PEPPERDINE UNIVERSITY

Pepperdine Law Review

Volume 48 | Issue 1 Article 13

2-10-2021

The Right to Conscience vs. The Right to Die: Physician-Assisted Suicide, Catholic Hospitals, and the Rising Threat to Institutional Free Exercise in Healthcare

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Abstract

An imminent conflict is developing between religious healthcare institutions opposed to physician-assisted death (PAD) and their healthcare employees who wish to offer PAD to their patients. When these interests clash, institutional conscience claims must prevail over doctors' desires and patients' demands.

This article catalogues the incomplete patchwork of conscience protections guaranteed to American healthcare workers and institutions, as well as the swiftly accelerating wave of PAD legalization sweeping the states. The article documents the tactical vocabulary—deployed with nearly identical language in every state PAD statute—that conspicuously anticipates conscience objections from the massive, and staunchly anti-PAD, Catholic healthcare system. Notably, in each state with legalized PAD, if a healthcare employee wishes to administer PAD to a patient, statutory loopholes render employing hospitals powerless to object on the basis of institutional conscience.

Finally, the article proposes a solution to this free exercise threat. In Hosanna-Tabor *and* Our Lady of Guadalupe*, the Supreme Court recognized that religious institutions have a First Amendment right to hire and fire employees who personify their beliefs, free from government interference. The Court has expressly declined to limit the scope of this right, but it has strongly indicated that the proper approach requires deference to the religious institution itself to define which employees personify its beliefs. Because healthcare workers personify the central Catholic mission of healing the sick, Catholic hospitals must be permitted to employ only healthcare employees willing to honor the Church's sincere beliefs about certain medical practices, such as PAD, that violate Catholic institutional conscience.*

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I. INTRODUCTION

> *"I swear by Apollo . . . that I will fulfill according to my ability and judgment this oath and this covenant. . . . I will keep [the sick] from harm and injustice. I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. . . . In purity and holiness I will guard my life and my art."*
>
> —From the original text of the Hippocratic Oath[1]

The Hippocratic Oath was not a common feature of medical school graduation ceremonies until after World War II, when international outrage over physician involvement in Nazi war crimes provoked a heightened focus on medical ethics.[2] Today, while nearly every U.S. medical school requires a recitation of some version of the Oath before graduates may obtain their degrees, the text of the Oath has evolved considerably in the decades since its rise to prominence.[3] The appeal to Apollo has been consigned to ancient history, along with, usually, the Oath's unequivocal prohibition against physician-assisted death (PAD).[4] This age-old edict preventing doctors from killing their patients has fallen victim to the progressive whims of modern culture, a development which perfectly symbolizes the ongoing erosion of the medical field's ethical foundation in recent decades.[5] Untethered from any consistent ethical position regarding morally contentious procedures like PAD, modern healthcare workers who affirm PAD may validly arrive at differing moral conclusions from their peers who oppose PAD, and—of particular concern here—from the religious hospitals employing them.[6]

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1. LUDWIG EDELSTEIN, *The Hippocratic Oath: Text, Translation and Interpretation*, *in* ANCIENT MEDICINE: SELECTED PAPERS OF LUDWIG EDELSTEIN 3, 6 (O. Temkin & C.L. Temkin eds., Johns Hopkins Univ. Press 1967).

2. Howard Markel, *"I Swear by Apollo"—On Taking the Hippocratic Oath*, 350 NEW ENG. J. MED. 2026, 2026 (2004).

3. Dale C. Smith, *The Hippocratic Oath and Modern Medicine*, 51 J. HIST. MED. & ALLIED SCI. 484, 484–500 (1996).

4. Markel, *supra* note 2, at 2027. In 1993, only fourteen percent of Hippocratic Oaths administered in U.S. medical schools prohibited PAD. *Id.* For a discussion of the terminology of PAD, see *infra* note 37.

5. Markel, *supra* note 2, at 2027–28.

6. *See* Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 FORDHAM URB. L.J. 221, 221 (2002) ("In our morally diverse world, conscientious persons may come into conflict with each other and with society's moral val-

This article argues that conscience claims must always prevail when that struggle unfolds,[7] from the individual conscience of a single, anti-PAD healthcare worker to the institutional conscience of an entire anti-PAD hospital system.[8] Part II provides background for the issue by cataloguing the ever-evolving patchwork of "conscience protections" guaranteed to American healthcare workers as well as the swiftly accelerating wave of PAD legalization sweeping the states. Part III captures the threat posed by current PAD laws, forecasting the perfect storm brewing as a result of the massive, and staunchly anti-PAD, Catholic presence in the healthcare market clashing with two conspicuous and highly problematic loopholes currently embedded in every state statute legalizing PAD. Part IV argues that Catholic healthcare institutions can and should use the "ministerial exception" to terminate healthcare workers who defy their beliefs on PAD. Finally, Part V summarizes and concludes.

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ues. Except for the amoral sociopath, conflicts of conscience are a regular feature of the moral life.").

7. As a purely legal matter, the First Amendment protects the free exercise of "religion," not "conscience." *See infra* notes 9 and 10 and accompanying text. However, the Supreme Court has recognized, in a series of Vietnam War-era "conscientious objector" cases, that the protection of the religion clauses extends to "conscience claims" stemming from non-religious philosophical beliefs. *See, e.g.*, United States v. Seeger, 380 U.S. 163, 166 (1965) (finding conscience protection for belief in "goodness and virtue for their own sakes, and a religious faith in a purely ethical creed"); Welsh v. United States, 398 U.S. 333, 340, 343 (1970) (finding conscience protection for opposition to war based on "moral, ethical, or religious beliefs about what is right and wrong" where beliefs are "held with the strength of traditional religious convictions"); *see also* Michael Stokes Paulsen, *The Priority of God: A Theory of Religious Liberty*, 39 PEPP. L. REV. 1159, 1200 (2013) ("The logic of [*Seeger* and *Welsh*] is that any serious accommodation of religious conscience constitutionally must embrace analogous claims of non-religious conscience.").

8. *See* Pellegrino, *supra* note 6, at 227–28 ("To act against the dictate of conscience is to act against natural law—that portion of divine law accessible to human reason. . . . Often, to act against conscience is to violate personal identity so directly as to lead to severe psychosocial and emotional sequelae."). Because individual consciences are protected under every state PAD law, this article will focus on the serious threat to institutional consciences in the healthcare system, arguing that they must preserve their religious liberty by invoking their right to institutional free exercise. *See infra* Part IV. For a comprehensive overview of the history and doctrine of institutional free exercise, see Douglas Laycock, *Towards a General Theory of the Religion Clauses: The Case of Church Labor Relations and the Right to Church Autonomy*, 81 COLUM. L. REV. 1373, 1388–1414 (1981). For in-depth analysis of different theoretical justifications for institutional free exercise, see John Infranca, *Institutional Free Exercise and Religious Land Use*, 34 CARDOZO L. REV. 1693, 1718–26 (2013) (proposing and expounding on intrinsic, derivative, and pragmatic justifications).

II. STATE OF THE LAW: CONSCIENCE AND PAD

A. The Fight for Medical Freedom of Conscience

When the United States House of Representatives drafted the First Amendment and offered it to the Senate for review, their suggested bundle of religious freedoms included a "Conscience Clause" alongside the two religion clauses Americans know and love today: "Congress shall make no law establishing religion, or prohibiting the free exercise thereof; *nor shall the rights of conscience be infringed*."[9] After considerable debate over the issue, the Senate ratified the First Amendment without the House's third religion clause,[10] but the debate over "the rights of conscience" had only just begun, and continues to this day.[11]

Conscience is difficult, but not impossible, to define apart from religion.[12] It is a universal faculty, an innate, human instinct that links human

9. S. JOURNAL, 1ST CONGRESS, 1ST SESS. 63 (1789) (emphasis added). This draft reflects James Madison's initial proposal for the religion clauses, which he suggested inserting into the Constitution itself:

> That in article 1st, section 9, between clauses 3 and 4, be inserted these clauses, to wit: The civil rights of none shall be abridged on account of religious belief or worship, nor shall any national religion be established, nor shall the full and equal rights of conscience be in any manner, or on any pretext, infringed.

1 ANNALS OF CONG. 451 (1789) (Joseph Gales ed., 1834). Madison considered the individual conscience "the most sacred of all property." James Madison, *Politcal Essay: Property*, NAT'L GAZETTE, Mar. 29, 1792, *reprinted in* SELECTED WRITINGS OF JAMES MADISON 223 (Ralph Ketcham ed. 2006).

10. 1 ANNALS OF CONG. 757–59, 795–96 (1789) (Joseph Gales ed., 1834) ("Debate on Establishment of Religion and Rights of Conscience"). The critical difference between "conscience" and "religion," which would have been well-known to the authors of the First Amendment, is that conscience "emphasizes individual judgment" and religion "encompasses the corporate or institutional aspects of religious belief." Michael W. McConnell, *The Origins and Historical Understanding of Free Exercise of Religion*, 103 HARV. L. REV. 1409, 1490 (1990). The deliberate choice to constitutionally safeguard communal "religion" instead of individual "conscience" bolsters the doctrine of *institutional* free exercise, which protects claims brought on behalf of a religious collective. *Id.* at 1490 ("Religion binds believers together; conscience refers to the inner faculty of judgment.").

11. Pellegrino, *supra* note 6, at 231 ("[T]he recent erosion of the number of beliefs held in common, and the increasingly varied demography of our nation, has magnified the complexity and depth of our differences about what is morally right and wrong. The secular solution of moral or value neutrality has generated genuine conflicts of conscience.").

12. Nathan S. Chapman, *Disentangling Conscience and Religion*, 2013 U. ILL. L. REV. 1457, 1490 (2013) ("Conscience is not a *source* of moral law, but it applies moral knowledge—whether that knowledge is shaped by religious beliefs or not."). It is doubtful, however, whether it is useful to isolate religion from conscience in First Amendment analysis, or whether that feat is possible at

morality with human experience, "issu[ing] *judgments* [against] past actions and issu[ing] *commands* with respect to contemplated future actions."[13] This faculty does not necessarily require religious beliefs: "On a Venn diagram, conscience and religion would overlap, not overlay."[14] Like religion, conscience neither fears nor flees scientific scrutiny; however, like religion, conscience often operates in the unmeasurable, and therefore unscientific, realms of experience and faith—while conscience rarely counsels *against* human reason, it regularly extends *beyond* human reason.[15] Within the medical field, conscience protections for healthcare workers and institutions are of paramount importance, regardless of religious affiliation or lack thereof, because, unlike most professions, the role of doctors is to directly influence the length and quality of human lives.[16] Unsurprisingly, as medical technology increases, the ethical stakes will continue to compound exponentially.[17]

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all. *See* Michael Stokes Paulsen, *God is Great, Garvey is Good: Making Sense of Religious Freedom*, 72 NOTRE DAME L. REV. 1597, 1610–20 (1997) (book review). Analyzing the logic and philosophy underlying the religion clauses, Professor Paulsen notes:

> [T]he religion clauses . . . entail a series of essentially religious premises: God exists; God makes claims on the loyalty of human beings; these claims sometimes require action that may conflict with government regulation; the claims of God are, for the individual believer, prior to and superior in obligation to the claims of the state; and—this is the crucial point—even from the state's perspective, the claims of the state ordinarily should yield to the claims of God as sincerely articulated by the religious believer, because the claims of God rightfully have a stronger claim on human loyalty than do the claims of the state. In short, the religion clauses are God-fearing clauses. *The law* thinks that God exists and that He makes demands (rules, duties, prohibitions) on men, and that this reality requires the state to yield.

Id. at 1611 (footnote omitted).

13. Chapman, *supra* note 12, at 1490 (arriving at this idea by way of Locke: "[E]veryone has a conscience that applies whatever moral knowledge they possess," but "people may discover their moral obligations by reason alone . . . .").

14. *Id.* at 1491 (concluding that conscience "is an exercise of moral judgment—whether informed by religious beliefs or not").

15. *See* ROBERT P. GEORGE, CONSCIENCE AND ITS ENEMIES 6 (2016) ("Increasingly, enemies of what James Madison called the 'sacred rights of conscience' cloak themselves in the mantle of science to marginalize their opponents. But close scrutiny reveals that it is their own views that are thinly supported—that are, as they might say dismissively, nothing but articles of faith."). For a discussion of the inherently spiritual dimension of the healthcare industry, see *infra* Section IV.B.I.

16. *See* Pellegrino, *supra* note 6, at 231 (In the physician's "perception of professional ethics" and "personal set of moral beliefs . . . we confront such crucial issues as the licitness of abortion, euthanasia, assisted suicide, in vitro fertilization, and stem cell research—the whole Pandora's box of 'human life' issues, emerging from our unprecedented control of every phase of human life. These issues center on how we value human life itself, its purposes, quality, destiny, and utility.").

17. *See id.* at 221, 224–25 ("To what extent can [conscience rules] secure rights of conscience in the face of a liberal, democratic, and secular society's commitments to moral relativism, personal

The concept of medical conscience protection began evolving decades ago as a direct response to this new and fundamental threat.[18]

The first significant piece of conscience-protecting legislation for medical professionals, the 1973 Church Amendments, was designed in response to the legalization of the most controversial practice in the field of American medicine: abortion.[19] Following *Roe v. Wade*'s judicial declaration of a constitutional right to abortion, members of the medical community who refused to perform abortions became conscientious objectors, overnight, to the Court's new ethical norms.[20] The Church Amendments addressed this new conscience threat, and were bolstered in 1996 when Congress passed the Coats-Snowe Amendment, which shielded conscientious medical students and healthcare entities from mandatory abortion training.[21] In 2004, Con-

freedom of choice, and an implicit social contract with its professionals?").

