rise. Not only do these broad conscience clauses put transgender patients at risk, they also provide an opportunity for doctors and providers to serve their own self-interests and become excused from standards of care set forth by nationally established medical associations, ultimately causing transgender patients to receive a lower standard of care.

As federal laws such as Title II, Title VII, and the RFRA have shown, religious freedoms are not unlimited in the context of public accommodations, the workplace, and when there is a compelling governmental interest. The healthcare context encompasses all three of these legal provisions, and each supports a narrow application of conscience clauses. In the context of healthcare refusals, the religious rights of the objector must be considered against the third-party harm that the objector imposes on those who do not share the objector's beliefs.

The Supreme Court has given guidance as to how protections of the LGBTQ community should be approached through its opinion in *Masterpiece Cakeshop*. The Court encourages the use of a general public accommodations law and has discouraged the idea that refusing to accommodate an LGBTQ individual is analogous to religious exemptions to abortions. Consequently, the Court has seemingly accepted the idea that discrimination based on sexual orientation

287. Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n, 138 S. Ct. 1719, 1727 (2018).
288. *See Grassroots Advocacy*, AM. MED. ASS'N, https://www.ama-assn.org/health-care-advocacy/access-care/grassroots-advocacy (last visited May 27, 2020).

is more analogous to discrimination based on race and should therefore be approached in a similar fashion in public accommodations. Public accommodations would thereby include hospitals and physicians who provide healthcare services to the public.

In order to ensure equal access to all transgender patients, a uniform federal law is required to fix the disarray of conscience clause legislation among the states—whether it be a federal law which prevents refusal as a whole, requires hospitals to provide healthcare while physicians individually refuse, or requires hospitals and physicians to simply provide notice to the public on what services are not performed and where to find such care—to provide a protective floor to transgender patients. A cultural change within the healthcare system is also necessary to address the discriminatory behavior against transgender patients and to relieve the stigma that surrounds them. By implementing a general healthcare public accommodations law and by encouraging cultural change within the healthcare community, the hope is to ensure that transgender patients will receive the respect and the care they are entitled to receive by providing equal access to healthcare.