18. *See id.* at 231 ("Conflicts of belief in [the 'human life' issues] are more profound and deeply felt in one's conscience than other issues of professional behavior with patients. For religious individuals of many persuasions, these issues bear directly on their personal spiritual destinies and are, therefore, least subject to compromise.").

19. 42 U.S.C. § 300a-7(b)(2) (2018). The Church Amendments guaranteed that no hospital could be required to "make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions." *Id.*; *see also* Angela C. Carmella, *Catholic Institutions in Court: The Religion Clauses and Political-Legal Compromise*, 120 W. VA. L. REV. 1, 68 (2017) ("Forty-four states have . . . enacted conscience clauses [since 1974] that also protect the refusal to provide abortions . . . ."). The sponsor of the Church Amendments, Idaho Senator Frank Church, stated that they were a response to *Roe v. Wade*. 119 CONG. REC. 9,595 (1973). In *Roe* itself, the Supreme Court quoted the American Medical Association House of Delegates resolution that "no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, *hospital*, nor hospital personnel shall be required to perform any act violative of personally-held moral principles." 410 U.S. 113, 144–45 n.38 (1973) (emphasis added). In *Doe v. Bolton*, the companion case decided the same day as *Roe*, the Court gave a nod of approval to the conscience protection in the statute at issue, which allowed "a physician or any other employee . . . the right to refrain, for moral or religious reasons, from participating in the abortion procedure" because this "afford[ed] appropriate protection to the individual *and to the denominational hospital*." 410 U.S. 179, 197–98 (1973) (emphasis added) (citations omitted).

20. *See* Pellegrino, *supra* note 6, at 224–25 (noting that the Catholic Church's "positions on many crucial issues are distinctly and unapologetically ethically counter-cultural" and adding that "[m]any Jewish, Protestant, and Moslem physicians share some of the same beliefs and experience equivalent challenges to their moral integrity"); *see also* Leslie Steven Rothenberg, *The Role of Judges and the Courts as Definers of Ethical Norms*, SELECTED PAPERS FROM THE ANNUAL MEETING (AMERICAN SOCIETY OF CHRISTIAN ETHICS) 104, 104 (1977) (providing "a brief historical review of the manner in which U.S. courts have defined ethical norms in diverse factual situations").

21. 42 U.S.C. § 238n(a) (2018). This Amendment responded to new standards created by the Accreditation Council for Graduate Medical Education, which had mandated "experience with elec-

gress responded to attempts to construe the term "health care entity" in conscience protections as protecting only individuals by broadening conscience protection with the Weldon Amendment, which explicitly guarantees conscientious healthcare institutions the same protections as individuals.[22] This haven for institutional free exercise was passed as part of the original appropriations for the Department of Health and Human Services (HHS), and "has been readopted (or incorporated by reference) in [every] HHS appropriations act" thereafter.[23]

In December 2008, outgoing President George W. Bush issued a sweeping and comprehensive Conscience Rule through HHS, set to take effect on the day of incoming President Barack Obama's inauguration.[24] This unifying rule collected all the protections afforded among the Church, Coats-Snowe, and Weldon Amendments, as well as protections appearing elsewhere throughout federal law, and codified them in a single, cohesive rule.[25] The 2008 Conscience Rule also gave the scattered and oft-ignored conscience protections the power of enforceability by requiring recipients of HHS funding to provide a "[w]ritten certification of compliance" with the rule and by designating HHS's Office of Civil Rights as the coordinator of handling complaints under the new rule.[26] These new features would have fortified conscience rights and added layers of much-needed accountability to ensure compliance with the rule, but the 2008 Conscience Rule never took effect—President Obama struck it down as one of his first actions in office.[27]

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tive abortion [as] a required component of an approved residency training program"—a requirement that, while contingent on a resident's willingness to participate, had previously been both purely voluntary and unnecessary for residency accreditation. 142 Cong. Rec. S2271 (1996) (statement of the Amendment's sponsor, Indiana Senator Dan Coats).

22. Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, Tit. V, § 508(d)(2), 118 Stat. 2809, 3163 (2004); *see also* Protecting Statutory Conscience Rights in Healthcare, 84 Fed. Reg. 23170, 23172 (May 21, 2018) (to be codified at 45 C.F.R. pt. 88) (detailing the statutory history and implications of the HHS appropriations, and in particular, the Weldon Amendment).

23. Office for Civil Rights, *Conscience Protections for Health Care Providers*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Mar. 22, 2018), https://www.hhs.gov/conscience/conscience-protections/index.html.

24. Rob Stein, *Rule Shields Health Workers Who Withhold Care Based on Beliefs*, WASH. POST, (Dec 19, 2008), https://www.washingtonpost.com/wpdyn/content/article/2008/12/18/AR2008121801556.html.

25. Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78072, 78072 (Dec. 19, 2008), https://www.govinfo.gov/content/pkg/FR-2008-12-19/pdf/E8-30134.pdf.

26. *Id.* at 78097, 78098, and 78101.

27. Rescission of the Regulation Entitled "Ensuring That Department of Health and Human Ser-

Despite his initial hostility towards the 2008 Conscience Rule, President Obama was later responsible for furthering conscience protection via a provision in the Affordable Care Act (ACA) of 2010, in a section titled "Prohibition against discrimination on assisted suicide"[28]:

> The Federal Government, and any State or local government . . . may not subject an individual *or institutional health care entity* to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.[29]

The ACA contains the first conscience protection to specifically mention PAD, likely prompting the inclusion of PAD in virtually all modern protective laws alongside other procedures known for inciting conscientious objection.[30]

In January 2018, the Trump administration's HHS announced an unprecedented new division in its Office of Civil Rights: The Conscience and Religious Freedom Division.[31] In May 2019, this division issued a new Conscience Rule, designed to "protect providers, individuals, and other healthcare entities from having to provide, participate in, pay for, provide

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vices Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law," 74 Fed. Reg. 10207 (Mar. 10, 2009) (to be codified at 45 C.F.R. pt. 88), https://www.govinfo.gov/content/pkg/FR-2009-03-10/pdf/E9-5067.pdf.

28. 42 U.S.C. § 18113(a) (Supp. IV 2010). The ACA defines the term "health care entity" as including "an individual physician or other health care professional, [and] a hospital." 42 U.S.C. § 18113(b) (Supp. IV 2010). Although the ACA refers to PAD as "assisted suicide" (a term considered highly objectionable to proponents and purposefully excluded from each state statute concerning the subject), the practice referenced in § 1811(a) was undoubtedly intended to encompass PAD as modern statutes define it. 42 U.S.C. § 18113(a) (Supp. IV 2010); *see infra* Section III.B.

29. 42 U.S.C. § 18113(a) (Supp. IV 2010) (emphasis added).

30. *See, e.g.*, Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78072, *supra* note 25, at 78076 (protecting, in the 2008 proposed rule, traditionally objectionable medical procedures including "abortion" and "sterilization," but declining to protect conscience objections to "assisted suicide").

31. Office for Civil Rights, *HHS Announces New Conscience and Religious Freedom Division*, U.S. DEP'T OF HEALTH & HUM. SERVICES (Jan. 18, 2018), https://www.hhs.gov/about/news/2018/01/18/hhs-ocr-announces-new-conscience-and-religious-freedom-division.html. This division was created in response to Executive Order 13798, issued by President Trump in May 2017, which instructs government agencies to "address conscience-based objections" of healthcare workers. Exec. Order No. 13798, 82 Fed. Reg. 21675 (May 4, 2017).

coverage of, or refer for," among other things, "assisted suicide."[32] In addition to defining critical terms and creating enforcement mechanisms, the newest conscience rule required extensive recordkeeping to further guarantee accountability.[33] The rule was set to take effect in July 2019, but the implementation was delayed until November 2019 "[in] light of significant litigation over the rule."[34] This litigation, initiated by a coalition of twenty states, Planned Parenthood, and other special interest groups, resulted in the District Court for the Southern District of New York vacating the rule entirely.[35] Although many significant and ongoing efforts exist at the federal level to protect conscience rights in healthcare, when it comes to the specific medical practice of PAD, the most important conscience clashes are unfolding state by state.[36]

32. HHS Press Office, *HHS Announces Final Conscience Rule Protecting Health Care Entities and Individuals*, U.S. DEP'T OF HEALTH AND HUM. SERVS. (May 2, 2019), https://www.hhs.gov/about/news/2019/05/02/hhs-announces-final-conscience-rule-protecting-health-care-entities-and-individuals.html. Explaining the need for a new conscience rule, HHS cited a "significant increase" in conscience-related complaints since November 2016, and expressed hope that the new rule would provide "the proper enforcement tools" to ensure adequate conscience protections for healthcare entities. *Id.*

33. *Id.*

34. Office for Civil Rights, *Conscience Rule Effective Date Moved to Nov. 22, 2019*, U.S. DEP'T OF HEALTH & HUM. SERVS. (July 3, 2019), https://www.hhs.gov/conscience/conscience-rule-effective-date-moved/index.html.

35. New York v. United States HHS, 414 F. Supp. 3d 475, 580 (S.D.N.Y. 2019); *see also* Office for Civil Rights, *Conscience Rule Vacated*, U.S. DEP'T OF HEALTH AND HUM. SERVS. (Nov. 8, 2019), https://www.hhs.gov/conscience/conscience-rule-vacated/index.html ("Under court order, the 2019 rule will remain vacated and not in effect unless OCR receives further direction from the courts."); Benjamin Weiser & Margot Sanger-Katz, *Judge Voids Trump-Backed 'Conscience Rule' for Health Workers*, N.Y. TIMES (Nov. 6, 2019), https://www.nytimes.com/2019/11/06/upshot/trump-conscience-rule-overturned.html.

36. *See infra* Part II.B.2. Skirmishes over conscience protection will undoubtedly continue at the federal level and, although the dust has not yet settled, public favor for a blanket, federal conscience protection for healthcare workers has long been, and currently remains, widespread. *See, e.g.*, Richard S. Myers, *On Law: On the Need for a Federal Conscience Clause*, 1 NAT'L CATH. BIOETHICS Q. 23, 25 (2001) ("A comprehensive assault on religious liberty, and this is in truth what we are facing, really warrants a comprehensive remedy. A federal law providing for full protection for those with conscientious objection to being forced to participate, through funding or otherwise, in health care activities that violate their religious and moral beliefs is well worth supporting.").

B. Current Status of PAD Laws in the United States

In the United States, the exact definition of PAD[37] varies from state to state, but all state statutes require that a patient seeking PAD must: (1) be at least 18 years old and a resident of the state, (2) be mentally and physically capable of self-administering the medication, (3) have a terminal disease that is overwhelmingly likely to cause death in six months or less as determined by two physicians, and (4) have voluntarily expressed his or her wish to die both orally and in writing.[38]

After Oregon became the first state to legalize PAD in 1994, only two other states, Washington and Vermont, followed suit over the next two decades; however, since 2016, the pace of legalization has been accelerating rapidly, with five states and the District of Columbia legalizing PAD in just three years.[39] Currently, PAD is legal by statute in eight states and the District of Columbia, and legal by judicial decision in one state, Montana.[40] PAD is currently not legalized in the other forty-one states: thirty-four have

37. It is critical to note that PAD is distinct from the practice of euthanasia, which remains illegal in all 50 states. Alyssa Thurston, *Physician-Assisted Death: A Selected Annotated Bibliography*, 111 L. LIBR. J. 31, 35, 39 (2019). Euthanasia is defined as a doctor administering fatal medication to a patient, such as by injection. *Id.* at 32. Each state statute legalizing PAD clearly and unequivocally excludes euthanasia using a nearly identical clause: "Nothing in this article authorizes a physician or any other person to end an individual's life by lethal injection, mercy killing, or euthanasia." COLO. REV. STAT. § 25-48-121 (2016). Equally critical is the distinction between PAD and the patient's right to refuse further treatment, which is legal in all 50 states. Patient Self-Determination Act of 1990, Pub. L. No. 101–508, §§ 4206, 4751, 104 Stat. 1388 (1990) (requiring hospitals that receive federal funds to tell patients that they have a right to demand or refuse treatment); *see also* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 285 (1990) (holding that doctors may remove patients from life support after clear and convincing evidence of their prior wishes to do so, leading to the creation of advance health directives); In re Quinlan, 70 N.J. 10 (1976) (parents permitted to remove daughter in persistent vegetative state from ventilator); Robert P. George, *Terri Schiavo: A Right to Life Denied or a Right to Die Honored?*, 22 CONST. COMMENT. 419, 425–26 (2005) (discussing and criticizing the famous—or infamous—right-to-die case of Terri Schiavo, a vegetative patient whose feeding tube was removed after over a decade of litigation). Additionally, the Supreme Court distinguished PAD from refusing treatment in *Washington v. Glucksberg*: "The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection." 521 U.S. 702, 725 (1997). The precise terminology for this practice is also fiercely contested for emotional and political reasons. *See infra* Section III.

38. *See, e.g.*, OR. REV. STAT. 127.805 § 2.01(1) (1994); *see also* OR. REV. STAT. 127.805 § 2.01(1) (1994); OR. REV. STAT. 127.815 § 3.01 (1994).

39. *See infra* Sections II.B.2.a.–j. (California (2016); Colorado (2016); Washington, D.C. (2017); Hawaii (2018); New Jersey (2019); and Maine (2019)).

40. *See infra* Section II.B.2.

laws prohibiting PAD, three prohibit PAD by common law, and four have no specific law or are unclear as to the legality of PAD.[41]

1. *Glucksberg* and *Quill*: No Constitutionally Protected "Right to Die"

In 1997, the Supreme Court upheld state-wide bans on PAD in Washington and New York in two cases decided contemporaneously: *Washington v. Glucksberg* and *Vacco v. Quill*.[42]

In *Glucksberg*, the Court examined the specific issue of "whether the 'liberty' specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so," and concluded that "our Nation's history, legal traditions, and practices do not support the existence of such a right."[43] The Court further found that the constitutional requirement "that Washington's assisted-suicide ban be rationally related to legitimate government interests" was "unquestionably met," because "Washington has an 'unqualified interest in the preservation of human life'" and its "prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this interest."[44] Thus, the Court reversed the Ninth Circuit's finding of a "constitutionally-recognized 'right to die,'" entrusting the "extensive and serious evaluation of physician-assisted suicide" to the "'laboratory' of the States."[45]

Simultaneous with its rejection of *Glucksberg*'s argument for PAD based on the Due Process Clause, in *Vacco v. Quill* the Supreme Court also rejected an argument for PAD based on the Equal Protection Clause.[46] Responding to a group of New York doctors arguing that "the distinction between refusing lifesaving medical treatment and assisted suicide is 'arbitrary' and 'irrational,'" the Court ruled that "[l]ogic and contemporary

41. *See States with Legal Physician-Assisted Suicide*, PROCON.ORG, https://euthanasia.procon.org/view.resource.php?resourceID=000132 (last updated July 25, 2019) (citing common law prohibitions in Alabama, Massachusetts, and West Virginia; no specific law or unclear laws in Nevada, North Carolina, Utah, and Wyoming; and explicit prohibitions in the remaining thirty-four states).

42. 521 U.S. 702 (1997) (rejecting a challenge by Washington physicians and patients, along with non-profit Compassion in Dying, to Washington's Natural Death Act of 1979, which banned PAD); 521 U.S. 793 (1997) (upholding New York anti-PAD law and finding no constitutional "right to die").

43. *Glucksberg*, 521 U.S. at 723, 736 (O'Connor, J., concurring).

44. *Id.* at 728 (citation omitted).

45. *Id.* at 709 (majority opinion), 737 (O'Connor, J., concurring) (citations omitted).

46. *Vacco*, 521 U.S. at 793.

practice support . . . treat[ing] them differently."[47] The Court also noted that "[b]y permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction."[48] Through these two cases, the Supreme Court clearly established that Americans do not have any constitutional right to PAD, and the ultimate decisions regarding the practice must therefore be decided on a state-by-state basis.[49]

2. Current State of the Experiment in "The Laboratory of the States"

The following chronological list documents the history of PAD legalization in the United States.[50] As the list illustrates, the pro-PAD movement has generated an accelerating wave of well-funded ballot initiatives and heavily lobbied state statutes to overcome resistance from deeply rooted public disapproval of PAD and to overpower sustained opposition from conscientious religious groups.[51]

a. Oregon (1994)

Oregon legalized PAD in 1994 via ballot initiative, with citizens approving the measure by the narrowest possible margin: 51% for and 49% against.[52] However, due to a judge's injunction, extended political and legal proceedings, and a second ballot initiative attempting to repeal the measure, the Oregon Death With Dignity Act (DWDA) was not implemented until 1998.[53] Attempts to overrule the new DWDA continued at the federal level,

47. *Id.* at 807–08.

48. *Id.* at 808.

49. *Glucksberg*, 521 U.S. at 735 ("Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.").

50. *See infra* Sections II.B.2.a.–j.

51. *See generally* Thurston, *supra* note 37.

52. *Physician-Assisted Death Initiative (1994)*, Oregon Measure 16 (1994) (approved 51.31% to 48.69%); *see also* K.K. DuVivier, *Fast-Food Government and Physician-Assisted Death: The Role of Direct Democracy in Federalism*, 86 OR. L. REV. 895 (2007) (discussing the efficacy of ballot initiatives to pass moral legislation).

53. OR. REV. STAT. 127.885 § 4 (1994); *see also* Kathryn L. Tucker, *When Dying Takes Too Long: Activism for Social Change to Protect and Expand Choice at the End of Life*, 33 WHITTIER L. REV. 109, 115–21 (2011). Professor Tucker, former Director of Legal Affairs at national pro-PAD non-profit Compassion & Choices, studied the Oregon ballot initiative's success in the wake of

culminating in the 2006 Supreme Court ruling in *Gonzalez v. Oregon*, where the Court ruled that the Controlled Substances Act did not prohibit Oregon doctors from distributing federally controlled substances for the purpose of assisting an individual's suicide.[54] After this challenge was defeated, no further legal challenges remained and Oregon's DWDA has functioned unimpeded ever since.[55] Since implementation, it has become a template for PAD laws across the nation.[56]

b. Washington (2008)

The first attempt to legalize PAD in Washington was a failed ballot initiative in 1991, in which the citizens rejected the measure 54% to 46%.[57] After Oregon implemented its DWDA and resolved its various legal challenges, however, a coalition of pro-PAD organizations identified Washing-

Washington and California voters' rejection of PAD, noting that "Oregon learned from these campaigns across its borders and tailored its measure to pass . . . ." *Id.* at 115.

54. 546 U.S. 243 (2006). Dissenting, Justice Scalia summarized the somewhat circular logic of the majority, which "conclude[d] that the Attorney General [of Oregon] lacked authority to declare assisted suicide illicit under the Controlled Substances Act . . . because [the Act] is concerned only with *illicit* drug dealing and trafficking," and the drugs used to perform assisted suicide were no longer "illicit" under Oregon law. *Id.* at 275 (Scalia, J., dissenting) (internal quotation marks omitted).

55. For a detailed account of Oregon's implementation of PAD, see NEIL M. GORSUCH, THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA 115–25 (Princeton Univ. Press 2006). In the first five years after implementation, 198 lethal prescriptions were written in Oregon, and this number increased by 76 percent from 1999 to 2002. *Id.* at 119. A high volume of prescriptions appeared to come from "a very small handful of politically active physicians." *Id.* Justice Gorsuch, writing in the year of his appointment to the Tenth Circuit Court of Appeals, documented a troubling footnote in the early history of PAD in America:

> In its first-year questionnaire, the Oregon Health Division specifically asked physicians whether the patients they helped kill were referred to them by advocacy organizations, such as Compassion in Dying or the Hemlock Society, but the state inexplicably declined to publish the answer. However, it was later revealed by the media that . . . at least twelve of fourteen, or 86 percent, of the assisted suicide cases were handled by groups politically active in promoting legalization of assisted suicide . . . . Just as it is inexplicable that Oregon would suppress results from its first-year questionnaire, it is equally troubling that the state has chosen to drop this question from each of its subsequent annual surveys, and to do so without public mention (let alone defense) of its decision . . . .

Id. at 119–20 (citations omitted).

56. *See* Thurston, *supra* note 37, at 43 ("The provisions of Oregon's DWDA have provided a model for other state laws that have since legalized physician-assisted suicide.").

57. *Washington Physician-Assisted Death*, Initiative 119 (1991) (rejected 53.6% to 46.4%).

ton as the next state to target for legalization.[58] In 2008, Initiative 1000 was put before Washington voters after the first pro-PAD campaign in history in which the proponent's fundraising exceeded that of their opponents.[59] Voters approved the measure 58% to 42%, and the Washington DWDA, virtually identical in substance to the Oregon DWDA, was implemented in March 2009.[60]

c. Montana (2009)

PAD has been legal in Montana since the 2009 case *Baxter v. Montana*, where the Montana Supreme Court found nothing in the state's law that would prohibit a physician from offering PAD to a patient.[61] Citing Montana's Rights of the Terminally Ill Act, the court took an unprecedented judicial stance that remains unique to this day, holding that there is no discernable public policy difference between taking a patient off life support and prescribing lethal medication to kill that patient.[62] Since *Baxter*, numerous bills have been introduced in the Montana state legislature both to ban PAD

58. *Attempts to Legalize Euthanasia/Assisted-Suicide in the United States*, PATIENTS RIGHTS COUNCIL, http://www.patientsrightscouncil.org/site/failed-attempts-usa/ (last visited Oct. 29, 2020) ("It took fourteen years [after Oregon] before another state legalized [PAD], and, even then, only after advocates spent a whole year preparing the campaign and raising millions of dollars to insure the victory they so desperately wanted. That state was Washington, the state consultants said was demographically most like Oregon and, therefore, most likely to favor assisted suicide."). By the time of the vote on the next initiative, the pro-PAD campaign had raised $4,890,020, with $300,000 coming from the single largest contributor, then-Governor of Washington Booth Gardner. *Washington Death with Dignity Act: A History*, DEATH WITH DIGNITY NATIONAL CENTER, https://www.deathwithdignity.org/189washington-death-with-dignity-act-history/ (last visited Oct. 29, 2020).

59. *Washington Death with Dignity Act*, Initiative Measure No. 1000 (2008) (approved 57.82% to 42.18%).

60. WASH. REV. CODE § 70.245 (2008).

61. 224 P.3d 1211 (Mont. 2009). In *Baxter*, a patient dying of lymphocytic leukemia, four physicians, and Compassion & Choices challenged the application of a Montana homicide statute against a physician providing life-ending medication. *Id.* at 1213–14. The Montana Supreme Court declined to rule on the district court's finding that the Montana State Constitution's guaranteed rights of privacy and dignity entitled Montanans to the "right to die." *Id.* at 1214; *see also* MONT. CONST. art. II, §§ 4, 10 (guaranteeing Montana citizens the right of "[i]ndividual dignity" and of "privacy.").

62. *Baxter*, 224 P.3d at 1217 ("The Rights of the Terminally Ill Act very clearly provides that terminally ill patients are entitled to autonomous, end-of-life decisions, even if enforcement of those decisions involves direct acts by a physician. Furthermore, there is no indication in the Rights of the Terminally Ill Act that an additional means of giving effect to a patient's decision—in which the patient, without any direct assistance, chooses the time of his own death—is against public policy.").

and to legalize it via statute, but none have been successful thus far.[63]

d. Vermont (2013)

Almost two decades after Oregon's successful ballot initiative, Vermont became the first state to legalize PAD through the legislative process.[64] Previous PAD bills had failed in Vermont in 1995, 1997, 1999, 2003, 2005, 2007, 2009, and 2011, but activist groups organized sufficient awareness and fundraising to finally pass Act 39, Patient Choice and Control at End of Life, in 2013.[65] Sparks flew within three years: the Vermont Board of Medical Practice and the Office of Professional Regulation published their own interpretation of Act 39, in which the state agencies construed the Act as *requiring* doctors to either counsel all terminal patients of their new right to PAD or, if unwilling to do so, refer the patient to another source for information concerning PAD.[66] After Vermont healthcare workers filed a complaint in 2016 in the Federal District Court in Vermont, the state entered into a Consent Agreement and Stipulation establishing that the state agencies' interpretation of the statute was false and requiring it to "revise all State-owned web sites that describe a medical professional's obligations with respect to [Act 39], in accordance with [the] agreement."[67] The district court

63. *See, e.g.*, H.B. 284, 66th Leg., Reg. Sess. (Mont. 2019) (attempting to ban PAD); H.B. 536, 65th Leg., Reg. Sess. (Mont. 2017); *see also* S.B. 202, 64th Leg., Reg. Sess. (Mont. 2015) (attempting to legalize PAD); S.B. 167, 62nd Leg., Reg. Sess. (Mont. 2011), S.B. 220, 63rd Leg., Reg. Sess. (Mont. 2013).

64. *See* Kathryn L. Tucker, *Vermont's Patient Choice at End of Life Act: A Historic "Next Generation" Law Governing Aid in Dying*, 38 VT. L. REV. 687, 687 (2014) ("A 'next generation' model for legislation, . . . the [Act] is of historic significance . . . because this is the first time a legislature has adopted a statute specifically permitting aid in dying.").

65. VT. STAT. ANN. Tit. 18, § 113 (2013); *Attempts to Legalize Euthanasia/Assisted-Suicide in the United States*, *supra* note 58.

66. Steven H. Aden, *Vermont Health Professionals: Don't Force Us to Help Kill Our Patients*, ALL. DEFENDING FREEDOM (July 20, 2016), http://www.adfmedia.org/News/PRDetail/10027. The state of Vermont contrived this requirement using Vermont's "Patient's Bill of Rights for Palliative Care and Pain Management" (incorporated by Act 39), which guarantees the right of "[a] patient with a terminal illness . . . to be informed by a clinician of *all available options related to terminal care*; to be able to request any, all, or none of these options; and to expect and receive supportive care for the specific option or options available." VT. STAT. ANN. Tit. 18, § 1871 (2017) (emphasis added). *See also* Pellegrino, *supra* note 6, at 239–40 ("To cooperate in an act which is regarded as inherently morally wrong, such as arranging for an abortion or assisted suicide, is to be a moral accomplice. . . . Obviously the patient cannot be abandoned, legally or morally, and must be cared for until a transfer has been effected.") (citation omitted).

67. Consent Agreement and Stipulation, *Vt. All. For Ethical Healthcare, Inc. v. Hoser*, No. 5:16-

denied a motion from Compassion & Choices to strike the agreement from public records, but carefully noted that "[t]he agreement does not represent the views of the court," and that the 2016 armistice was "not a judicial ruling"—pointedly leaving the adjudicative door ajar for future examination.[68]

e. California (2016)

The Californian pro-PAD movement began in 1980, when Derek Humphrey established the Hemlock Society in Santa Monica, California, advocating for PAD and distributing "how-to-die information."[69] Within a decade, membership in the Hemlock Society had grown to over 50,000 supporters.[70] In 2005, the Society merged with Compassion in Dying, another national pro-PAD non-profit, to form Compassion & Choices, the largest pro-PAD organization in the United States, which continues to tirelessly and strategically fund, litigate, and lobby PAD efforts in every state.[71]

After many attempts to legalize PAD failed at various stages in the California legislature, public sentiment began to shift in 2014 with the story of Brittany Maynard, widely circulated through a publicity campaign with Compassion & Choices.[72] Maynard, a twenty-nine year-old Californian diagnosed with incurable brain cancer, advocated legalization of PAD in California, taking her case before the state legislature and the governor.[73] After her attempts were unsuccessful, she moved to Oregon for access to legal

cv-205, 2016 WL 7015717 (D. Vt. 2016). Despite this agreement, the FAQ page for the state-run Vermont Ethics Network continues to assert that the "voluntariness clause" of Act 39 "does not alter the rights and duties existing under Vermont's Patient's Bill of Rights," erroneously indicating that referrals may still be a requirement under Vermont law. *Physician Assisted Death (PAD)*, VT. ETHICS NETWORK, https://vtethicsnetwork.org/medical-ethics/pad (last visited Oct. 29, 2020).

68. Order on Defendant-Intervenors' Motion to Strike Docket Entry #57 (2017), *Hoser*, 2016 WL 7015717 (denying motion from Compassion & Choices, defendant-intervenor, to strike the Consent Agreement from public records and noting that the agreement is not the court's opinion on this issue).

69. *Death with Dignity in California: A History*, DEATH WITH DIGNITY NATIONAL CENTER, https://www.deathwithdignity.org/death-with-dignity-california-history/ (last visited Oct. 29, 2020).

70. *Id.*

71. *See History of the End-of-Life Choice Movement*, COMPASSION & CHOICES, https://compassionandchoices.org/resource/history-end-life-choice-movement/ (last visited Oct. 29, 2020).

72. *See id.* (recounting the results of the publicity campaign, during which "coverage from every major news outlet catalyze[d] . . . a nationwide conversation" on PAD).

73. *See Death with Dignity in California: A History*, *supra* note 69.

PAD, which she used to end her life in 2014.[74] Less than three months after Maynard's death, the California Senate introduced the bill that would ultimately become the End of Life Option Act (ELOA), enacted in 2016.[75] The ELOA has been implemented despite facing immediate legal challenges, and has remained continuously embattled in California state courts ever since.[76]

f. Colorado (2016)

After two attempts to pass bills in the state legislature were defeated, Colorado eventually legalized PAD using a ballot initiative, with voters passing Proposition 106, the End of Life Options Act, 65% to 35%.[77] The new law went into effect in December 2016, marking the first time two states legalized PAD in the same year.[78]

g. Washington, D.C. (2017)

The D.C. Death with Dignity Act, approved by the District of Columbia Council and signed by D.C. Mayor Muriel Bowser in 2016, went into effect in February 2017.[79] Since then, Congress has initiated multiple, unsuccessful attempts to repeal the Act.[80]

h. Hawaii (2018)

After multiple failed bills in the state legislature, Compassion & Choices contended that PAD had been legal in Hawaii since 1909 based on an obscure Hawaiian territorial law.[81] After the Hawaii Attorney General rejected

74. *Id.*

75. End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443 (West 2016).

76. *See, e.g.*, People ex rel. Becerra v. Superior Court, 240 Cal. Rptr. 3d 250 (Cal. Ct. App. 2018) (petition for review, S253424, denied by the California Supreme Court,); *see also Death with Dignity in California: A History*, *supra* note 69.

77. *Colorado Physician-Assisted Death Initiative* (2016), Colorado Proposition 106 (2016) (approved 64.87% to 35.13%).

78. COLO. REV. STAT. § 25-48-101 (2016).

79. D.C. Act 21-577 (2016) (to be codified at D.C. CODE § 21-182); *see also* Thurston, *supra* note 37, at 41.

80. *See, e.g.*, H.J. Res. 27, 115th Cong. (2018); S.J. Res. 4, 115th Cong. (2018).

81. Andrew Walden, *Colette Machado: I Look at Kalaupapa—Native Hawaiians Will Fight Against Assisted Suicide*, HAWAI'I FREE PRESS (Dec. 10, 2011, 6:35 PM), http://www.hawaiifreepress.com/ArticlesMain/tabid/56/ID/5639/Colette-Machado-I-look-at-

these claims, pro-PAD groups began pushing PAD bills in Hawaii's state legislature—with at least five in 2017 and four in 2018—until the Hawaii Our Care, Our Choice Act passed in 2018.[82]

i. New Jersey (2019)

The Aid in Dying for the Terminally Ill Act took effect in New Jersey on August 1, 2019, and is currently in effect pending litigation.[83]

j. Maine (2019)

On June 12, 2019, Maine Governor Janet Mills signed the Maine Death with Dignity Act, making Maine the most recent state to enact PAD legalization.[84] Although the Christian Civic League of Maine filed a petition to repeal the Act using a ballot initiative, they failed to gather enough signatures and the Act took effect in September 2019.[85]

III. SETTING THE STAGE FOR AN ASSAULT ON RELIGIOUS LIBERTY

A. Catholic Hospitals Are the Greatest Obstacle for PAD Legalization in America

On October 28, 2019, global leaders representing Islam, Judaism, and Christianity (including Protestant, Orthodox, and Catholic Christians) united at the Vatican to sign a joint statement unequivocally opposing assisted suicide.[86] Organized by the Vatican's Pontifical Academy for Life and coordi-

Kalaupapa-Native-Hawaiians-will-fight-against-Assisted-Suicide.aspx; *see also* Kathryn L. Tucker, *Aid in Dying: An End of Life-Option Governed by Best Practices*, 8 J. HEALTH & BIOMEDICAL L. 9, 10–26 (2012).

82. H.B. 2739, 29th Leg., Reg. Sess. (Haw. 2018) (codified at HAW. REV. STAT. § 327L (2019)); for failed attempts, see *Attempts to Legalize Euthanasia/Assisted-Suicide in the United States*, *supra* note 58.

83. N.J. STAT. ANN. § 26:16 (2019); *New Jersey*, DEATH WITH DIGNITY NATIONAL CENTER, https://www.deathwithdignity.org/states/new-jersey/ (last visited Oct. 29, 2020).

84. ME. REV. STAT. ANN. tit. 22, § 418 (2019).

85. *Maine*, DEATH WITH DIGNITY NATIONAL CENTER, https://www.deathwithdignity.org/states/maine/ (last visited Oct. 29, 2020).

86. Robin Gomes, *Abrahamic Religions: No to Euthanasia, Assisted Suicide, Yes to Palliative Care*, VATICAN NEWS (Oct. 28, 2019), https://www.vaticannews.va/en/vatican-city/news/2019-10/abrahamic-religions-life-euthanasia-suicide-palliative.html.

nated by Archbishop Vincenzo Paglia, the interfaith group drafted a declaration to "oppose any form of . . . physician assisted suicide—that is the direct, deliberate and intentional support of committing suicide—because [it] fundamentally contradict[s] the inalienable value of human life."[87] The statement maintained that PAD "should be forbidden without exceptions," noting that "[m]atters pertaining to the duration and meaning of human life should not be in the domain of health care providers," and concluded that caring for the sick "demands of us also to reform the structures and institutions by which health and religious care are delivered."[88]

The basis for Catholic opposition to PAD, and thus the Vatican's motivation to organize this event, is the Ethical and Religious Directives for Catholic Health Care Services ("the ERDs") issued by the United States Conference of Catholic Bishops.[89] Catholic healthcare workers and institutions look to the ERDs rather than to their respective governments for their moral guidelines, and the ERDs unequivocally forbid participation in certain medical procedures, including abortion, sterilization, euthanasia, and, since 2001, PAD.[90] As extensions of the Catholic Church itself, Catholic hospitals provide care in accordance with the ERDs, thereby expanding the governing authority of the ERDs from individual doctors to the moral framework of entire healthcare institutions owned or operated by the Catholic Church.[91]

87. *Position Paper of the Abrahamic Monotheistic Religions on Matters Concerning the End of Life*, PONTIFICAL COUNCIL FOR PROMOTING CHRISTIAN UNITY (Oct. 28, 2019), http://www.christianunity.va/content/unitacristiani/en/commissione-per-i-rapporti-religiosi-con-l-ebraismo/other-documents-and-events/2019-position-paper-of-the-abrahamic-monotheistic-religions-on-m.html.

88. *Id.*

89. *Ethical and Religious Directives for Catholic Health Care Services*, UNITED STATES CONFERENCE OF CATHOLIC BISHOPS (6th ed., 2018), http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf [hereinafter *ERDs*].

90. *Id.* at 25. Justifying this practice, the ERDs elaborate: "We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options. The task of medicine is to care even when it cannot cure." *Id.* at 20.

91. *See generally About USCCB*, UNITED STATES CONFERENCE OF CATHOLIC BISHOPS (last visited Oct. 29, 2020), http://www.usccb.org/about/. For a detailed analysis of the spread of the ERDs in American hospital systems, see Elizabeth Sepper, *Zombie Religious Institutions*, 112 NW. U. L. REV. 929, 937 (2018) (documenting the phenomenon whereby "Catholic healthcare systems have increased in size and scope by acquiring, affiliating with, and merging with non-Catholic hospitals" in a multitude of "commercial transactions [that] have blurred the lines between religious and nonreligious entities"). Restrictive covenants in deeds and other legal measures can impose Catholic med-

Further, the ERDs teach that cooperating with or supporting the immoral actions of another is as forbidden as the action itself, even on an institutional scale.[92] Importantly, this stance has been acknowledged by the Supreme Court, which has held that forced complicity in an act one perceives as immoral creates an unconstitutional intrusion into the right of conscience.[93]

As of 2010, the Catholic Church managed 26% of all healthcare facilities in the world.[94] In the U.S. healthcare market, where approximately 59% of hospitals are nonprofit, Catholic healthcare dwarfs all other religious healthcare providers combined, comprising four of the ten largest nonprofit systems.[95] More than one in six acute care beds in the United States is in a hospital connected to the Church.[96] The Catholic healthcare market has experienced steady growth for well over a century: in 1885, there were around 150 Catholic hospitals in the United States; by 1910, there were over 400; and between 2001 and 2016, the number rose 22%, from 449 to 548.[97] Today, 660 officially designated Catholic hospitals operate in the United States, constituting approximately 14.5% of the national market.[98] These hospitals account for over 30% of acute care beds in five states and over

ical ethics on hospitals even after all commercial relationship with the Church has ended, expanding the influence of the ERDs through what Professor Sepper has termed "[z]ombie religious institutions." *Id.* at 931.

92. *ERDs*, *supra* note 89, at 25 ("Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral.").

93. *See* Douglas Nejaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2533–38 (2015).

94. *Catholic Hospitals Comprise One Quarter of World's Healthcare, Council Reports*, CATHOLIC NEWS AGENCY (Feb. 10, 2010), https://www.catholicnewsagency.com/news/catholic_hospitals_represent_26_percent_of_worlds_health_facilities_reports_pontifical_council.

95. Sepper, *supra* note 91, at 934–35; *see also* LOIS UTTLEY & CHRISTINE KHAIKIN, GROWTH OF CATHOLIC HOSPITALS AND HEALTH SYSTEMS: 2016 UPDATE OF THE MISCARRIAGE OF MEDICINE REPORT, MERGER WATCH (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/M (tracking the growth of Catholic hospitals in the United States).

96. Jilian Mincer, *Watchdog Finds Much Larger Catholic Influence on U.S. Hospitals*, REUTERS, https://www.reuters.com/article/us-usa-healthcare-hospitals-idUSKCN0XW15L (May 5, 2016).

97. Stephanie M. Wurdock, *Doctors, Dioceses, and Decisions: Examining the Impact of the Catholic Hospital System and Federal Conscience Clauses on Medical Education,* 6 PITT. J. ENVTL. L. & PUB. HEALTH L. 179, 186–87 (2012).

98. CATHOLIC HEALTH ASS'N OF THE U.S., U.S. CATHOLIC HEALTHCARE (2019), https://www.chausa.org/docs/default-source/default-document-library/cha_2019_miniprofile.pdf?sfvrsn=0. *But see* Sepper, *supra* note 91, at 970 (documenting the increasing control of the Catholic Church over non-Catholic hospitals, indicating the number of "unofficial[ly] Catholic" hospitals is even higher).

40% in another five states.[99] In Washington, over half of the state's acute care beds are in the Catholic healthcare system.[100] More than half a million people are employed full-time by Catholic hospitals, and another quarter of a million part-time.[101]

The bishop of the diocese where a Catholic hospital sits has "final interpretive authority over compliance with the ERDs," whose authority "also control[s] in the case of mergers and acquisitions between Catholic and secular hospitals . . . ."[102] In such cases, the ERDs will often continue to govern the secular hospitals after they leave the Catholic system because the church makes the ERDs perpetual, contractual requirements.[103] And as the percentage of doctors employed by hospitals is rapidly increasing, the number of healthcare professionals controlled by the ERDs, and therefore forbidden from participating in PAD, is simultaneously increasing.[104]

An example of the expanding control of the Catholic Church over legalized PAD arose in 2018 at the Kahala Nui retirement home in Honolulu, Hawaii.[105] Although the home is not explicitly Catholic, it leases the land underneath it from the Roman Catholic Church, and the terms of that lease "prohibit[] the home from assisting, promoting[,] or coordinating medically assisted suicide . . . ."[106] After notifying its residents that it would be opting

99. Sepper, *supra* note 91, at 935.

100. Danny Westneat, *Is Catholic Church Taking Over Health Care in Washington?*, THE SEATTLE TIMES (May 21, 2013), https://www.seattletimes.com/seattle-news/is-catholic-church-taking-over-health-care-in-washington/.

101. Wurdock, *supra* note 97, at 188.

102. Carmella, *supra* note 19, at 67.

103. *Id.* at 68–9 ("In seeking to continue its moral influence over the delivery of health care even when no longer a direct provider, the Church makes the ERD requirements perpetual, in contracts and even as deed restrictions that encumber title to real property."); *see also* Sepper, *supra* note 91 (explaining the process in depth by which formerly Catholic hospitals are contractually bound to ERDs post-sale).

104. *Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012–2018*, PHYSICIANS ADVOC. INST., (Feb. 2019), http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf?ver=2019-02-19-162735-117. According to a 2019 report from the Physicians Advocacy Institute, the number of hospital-owned practices increased by 129% between July 2012 and January 2018 (more than doubling the ownership percentage in just 5.5 years), with physician employment increasing by 70% over the same period. *Id.* This trend was consistent across all U.S. geographic regions. *Id.*

105. Audrey McAvoy, *Hawaii Retirement Home Clarifies Assisted Suicide Rules*, ASSOCIATED PRESS (Nov. 13, 2018), https://apnews.com/f981b6d1dfe64ed4aaef0ac56c9f502f.

106. *Id.*

out of participation in Hawaii's newly legalized PAD Act due to its Catholic lease terms, the home received a letter from the ACLU demanding it "stop discriminating against non-Catholic residents."[107] This conflict perfectly foreshadows the imminent clash between the colossal, wide-reaching Catholic healthcare system and legalized PAD in a growing number of states.[108]

Since the earliest PAD legalization efforts began in the United States, the Catholic Church has consistently expressed unwavering opposition.[109] The drafters of proposed state PAD legislation were undoubtedly aware of the monolithic system of anti-PAD Catholic hospitals throughout the United States, and two carefully worded clauses included in every state PAD bill may indicate a deliberate attempt to preemptively undercut the opposition: (1) the definition clauses, and (2) the premises clauses.[110]

B. Tactical Vocabulary: If It's Not "Suicide," What Is It?

The intensity of the national controversy surrounding PAD is illustrated by the fact that merely naming the issue elicits fierce debate among proponents and critics alike.[111] As with many politicized topics in modern Ameri-

107. *The Latest: Retirement Home Says It Doesn't Discriminate*, ASSOCIATED PRESS (Nov. 1, 2018), https://apnews.com/7e59dce0d8944583abcce5d3e4f42e08.

108. *See* Sepper, *supra* note 91, at 963–68 (discussing the distinct role that religious institutions, including the Catholic Church, play in the social order due to their size and reach).

109. *See* Lindsay Reynolds, Note, *Losing the Quality of Life: The Move Toward Society's Understanding and Acceptance of Physician Aid-in-Dying and the Death with Dignity Act*, 48 NEW ENG. L. REV. 343, 344 (2014) (arguing that "the Death with Dignity Act's (DWDA) nemesis is religion" and that "[r]eligious affiliates abuse their power—trampling on an individual's right to determine their future—thus extinguishing any hope of enacting the DWDA"); *see also* Tucker, *supra* note 53, at 123 ("The [Catholic Church] has been the largest single contributor opposing aid in dying legislation."). Professor Tucker has documented Catholic donations to anti-PAD efforts in state referenda: "$777,782 (53.74% of the opponents' budget) in Washington State in 2008; $1,288,894 (73.9%) in Maine in 2000; $2,173,330 (38.0%) in Michigan in 1998; $1,677,699 (73.6%) in the 1997 Oregon campaign." *Id.* at 123 n.54.

110. *See infra* Sections III.B and III.C, respectively.

111. *See* Thurston, *supra* note 37, at 33–35; *see also* Kathryn L. Tucker & Fred B. Steele, *Patient Choice at the End of Life: Getting the Language Right*, 28 J. LEGAL MED. 305–25 (2007); *Terminology of Assisted Dying*, DEATH WITH DIGNITY NATIONAL CENTER, https://www.deathwithdignity.org/terminology/ (last visited Oct. 29, 2020) (advising readers to refrain from using the term "suicide" in describing PAD and recommending alternate "value-neutral" terminology); *Medical Aid in Dying is not Assisted Suicide, Suicide or Euthanasia*, COMPASSION & CHOICES, https://compassionandchoices.org/about-us/medical-aid-dying-not-assisted-suicide/ (last visited Oct. 29, 2020) (explaining how "medical aid-in-dying" is "fundamentally different" than suicide or euthanasia).

can culture, the language identifying the issues is tactically formulated to nudge the listener toward a certain emotional stance.[112] Concerning PAD, the semantic debate hinges on whether to use the word "suicide" when describing the practice.[113] Although proponents of PAD argue that using the word "suicide" offends patients and perpetuates a negative connotation toward the procedure, they also have a significant, practical interest in avoiding the word: polling support for PAD drops when the word "suicide" is included in the question and rises when the word is removed.[114]

All nine of the statutes legalizing PAD include a strict directive for describing the patient's death: "Actions taken in accordance with this [Act] do not, for any purpose, constitute suicide [or] assisted suicide . . . ."[115] The Washington PAD Act and the Maine PAD Act further limit the permissible language, stipulating that "state reports" cannot refer to the patient's cause of death as "suicide" or "assisted suicide," restricting them instead to more oblique phraseology: "[o]btaining and self-administering life-ending medication."[116] And going even further to distance the practice from the word "suicide," the PAD Acts from Washington, Colorado, Washington, D.C., and Hawaii mandate that the patient's death certificate "shall list the [patient's] underlying terminal disease as the cause of death"—despite the fact that the entire premise of PAD is that the patient willfully takes their own life *instead of* the underlying terminal disease.[117]

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112. *See, e.g.*, *Verbal Engineering*, PATIENTS RIGHTS COUNCIL (2013), http://www.patientsrightscouncil.org/site/verbal-engineering/ (noting that "[a]ll social engineering is preceded by verbal engineering" and collecting articles documenting the "[w]ords [and] platitudes used by advocates of euthanasia [and] doctor-prescribed suicide").

113. Katy Butler, *Aid in Dying or Assisted Suicide? What to Do When Every Phrase Is Fraught*, CTR. FOR HEALTH JOURNALISM (Oct. 26, 2015), https://www.centerforhealthjournalism.org/2015/10/23/aid-dying-or-assisted-suicide-what-do-when-neutral-terms-can%e2%80%99t-be-found.

114. Lydia Saad, *U.S. Support for Euthanasia Hinges on How It's Described*, GALLUP (May 29, 2013), https://news.gallup.com/poll/162815/support-euthanasia-hinges-described.aspx ("Americans generally favor allowing doctors to assist terminally ill patients in ending their lives, but the degree of support ranges from 51% to 70%, depending on how the process is described.").

115. COLO. REV. STAT. § 25-48-121 (2016). This quote is from the Colorado PAD Act, but all nine Acts contain virtually identical orders. *See, e.g.*, VT. STAT. ANN. tit. 18, § 5292 (2013) ("Action taken in accordance with this chapter shall not be construed for any purpose to constitute suicide [or] assisted suicide.").

116. WASH. REV. CODE § 70.245.180(1) (2008); ME. REV. STAT. ANN. tit. 22, § 2140(20) (2019).

117. WASH. REV. CODE § 70.245.040(2) (2009). This quote is from the Washington PAD Act, but the others are virtually identical. *See, e.g.*, COLO. REV. STAT. § 25-48-1(2) (2016). Washington, D.C.'s PAD Act adds that the underlying illness must be listed as the patient's cause of death "*without* reference to the fact that the qualified patient ingested a covered medication." D.C. Code § 7–

"Suicide," as defined by Black's Law Dictionary, "is the willful and voluntary act of a person who understands the physical nature of the act, and intends by it to accomplish the result of self-destruction," or "the deliberate termination of one's existence, while in the possession and enjoyment of his mental faculties."[118] Unquestionably, PAD exemplifies suicide under this definition: PAD is the voluntary self-destruction of a fully aware patient.[119] This renders the statutory insistence on avoiding the obviously applicable term ("suicide") puzzling at first glance.[120]

This preemptive eradication of all references to "suicide" lays the groundwork for the invasion of religious liberty posed by PAD, because the specific wording of the ERDs issued by the Catholic Church bans Catholic doctors and hospitals from participating in, literally, "assisted suicide."[121] By performing a semantic sidestep, all nine state statutes legalizing PAD have rendered the practice ostensibly compliant with the Catholic ERDs: How can a doctor offering PAD be performing an "assisted suicide" if the state statute has pointedly defined PAD as "not assisted suicide"?[122]

The notion that such linguistic hairsplitting contributed to the careful "non-suicide" verbiage in every American PAD statute is supported by the fact that the argument has already been offered with a straight face in *Mahoney v. Centura Health Corporation*.[123] Dr. Barbara Morris, represented by (among others) the End of Life Liberty Project,[124] brought this Colorado

661.05(h) (2016) (emphasis added).

118. *Suicide*, BLACK'S LAW DICTIONARY, 11th ed. (2019).

119. *See supra* text accompanying note 38. Indeed, each state PAD Act unequivocally mandates the characteristics and faculties of a patient eligible for PAD, which follow Black's definition of "suicide" to the letter: the patient must act voluntarily, understand the consequences of the act, intend to terminate his own existence, and possess all mental abilities at the time. *See supra* text accompanying note 38.

120. *See* Susan Gilbert, *Physician Aid in Dying? Euthanasia? Getting the Terminology Straight*, CTR. FOR HEALTH JOURNALISM (Sept. 16, 2015), https://www.centerforhealthjournalism.org/2015/09/15/physician-aid-dying-euthanasia-getting-terminology-straight.

121. *See ERDs*, *supra* note 89.

122. If the court validates this euphemistic dodge, would it then apply consistent logic to validate a statute permitting doctors to perform "fetal terminations" in Catholic hospitals, since the ERDs only prohibit "abortion"? *See* GEORGE ORWELL, NINETEEN EIGHTY-FOUR 50 (Secker & Warburg 1949) ("Don't you see that the whole aim of Newspeak is to narrow the range of thought? In the end we shall make thoughtcrime literally impossible, because there will be no words in which to express it. . . . The Revolution will be complete when the language is perfect.").

123. Complaint, Mahoney et al. v. Centura Health Corporation, 2019-cv-31980 (2019) [hereinafter "Centura Complaint"].

124. *End of Life Liberty Project*, CASCADIANOW!, https://www.cascadianow.org/end-of-life-

case against the Catholic healthcare group Centura Health Corporation for firing Dr. Morris after she tried to offer PAD to a patient in violation of her contract with the hospital.[125] A September 2019 press release from Morris's counsel captures the semantic sidestep argument: "Centura fired Dr. Morris because she violated [the ERDs] . . . [which] state that Catholic health care institutions may not 'participate in euthanasia or assisted suicide.' But as the [Colorado PAD] Act makes clear, *medical aid-in-dying is not euthanasia or assisted suicide*."[126]

The case has not yet been decided, and whether courts will recognize a legal difference between "medical aid-in-dying" and "assisted suicide" remains to be seen.[127] Either way, the effects of such a decision will be far-reaching: nearly one-third of Colorado's hospitals have asserted their refusal to offer PAD since legalization in 2016.[128]

C. The "Premises Loophole"

Every state law permitting PAD contains a clause purportedly classifying all participation in any PAD-related services for both physicians and healthcare institutions as entirely voluntary.[129] Additionally, each law permits "a health care provider [to] prohibit another health care provider from

liberty-project (last visited Oct. 29, 2020). This organization was founded and is currently directed by career-PAD-advocate Professor Kathryn L. Tucker, who argued in favor of PAD before the Supreme Court in *Glucksberg* when she was head of Compassion & Choices in 1997. *Id.*

125. *Colorado Doctor Challenges Firing by Centura Health over Aid in Dying*, THE DENVER POST (Oct. 9, 2019), https://www.denverpost.com/2019/10/09/colorado-centura-health-assisted-suicide-lawsuit/.

126. *FGMC Attorneys Represent Doctor and Patient in Landmark Medical Aid-in-Dying Case*, FOSTER GRAHAM MILSTEIN & CALISHER, LLP (Sept. 3, 2019) [hereinafter *FGMC*], https://fostergraham.com/2019/09/fgmc-attorneys-represent-doctor-and-patient-in-medical-aid-in-dying-case/ (emphasis added).

127. *Id.*

128. Judith Graham, *Colorado's Aid in Dying Law in Disarray as Big Catholic Health Systems Opt Out*, STAT NEWS (Jan. 19, 2017), https://www.statnews.com/2017/01/19/aid-in-dying-catholic-hospitals-colorado/ (adding that "two of the state's biggest health care systems, both faith-based, appear poised to bar their doctors from providing [PAD] to patients at any of their facilities, under any circumstances").

129. *See, e.g.*, OR. REV. STAT. 127.885 § 4.01(2) (1994): "No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with [this Act]." Every state statute permitting PAD contains a similar "voluntary" provision for both physicians and healthcare providers. *See, e.g.*, WASH. REV. CODE § 70.245.190(1)(b) (2008).

participating in [the state's PAD Act] *on the premises of the prohibiting provider*. . . ."[130] This "premises clause" creates an immense limitation on the ability of healthcare institutions to control whether or not their employees will offer PAD to their patients, regardless of any conscience objections from the employing hospital.[131] If, for example, a doctor wishes to prescribe death-inducing medication to a terminal patient, and the hospital employing that doctor expresses a conscientious objection to PAD, the hospital is nevertheless rendered legally powerless to stop the doctor from prescribing the medication—so long as the patient leaves the hospital premises before ingesting it.[132] While pro-PAD activists may view the premises loophole as a victory for patients, this suspicious technicality enables the lawful violation of conscience rights and forces healthcare institutions to provide services inconsistent with their moral principles.[133]

The magnitude of this loophole is illustrated by the fact that, in 2018, an overwhelming majority of patients utilizing legal PAD did so at home, rather than on the premises of a hospital: 92% in California,[134] 85.6% in Colorado,[135] 87.5% in Oregon,[136] and 86% in Washington.[137] These statistics sup-

130. OR. REV. STAT. 127.885 § 4.01(5)(a) (1994) (emphasis added). This quote is from the Oregon DWDA, but each state statute contains a nearly identical "premises clause," allowing hospitals to prohibit healthcare providers from administering PAD *only* at the specific site of the physical hospital. *See, e.g.*, VT. STAT. ANN. tit. 18, § 113.5286 (2013).

131. *See infra* text accompanying notes 142–144.

132. *See infra* text accompanying notes 142–144. For example, if the Kahala Nui retirement home in Honolulu succeeded in implementing the ERDs, thereby preventing its facilities and healthcare workers from promoting or practicing PAD, the home would still be incapable of preventing any of its workers from giving death-inducing medication to every single resident who requested it and qualified for it under Hawaii law, so long as those residents crossed the property line to exit the "premises" before taking that medication. *See supra* notes 105–108 (describing the dilemma forced upon the Kahala Nui retirement home by Hawaii's PAD act).

133. *See* Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 58 (1994) ("As patient autonomy receives more and more legal sanction, the problem of preserving the physician's moral integrity will grow. This danger is accentuated by the deficiency of 'conscience clauses,' which could provide statutory protection for physicians who refuse to provide or participate in procedures they find repugnant on moral or religious grounds.").

134. *California End of Life Option Act 2018 Data Report*, CAL. DEP'T OF PUB. HEALTH 1, 6, 9 (July 2019), https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH%20End%20of%20Life%20Option%20Act%20Report%202018-FINAL.pdf.

135. *Colorado End-of-Life Options Act, Year Three 2019 Data Summary with 2017–2019 Trends and Totals*, COLO. DEP'T OF PUB. HEALTH & ENV'T 1, 5 (2019), https://drive.google.com/file/d/1FmoyCcL2gHopDO9rCJ2lGFEMUye8FQei/view.

136. *Oregon Death with Dignity Act 2018 Data Summary*, PUB. HEALTH DIVISION, CTR. FOR

port the common claim from PAD activists that one of the central benefits of PAD is the patient's ability to choose the time and location of his or her death; understandably, most terminal patients choose to die in their own homes rather than on the premises of a hospital.[138] The fact that PAD nearly always takes place at the patient's home demonstrates that every PAD law's "premises clause" renders its institutional conscience protections functionally ineffective at best, and ominously duplicitous at worst.[139]

The "premises clause" issue was raised against the Catholic healthcare system in *Mahoney*, the case unfolding in Colorado, with Dr. Morris citing Colorado's premises clause in defense of her decision to offer PAD to her patient in violation of her employer's religious beliefs.[140] Specifically, she argued, "[t]he Act contains an 'opt-out' provision that permits hospitals to prohibit their physicians from prescribing aid-in-dying medication to patients who intend to use the medication on hospital premises. The Act does not allow hospitals to opt out of the Act altogether."[141] Centura acknowledged its policy "conflicts with Colorado law," but maintained that the policy was "nevertheless required by [its] religious beliefs"—perfectly capturing the unethical dilemma forced upon conscientious healthcare institutions by premises clauses.[142] Absent constitutional protection, the premises clause in

HEALTH STAT. 1, 6 (last updated April 25, 2019), www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/Documents/year21.pdf.

137. *2018 Death with Dignity Act Report*, WASH. ST. DEP'T OF HEALTH 1, 13 (July 2019), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf.

138. *See* Tucker, *supra* note 53, at 120 ("The availability of the option of aid in dying gives the terminally ill autonomy, control and *choice*, the overwhelming motivational factor behind the decision to request assistance in dying.").

139. *See* Stormans, Inc. v. Wiesman, 794 F.3d 1064 (9th Cir. 2015), *cert. denied*, 136 S. Ct. 2433 (2016) (Alito, J., dissenting) (denying to hear case about a family-owned pharmacy ordered to stock and sell contraceptives in violation of religious beliefs). Dissenting against denial of certiorari, Justice Alito labeled the case "an ominous sign" and warned that "[i]f this is a sign of how religious liberty claims will be treated in the years ahead, those who value religious freedom have cause for great concern." *Stormans*, 136 S. Ct. at 2433 (Alito, J., dissenting). In a description directly analogous to Catholic hospitals like Centura that object to PAD under new state PAD laws, Justice Alito captured the conscientious pharmacists' plight: "The dilemma . . . is plain: Violate your sincerely held religious beliefs or get out of the pharmacy business." *Id.* at 2434; *see also* Pellegrino, *supra* note 6, at 233–34 ("One can foresee the day when patients may gain legal rights to demand a full range of death 'services' from every licensed physician . . . . If universal health-care were to be instituted and 'death care,' as well as birth and reproductive care, were to be entitlements, would Catholic physicians be given only limited practice licenses?").

140. Centura Complaint, *supra* note 123, at 11–12.

141. *FGMC*, *supra* note 126.

142. *Id.*

Colorado's PAD Act would force Centura to violate its institutional conscience and religious directives by allowing a doctor it employs to give a patient being treated on its premises medicine to end his own life—provided the patient simply leaves the hospital premises before ingesting the medicine. This is a violation of Centura's constitutional right to freely exercise its religious beliefs, and every Catholic hospital in a state with legal PAD faces the same threat from its own state's premises clause.[143]

IV. MEDICAL MINISTERS: FORTIFYING THE INSTITUTIONAL RIGHT TO CONSCIENCE IN HEALTHCARE

A well-coordinated, pro-PAD army of activist groups, donors, and lobbyists is overhauling historic anti-PAD public opinion and laying siege to state governments through lawsuits, ballot initiatives, and an unrelenting onslaught of PAD-legalization bills, and this effort will continue to accelerate in the coming decades.[144] The threat to religious liberty posed by this social upheaval is clear and imminent, and has already manifested in at least one foreboding case, *Mahoney v. Centura*.[145] Religious liberty advocacy is often reactive in nature, addressing threats and grievances as they arise rather than legislating preemptively, in part because the next antireligious legal attack can be difficult to predict.[146] In the case of PAD, the opposite is true: the

143. *See* Pellegrino, *supra* note 6, at 236 ("Catholic hospitals can properly be considered to have a definable institutional 'conscience,' one, which given the content of the Catholic moral tradition, could and does come into conflict with secular society and its 'values.'").

144. *See generally Attempts to Legalize Euthanasia/Assisted-Suicide in the United States*, *supra* note 58 (presenting a brief history of the assisted suicide movement).

> [S]ince Oregon legalized assisted suicide in 1994, many states have rejected assisted-suicide measures, some multiple times. Between January 1994 [and] February 2020, there have been 284 proposals in more than 43 states and the District of Columbia. Yet, over and over again, bills were either defeated, tabled for the session, withdrawn by sponsors, or languished with no action taken.

Id.

145. *See* Centura Complaint, *supra* note 123.

146. *See* LUKE W. GOODRICH, FREE TO BELIEVE: THE BATTLE OVER RELIGIOUS LIBERTY IN AMERICA 182 (2019). Goodrich notes another reason for the generally reactive nature of religious liberty: victory for Christians is not about securing favorable court decisions and laws, but about living a certain kind of life. *Id.* After recounting his numerous experiences advocating for religious liberty in American courts, Goodrich pauses to explain this concept:

> [S]tarting with a strategy for "winning" is the wrong way to approach the question. It assumes the primary goal in religious freedom conflicts is to "win," and it's often driven by fear—fear that our rights will be taken away or other bad things will happen if we lose. That fear, in turn, produces anger, hostility, frustration, and despair. Scripture, however,

battle lines are drawn, the clash is inevitable, and the stakes are literally life-or-death. Accordingly, religious hospitals can and should apply the broad latitude afforded to religious employers by the Supreme Court's unanimous ruling in *Hosanna-Tabor Evangelical Lutheran Church v. Equal Employment Opportunity Commission* to terminate healthcare workers who fail to personify the hospital's conscientious beliefs.[147]

A. What Is a "Minister"?

The judge-created "ministerial exception"—a legal doctrine rooted in both Religion Clauses of the First Amendment, which guarantees religious institutions the right to hire employees who represent and personify their beliefs free from government oversight—is well-established but poorly named.[148] Judicial recognition of this right, as well as its misleading moniker, originated in the Fourth Circuit in 1985.[149] In the same sentence where

> calls us to a radically different approach. We're not called to win but to be like Jesus; not to fear suffering but to fear God; not to be surprised at hostility but to expect it; not to complain when we lose but to rejoice; not to lash out at our opponents but to love them. We're called not to avoid losing at all costs but to glorify God at all costs.

Id.

147. Hosanna-Tabor Evangelical Lutheran Church & Sch. v. Equal Emp't Opportunity Comm'n, 565 U.S. 171, 190 (2012) (recognizing "a ministerial exception grounded in the Religion Clauses of the First Amendment," which guarantees religious institutions the right to hire employees who represent and personify their beliefs); *see also infra* Sections IV.A.–B. *Hosanna-Tabor* effectively reinterpreted the landmark case of *Employment Division v. Smith*, which had drastically narrowed the scope and redefined the parameters of religious freedom. *See, e.g.*, Michael W. McConnell, *Free Exercise Revisionism and the* Smith *Decision*, 57 U. CHI. L. REV. 1109, 1110 (1990); Douglas Laycock, *The Remnants of Free Exercise*, 1990 SUP. CT. L. REV. 1 (1990). For a discussion of the interrelation between *Smith*, *Hosanna-Tabor*, and PAD, see *infra* Section IV.C.

148. *See Hosanna-Tabor*, 565 U.S. at 190 (recognizing "a ministerial exception grounded in the Religion Clauses of the First Amendment"); *Our Lady of Guadalupe Sch. v. Morrisey-Berru*, 140 S. Ct. 2049, 2060 (2020) ("The rule appears to have acquired the label 'ministerial exception' because the individuals involved in pioneering cases were described as 'ministers.'"); *see also* Michael Stokes Paulsen, *Hosanna in the Highest!*, PUB. DISCOURSE (Jan. 13, 2012), https://www.thepublicdiscourse.com/2012/01/4541/ ("The 'ministerial exception' label really ought to be discarded, for it is now something of a misnomer, a relic of the pre-*Hosanna-Tabor*, lower court-developed doctrinal approach. Rather, the right should be understood as the 'religious autonomy *right*'—an 'exception' to nothing but a principle of its own.").

149. *See* Rayburn v. Gen. Conference of Seventh-Day Adventists, 772 F.2d 1164, 1168 (4th Cir. 1985) (applying "[t]he 'ministerial exception' to Title VII first articulated in [*McClure*]" to the case of a female applying to work on a church pastoral staff) (citing McClure v. Salvation Army, 460 F.2d 553 (5th Cir.), *cert. denied*, 409 U.S. 896 (1972)). *McClure* articulated the doctrine in a case dealing with "the church-minister relationship," but *Rayburn* first bestowed the inarticulate title. *McClure*, 460 F.2d at 555.

it established the now-famous phrase "ministerial exception," the court immediately qualified its language by broadening it substantially: the exception "does not depend upon ordination but upon the function of the position."[150] In other words, from the moment of its judicial inception, the "ministerial exception" has been more than just an exception and applied to more than just ministers; rather, it is an affirmative right guaranteed to any religious institution with employees who represent or personify its beliefs based on their *function*, not their *title*.[151] As other courts of appeals began readily applying this right across the country, the name, regrettably, stuck.[152] Conceptually, however, the breadth of the ministerial exception continued to exceed the nominal borders suggested by its name, with circuit courts identifying sufficient ministerial function in non-ordained seminary professors[153] and hospital chaplains.[154]

Finally, in 2012, the ministerial exception came before the Supreme Court in a landmark case concerning a narcoleptic kindergarten teacher at a Lutheran school in Michigan: *Hosanna-Tabor Evangelical Lutheran Church v. Equal Employment Opportunity Commission*.[155] After Cheryl Perich left her teaching job on disability and came back to find her position had been given away, she "violated the [Lutheran] Synod's belief that Christians should resolve their disputes internally" by threatening to sue the Church.[156] The school terminated her for this act of "insubordination," and the Equal Employment Opportunity Commission (EEOC) sued under the Americans with Disabilities Act for unlawful dismissal.[157] The district court granted summary judgment for Hosanna-Tabor, which claimed the ministerial exception permitted its dismissal of Perich.[158] The Sixth Circuit vacated and

150. *Rayburn*, 772 F.2d at 1168 (citing Equal Emp't Opportunity Comm'n v. Sw. Baptist Seminary, 651 F.2d 277 (5th Cir. 1981), *cert denied*, 456 U.S. 905 (1982)).

151. *See Hosanna-Tabor*, 565 U.S. at 188 n.2 (2012) (noting that "the Courts of Appeals have uniformly recognized the existence of a 'ministerial exception'" and documenting federal courts of appeals cases).

152. *Id.*

153. *See Sw. Baptist Theological Seminary*, 651 F.2d at 283–84.

154. *See* Scharon v. St. Luke's Episcopal Presbyterian Hosps., 929 F.2d 360, 362–63 (8th Cir. 1991); *see also Hosanna-Tabor*, 565 U.S. at 190 ("Every Court of Appeals to have considered the question has concluded that the ministerial exception is not limited to the head of a religious congregation, and we agree.").

155. 565 U.S. 171 (2012).

156. *Id.* at 180.

157. *Id.* at 179–80.

158. *Id.* at 180–81.

remanded, recognizing the ministerial exception's First Amendment justification but finding that Perich did not qualify as a "minister," and the Supreme Court granted certiorari.[159]

Confronted with an issue involving the ministerial exception for the first time in its history, the Supreme Court unflinchingly affirmed, enforced, and expanded it—unanimously.[160] Writing for the entire Court, Chief Justice Roberts declared that "[r]equiring a church to accept or retain an unwanted minister, or punishing a church for failing to do so . . . interferes with the internal governance of the church, depriving the church of control over the selection of *those who will personify its beliefs*."[161] Having validated the ministerial exception's constitutionality, the Court next explored whether Perich qualified as a minister under this broad, new definition: personifying beliefs.[162] Ruling that she was indeed a minister, the Court listed the details it found convincing, including her formal title, her religious training, the fact that she held a distinct role from other members, and the fact that her "job duties reflected a role in conveying the Church's message and carrying out its mission."[163] Although it thus categorized Perich as a minister, the Court concluded with a critical caveat: "We are reluctant . . . to adopt a rigid formula for deciding when an employee qualifies as a minister. It is enough for us to conclude, in this our first case involving the ministerial exception, that the exception covers Perich, given all the circumstances of her employment."[164]

By declining "to adopt a rigid formula," the Court instead offered a standard that outlines the broadest workable definition for a "minister": an employee of a religious institution who "personif[ies] its beliefs."[165] Chief

159. *Id.* at 181.

160. *Id.* at 175, 181.

161. *Id.* at 188 (emphasis added); *see also* Laycock, *supra* note 8, at 1389 (arguing that institutional free exercise includes the right of churches to autonomously "select their own leaders, define their own doctrines, resolve their own disputes, and run their own institutions," and noting that religious believers "exercise their religion through religious organizations, and these organizations must be protected by the [Free Exercise] clause") (footnotes omitted).

162. *Hosanna-Tabor*, 565 U.S. at 188–90.

163. *Id.* at 191–92.

164. *Id.* at 190.

165. *Hosanna-Tabor*, 565 U.S. at 188, 190; *see also* Paulsen, *supra* note 148 ("The Court's one-word descriptor perhaps says it best: ['ministers' are] those persons that the community identifies as *personifying* its religious identity. The Court decided only the case before it, but it made clear that the right itself is one of religious community autonomy, broadly understood. It is not a right limited to pastors alone.").

Justice Roberts seemed to affirm the standard's wide-ranging scope when he wrote that the ministerial exception affects "the interest of religious groups in choosing who will preach their beliefs, teach their faith, *and carry out their mission*."[166] The inclusion of this final category of individuals, which surely also includes those who "personify" the beliefs of the religious institution, captures the significant interpretive expansion the Supreme Court implemented to ministerial exception jurisprudence in *Hosanna-Tabor*.[167]

Within nine months, the Fifth Circuit applied the language of *Hosanna-Tabor* to identify Philip Cannata, a church's music director, as a minister in a wrongful termination case against a Catholic church in Austin, Texas.[168] Unlike Perich in *Hosanna-Tabor*, Cannata had no formal title indicating his role as minister, no teaching responsibilities whatsoever, and no theological or ecumenical training.[169] After quoting the "personifying beliefs" language from *Hosanna-Tabor*, the court reasoned that

> [a]pplication of the [ministerial] exception . . . does not depend on a finding that Cannata satisfies the same considerations [as Perich]. Rather, it is enough to note that there is no genuine dispute that Cannata *played an integral role* in the celebration of Mass and that by playing the piano during services, Cannata *furthered the mission of the church* and helped convey its message to the congregants.[170]

The factual considerations the Supreme Court noted in declaring Perich a minister were all absent when the Fifth Circuit declared Cannata a minister, underscoring the common trait between the two: personifying belief.[171]

166. *Hosanna-Tabor*, 565 U.S. at 196 (emphasis added).

167. *Id.* at 188–89.

168. Cannata v. Catholic Diocese of Austin, 700 F.3d 169, 180 (5th Cir. 2012).

169. *Id.* at 171. Cannata argued "that he merely played the piano at Mass and that his only responsibilities were keeping the books, running the sound system, and doing custodial work, none of which was religious in nature." *Id.* at 177. Cannata was given no "liturgical responsibilities" because he "lacked the requisite education, training, and experience." *Id.* at 171.

170. *Id.* at 177 (emphasis added). Here, the Fifth Circuit echoed the Supreme Court in *Hosanna-Tabor*, which rejected the EEOC's argument that "any ministerial exception 'should be limited to those employees who perform exclusively religious functions,'" declaring: "We cannot accept that view. Indeed, we are unsure whether any such employees exist." *Hosanna-Tabor*, 565 U.S. at 193 (quoting Brief for the Federal Respondent at 51, Hosanna-Tabor Evangelical Lutheran Church v. Equal Emp't Opportunity Comm'n, 565 U.S. 171 (2012) (No. 10–533)).

171. *Hosanna-Tabor*, 565 U.S. at 188; *Cannata*, 700 F.3d at 173, 177.

In 2020, the Supreme Court affirmed the "personifying belief" standard as the backbone of the ministerial exception in its second case addressing the doctrine, *Our Lady of Guadalupe School v. Morrissey-Berru*.[172] Agnes Morrissey-Berru, a teacher at a Catholic elementary school, alleged the school declined to renew her contract in order to replace her with a younger teacher in violation of the Age Discrimination in Employment Act.[173] The case was consolidated with *St. James School v. Biel*, which also involved a teacher at a Catholic elementary school alleging her contract was not renewed due to employment discrimination.[174] The Court ruled, 7–2, that both suits were barred by the ministerial exception.[175] Writing for the majority, Justice Alito first noted that neither teacher was "given the title of 'minister'" by her respective employer, and that both teachers had "less religious training than [Cheryl] Perich," the teacher the Court affirmed as a minister in *Hosanna-Tabor*.[176] Though the Court had recognized various factors in concluding that Perich qualified as a minister, that recognition "did not mean that [those factors] must be met—or even that they are necessarily important—in all other cases."[177] "What matters, at bottom," Justice Alito stressed, "is what an employee does."[178]

The Court's endorsement of functionality led Justice Sotomayor, in her dissent, to accuse the Court of "rewriting *Hosanna-Tabor*."[179] Factors like titles and training, she argued, were critical to *Hosanna-Tabor*'s definition of "minister" because they served to "separate leaders who 'personify' a church's 'beliefs'" from those who merely "relay religious tenets."[180] Justice Alito responded that this characterization of *Hosanna-Tabor* was incorrect—employees who only "relay religious tenets" could certainly be ministers, the exception was never limited to "leaders," and such an "unworkable

172. 140 S. Ct. 2049 (2020).

173. *Id.* at 2056–58.

174. 140 S. Ct. 680 (2020) (mem.); *Our Lady of Guadalupe*, 140 S. Ct. at 2058–59. Biel alleged her contract was not renewed because she requested a leave of absence to receive cancer treatment, but the school maintained that its decision was based on her "poor performance" as a teacher. *Our Lady of Guadalupe*, 140 S. Ct. at 2059.

175. *Our Lady of Guadalupe*, 140 S. Ct. at 2055.

176. *Id.*

177. *Id.* at 2063. Specifically, the Court identified formal titles and academic training as "circumstances [which], while instructive in *Hosanna-Tabor*, are not inflexible requirements and may have far less significance in some cases." *Id.* at 2064.

178. *Id.*

179. *Id.* at 2075 (Sotomayor, J., dissenting).

180. *Id.*

test" was never contemplated by the Court in *Hosanna-Tabor*.[181] Justice Sotomayor's dissent further charged that, because neither school "required its religion teachers to be Catholic," the schools could not show how "a non-Catholic 'personif[ies]' Catholicism."[182] The majority, however, declined to "delve into the sensitive question of what it means to be a 'practicing' member of a faith," and rejected Morrissey-Berru's argument that she could not be a Catholic minister because she was not "a practicing Catholic."[183] Though the Court ultimately echoed *Hosanna-Tabor* in declining to adopt a "rigid formula" to define ministers, *Our Lady of Guadalupe* clarified that an employee's ministerial status does not depend on any of the *Hosanna-Tabor* "factors," and does not require the employee to adhere to the religion of their employer.[184] The true extent of the ministerial exception, however, has not yet been defined.

B. Healthcare Workers at Catholic Hospitals Are "Ministers" Under Hosanna-Tabor *and* Our Lady of Guadalupe

1. Healthcare Workers at Catholic Hospitals Personify Catholic Beliefs

From its beginning, for almost two millennia, the Catholic Church has sought to imitate its founding figure, Jesus Christ, by embodying perhaps his most famous and widely celebrated characteristic: healing the sick.[185] Catholic missionaries have a well-documented history of spreading healthcare across the globe in their evangelization efforts, and the Catholic emphasis on healthcare as both spiritual outreach and as spiritual mission continues today

181. *Id.* at 2067 n.26 (majority opinion).

182. *Id.* at 2081 (Sotomayor, J., dissenting).

183. *Id.* at 2069 (majority opinion).

184. *Id.* ("[W]e declined to adopt a 'rigid formula' in *Hosanna-Tabor*, and the lower courts have been applying the exception for many years without such a formula. Here, as in *Hosanna-Tabor*, it is sufficient to decide the case before us.").

185. *See, e.g.*, *John* 9; *Luke* 17; *Mark* 5; *Matthew* 8. Jesus also charged his followers to heal the sick as he had done and promised that they would have power over disease. *Luke* 10:9; *Matthew* 10:8; *see also ERDs*, *supra* note 89, at 6 ("The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ.").

in the United States.[186] The preeminent Catholic authority on healthcare practices, the ERDs, summarize this core commitment and call for steadfastness in the face of modern moral turbulence: "Now, with American health care facing even more dramatic changes, we reaffirm the Church's commitment to health care ministry and the distinctive Catholic identity of the Church's institutional health care services."[187] Unambiguously, the ERDs uphold the healthcare arm of Catholic ministry ("the ecclesial mission of healthcare") as being at the very heart of the Church's identity.[188] Consequentially, the ERDs take care to identify the parties who will carry out, or personify, this core belief: institutional Catholic healthcare systems, including "the sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents of these institutions and services."[189] These healthcare workers are the sole representatives of their Catholic employers' spiritual commitment to healing the sick, and are thus the only possible means by which these religious institutions may carry out this tenet of

186. *See ERDs*, *supra* note 89, at 8 (explaining that the motivating factor leading "institutionally based Catholic health care services in the United States to become an integral part of the nation's health care system" is "[t]heir embrace of Christ's healing mission").

187. *Id.* at 4.

188. *Id.*; *see, e.g.*, *A Shared Statement of Identity*, CATHOLIC HEALTH ASS'N OF THE U.S., https://www.chausa.org/mission/a-shared-statement-of-identity (last visited Oct. 29, 2020) ("We are the people of Catholic health care, a ministry of the church continuing Jesus' mission of love and healing today. As provider, employer, advocate, citizen—bringing together people of diverse faiths and backgrounds—our ministry is an enduring sign of health care rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind, and spirit.").

189. *ERDs*, *supra* note 89, at 4; *see also Health and Health Care: A Pastoral Letter of the American Catholic Bishops*, U.S. CONFERENCE OF CATHOLIC BISHOPS 15 (1981), http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/health-and-health-care-pastoral-letter-pdf-09-01-43.pdf ("By its very nature a Catholic health care facility aims to take on the character of a Christian community. All who work there are participants in the Catholic health apostolate. Catholic institutions are encouraged to provide education and training programs to instruct and inform their employees in the Catholic philosophy of care of the sick."). Catholic healthcare institutions may soon have to include pharmacists in the explicit list of healthcare workers who carry out their medical mission and thus require protection from evolving secular norms: although the 2019 Our Care, Our Choice Act gives Hawaii doctors the right to opt out of performing PAD, in January 2019, the Hawaii legislature introduced a bill to "[e]stablish penalties for pharmacies and pharmacists who refuse to honor and fill a prescription for any qualifying patient." S.B. 542, 30th Leg., Reg. Sess. (Haw. 2019). For conscientious pharmacists who object to PAD, as well as for conscientious pharmacies exercising their institutional free exercise right to prohibit their employees from participating in PAD, this bill represents a creative, new attack on medical conscience in pharmacies, analogous to the attack currently unfolding against conscientious hospitals. *See generally Hawaii*, PATIENTS RIGHTS COUNCIL, http://www.patientsrightscouncil.org/site/hawaii/ (last visited Oct. 29, 2020) (tracking current and proposed legislation regarding PAD).

their faith.[190] In short, when it comes to the Catholic Church's sincerely held and centuries-old religious commitment to healing the sick, its healthcare employees necessarily personify its beliefs—they are "ministers."[191]

2. Catholic Healthcare Institutions Must Have the Final Say in Identifying Their Ministers

Justice Thomas and Justice Alito (joined by Justice Kagan) authored two concurring opinions alongside Chief Justice Roberts's opinion for the Court in *Hosanna-Tabor*.[192] Remarkably, these concurrences each contend that the Constitution requires the definition of "minister" to be expanded even *further*, to allow the religious institutions to identify and define for themselves which of their employees qualify as ministers.[193]

According to Justice Thomas, the First Amendment's Religion Clauses require courts to "defer to a religious organization's good-faith understanding of who qualifies as its minister."[194] Justice Thomas argued that the min-

190. *See generally* Kathleen A. Brady, *Religious Organizations and Free Exercise: The Surprising Lessons of* Smith, 2004 BYU L. REV. 1633, 1649–63 (detailing the decades-long journey of the ministerial exception through the circuit courts, documenting the various expansions of the role of "minister," and noting that "[n]o court has limited the ministerial exception to ordained clergy" and that it "covers all employees with ministerial functions").

191. *See* Myers, *supra* note 36, at 24 (capturing the incongruity of current conscience law: "[R]eligion only receives protection in areas such as religious belief and worship. But when religion is out in the world, running schools or hospitals or homeless shelters, it must be treated just like any other entity."). If religion only receives legal protection in designated ecumenical spaces during formal worship services, "there is no way religious entities can be faithful to their religious identities when they venture out into the public realm; these entities must be subject to the demands of the secular state." *Id.* In the same way, the law undermines religion when it defines ministers with the same restrictive formality: Must one personify *all* of Jesus' commands to his disciples before one can be classified as a minister, including "heal[ing] the sick, rais[ing] the dead, cleans[ing] lepers, [and] cast[ing] out demons"? *Matthew* 10:8. Under such a framework, even the canonized, world-renowned Saint Mother Theresa cannot qualify as a "minister," because she healed the sick and cleansed lepers, but failed to carry out Jesus' command to raise the dead. *Mother Theresa Biographical*, THE NOBEL PRIZE, https://www.nobelprize.org/prizes/peace/1979/teresa/biographical/ (last visited Oct. 29, 2020). Healthcare workers employed by the Catholic Church for the *explicit* purpose of carrying out its ministry to heal the sick need not simultaneously personify every potential arm of global Catholic ministry—they personify one ministry (healing the sick), and are, consequently, ministers. *See supra* Section IV.A.

192. Hosanna-Tabor Evangelical Lutheran Church & Sch. v. Equal Emp't Opportunity Comm'n, 565 U.S. 171, 196–206 (2012).

193. *Id.*

194. *Id.* at 196 (Thomas, J., concurring); *see also* Corp. of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos, 483 U.S. 327, 336 (1987) ("[I]t is a significant burden on

isterial exception would be rendered "hollow . . . if secular courts could second-guess the organization's sincere determination that a given employee is a 'minister' under the organization's theological tenets."[195] Using Perich as an example, Justice Thomas agreed that the facts of her case "amply demonstrate[d] [her] ministerial role," but maintained that far less would have been dispositive: "[T]he evidence demonstrat[ing] that Hosanna-Tabor sincerely considered Perich a minister . . . would be sufficient for me to conclude that Perich's suit is properly barred."[196] Like Chief Justice Roberts in the majority opinion, Justice Thomas rejected "a bright-line test or multifactor analysis," reasoning that different definitions between religious groups may "vary widely" and that such a rigid test "risk[s] disadvantaging those religious groups whose beliefs, practices, and membership are outside of the 'mainstream' or unpalatable to some."[197]

Justice Alito, joined by Justice Kagan, wrote separately to emphasize the majority's determination that employees' functions, rather than their formal titles or ordination statuses, identify them as ministers.[198] Because the literal word "minister" is used most commonly by Protestant Christians to refer to their leaders, and "virtually every religion in the world" is represented in the United States, terminology native to a single religion, even the current majority religion, must not define the legal standard.[199] Instead, individual religious employers must be left to "determine who is qualified to serve in positions of substantial religious importance."[200] Justice Alito was unconcerned that Perich performed a mixture of secular and religious duties for Hosanna-Tabor, concluding that "[w]hat matters is that [Perich] played an important role as an instrument of her church's religious message."[201] Ul-

a religious organization to require it, on pain of substantial liability, to predict which of its activities a secular court will consider religious.").

195. *Hosanna-Tabor*, 565 U.S. at 196–97. Tellingly, Justice Thomas avoided the name "ministerial exception," referring instead to "[a] religious organization's right to choose its ministers." *Id.*

196. *Id.* at 197–98.

197. *Id.* at 197.

198. *Id.* at 202 (Alito, J., concurring). Justice Alito emphasized that a formal title is "neither necessary nor sufficient," adding that "no circuit [considering the ministerial exception] has made ordination status or formal title determinative of the exception's applicability." *Id.*

199. *Id.* at 198 ("The term 'minister' . . . is rarely if ever used [to refer to members of their clergy] by Catholics, Jews, Muslims, Hindus, or Buddhists.").

200. *Id.* at 200 (adding that "[d]ifferent religions will have different views on exactly what qualifies as an important religious position").

201. *Id.* at 204.

timately, her function as an employee granted Hosanna-Tabor "the right to decide for itself whether [she] was religiously qualified to remain in her office."[202] Similarly, a religious employer's control over employees who personify its beliefs "is an essential component of its freedom to speak in its own voice, both to its own members and to the outside world."[203]

Justice Alito developed this idea further in *Our Lady of Guadalupe*, noting that both Catholic elementary schools in the case expressly regarded their teachers as "playing a vital part in carrying out the mission of the church."[204] As its rationale for weighing the schools' own perceptions in its analysis, the Court stated that "the schools' definition and explanation of [teachers'] roles is important."[205] The Court did not entirely relegate authority to employers to determine which of their employees are ministers, but by declaring employers' input "important," the Court seems to have taken a judicial baby step in that direction.[206] Further steps are likely, because deference to religious employers to classify their own ministers was strongly urged by both of the concurring opinions in *Hosanna-Tabor*[207] as well as the concurrence in *Our Lady of Guadalupe*.[208] These three concurring opinions were authored or joined by Justices Thomas, Alito, Kagan, and Gorsuch, indicating support from at least four justices for deference to employers in defining minsters.[209]

202. *Id.*

203. *Id.* at 201.

204. Our Lady of Guadalupe Sch. v. Morrissey-Berru, 140 S. Ct. 2049, 2066 (2020).

205. *Id.*

206. *Id.*

207. *See* Hosanna-Tabor Evangelical Lutheran Church v. Equal Emp't Opportunity Comm'n, 565 U.S. 171, 196 (2012) (Thomas, J., concurring) ("[I]n my view, the Religion Clauses require civil courts to apply the ministerial exception and to defer to a religious organization's good-faith understanding of who qualifies as its minister."); *Id.* at 206 (Alito, J., concurring) ("Hosanna–Tabor believes that the religious function that [Perich] performed made it essential that she abide by the doctrine of internal dispute resolution; and the civil courts are in no position to second-guess that assessment.").

208. *See Our Lady of Guadalupe*, 140 S. Ct. at 2070 (Thomas, J., concurring) ("To avoid disadvantaging . . . minority faiths and interfering in 'a religious group's right to shape its own faith and mission,' courts should defer to a religious organization's sincere determination that a position is 'ministerial.'" (internal citation omitted)). Justice Gorsuch, who was appointed to the Court five years after Hosanna-Tabor, joined Justice Thomas's concurrence. *Id.* at 2069.

209. In her dissenting opinion in *Our Lady of Guadalupe*, Justice Sotomayor identified the Court's deferential approach when she accused the majority of "collaps[ing] *Hosanna-Tabor*'s careful analysis into a single consideration: whether a church thinks its employees play an important religious role." *Id.* at 2072 (Sotomayor, J., dissenting). Justice Sotomayor concluded that employees potentially covered by *Our Lady of Guadalupe*'s more deferential approach to the ministerial exception

The post-*Our Lady of Guadalupe* addition of Justice Amy Coney Barrett to the Court may provide a fifth voice in support of this view.[210] In 2018, then-Judge Barrett joined a Seventh Circuit panel which concluded that the ministerial exception barred an employment discrimination suit from Miriam Grussgott, a Hebrew teacher terminated by a Jewish school.[211] The panel rejected the teacher's attempt to classify her duties as purely secular, cautioning that "drawing a distinction between secular and religious teaching . . . is inappropriate when doing so involves the government challenging a religious institution's honest assertion that a particular practice is a tenet of its faith."[212] The panel clarified that deferring to religious employers "does not mean that we can never question [their] designation of what constitutes religious activity, but we defer to the organization in situations like this one, where there is no sign of subterfuge."[213] In her confirmation hearing before the U.S. Senate Committee on the Judiciary, Justice Barrett articulated her personal view that "*Our Lady of Guadalupe* gives a lot of deference to the school's characterization of whether someone is a minister or not, not to encourage discrimination of course, but simply to protect religious freedom."[214]

Hosanna-Tabor and *Our Lady of Guadalupe* serve to both define and forecast the Court's vision for the ministerial exception, and strongly suggest judicial priorities in identifying "ministers"—namely, that function trumps title, secular duties may predominate over religious duties, an employee need not adhere to the faith of its employer, and the employing religious institution must have the final say in identifying its own ministers.[215] Taken together with the majority's "personifying belief" standard for ministers,

would include "nurses, social-service workers . . . and many others who work for religious institutions." *Id.* at 2082.

210. *See Senate Confirms Amy Coney Barrett For Supreme Court*, THE WHITE HOUSE (Oct. 26, 2020), https://www.whitehouse.gov/articles/senate-confirms-amy-coney-barrett-supreme-court/.

211. Grussgott v. Milwaukee Jewish Day Sch., Inc., 882 F.3d 655 (2018) (per curiam).

212. *Id.* at 660.

213. *Id.*

214. *Nomination of the Honorable Amy Coney Barrett to be an Associate Justice of the Supreme Court of the United States (Day 3)*, COMMITTEE ON THE JUDICIARY (Oct. 14, 2020) (beginning at 2:14:45), https://www.judiciary.senate.gov/meetings/nomination-of-the-honorable-amy-coney-barrett-to-be-an-associate-justice-of-the-supreme-court-of-the-united-states-day-3.

215. *See also* John H. Garvey, *Churches and the Free Exercise of Religion*, 4 NOTRE DAME J.L. ETHICS & PUB. POL'Y 567, 578 (1990) ("The group is a legal and moral person distinct from its members; its interests may conflict with theirs. Its freedom is not a compound of individual liberties[;] . . . it is a right to act in ways peculiar to the group.") (footnote omitted).

these qualities perfectly outline the role healthcare workers play in Catholic hospitals. While doctors and nurses are by no means employed for the purpose of providing religious instruction in a literal sense, they are indispensable to the core Catholic ministry of healthcare, and functionally perform the role of ministers in that context.[216] Furthermore, if the discretionary labels of the religious institution itself are to guide the process, healthcare workers must be classified as ministers if the Catholic Church regards them as such.[217] Finally, this categorization would affect healthcare workers in only a narrow subset of medical situations, given that the secular standard of care is acceptable to Catholic healthcare institutions unless a patient requests a procedure forbidden by the ERDs.[218]

C. Denying Conscience Protections for Healthcare Institutions Is "Courting Anarchy"

Because every state PAD Act is a "neutral law of general applicability," their effect on religious liberty must be discussed in light of the oft-reviled Supreme Court ruling in *Employment Division v. Smith*.[219] In *Smith*, an out-of-character Justice Scalia interpreted the Free Exercise Clause as allowing the government to enact laws restricting the free exercise of religion, provided that the restriction is a side-effect of the law and not its stated purpose and that the law is "neutral" on its face (i.e., it applies equally to non-

216. *See Health and Health Care: A Pastoral Letter of the American Catholic Bishops*, *supra* note 189, at 15–19.

217. For an acknowledgment of the inevitable, knee-jerk objection to this deference to religious organizations to determine which exemptions their free exercise rights require (namely, that false claims and pandemonium will ensue), see Ira C. Lupu, *Where Rights Begin: The Problem of Burdens on the Free Exercise of Religion*, 102 HARV. L. REV. 933, 947 (1989) ("Behind every free exercise claim is a spectral march; grant this one, a voice whispers to each judge, and you will be confronted with an endless chain of exemption demands from religious deviants of every stripe."). For a suggested answer to this challenge under the federal Religious Freedom Restoration Act (RFRA) (discussed *infra* note 222), see Michael Stokes Paulsen, *A RFRA Runs Through It: Religious Freedom and the U.S. Code*, 56 MONT. L. REV. 249, 255 (1995) ("Government does not have a compelling interest in avoiding the costs of evaluating the sincerity of claims for religious exemption. . . . [RFRA] compels an evaluation of burdens on religious exercise. It would be nonsensical for Government to then claim a compelling interest in avoidance of the bureaucratic or administrative costs of complying with the statute's accommodation mandate.").

218. *See ERDs*, *supra* note 89, at 20–22 (discussing issues in care for the seriously ill and dying).

219. 494 U.S. 872, 879 (1990). For a scathing critique of *Smith*, see Michael Stokes Paulsen, *Justice Scalia's Worst Opinion*, PUBLIC DISCOURSE (Apr. 17, 2015), https://www.thepublicdiscourse.com/2015/04/14844/.

religious and religious conduct).[220] Criticism of this momentous opinion erupted immediately and continues to this day,[221] but Congress acknowledged the public outcry by passing the Religious Freedom Restoration Act (RFRA) three years later.[222] Although the twenty-first century has witnessed a resurgence of judicial support for religious liberty, *Smith* endures as a thorn in the side of Free Exercise Clause jurisprudence—except, since *Hosanna-Tabor*, in the case of the Free Exercise doctrine of the ministerial exception.[223]

Although *Smith*'s holding appeared to govern the holding of *Hosanna-Tabor*, Chief Justice Roberts meticulously distinguished the ostensibly discriminatory statute the Court upheld in *Smith* (an Oregon law prohibiting peyote use that cost two Native American religious peyote-users their jobs) from the ostensibly discriminatory statute the Court set aside in *Hosanna-Tabor* (the ADA's prohibition on retaliation).[224] With the finesse of a surgeon's scalpel, Chief Justice Roberts dissected the nearly-identical legal scenarios to excise the jurisprudential tumor of *Smith*: where *Smith* examined government regulation of "only outward physical acts," *Hosanna-Tabor* examined "government interference with an internal church decision that affects the faith and mission of the church itself."[225] By predicating the consti-

220. *Smith*, 494 U.S. at 878–79, 890.

221. *See, e.g.*, Paulsen, *supra* note 219.

222. Religious Freedom Restoration Act, 42 U.S.C. § 2000bb (1993) [hereinafter RFRA]. For a detailed analysis of the contents and impact of RFRA, see Paulsen, *supra* note 217. Under RFRA, religious laws *directly targeting* religious exercise must survive strict scrutiny analysis by demonstrating a compelling state interest. RFRA. Though RFRA only applies to the federal government, it has been mirrored in twenty-one state RFRAs since 1993. *See State Religious Freedom Restoration Acts*, NAT'L CONFERENCE OF STATE LEGISLATURES (May 4, 2017), https://www.ncsl.org/research/civil-and-criminal-justice/state-rfra-statutes.aspx. The RFRA standard may very well implicate state PAD laws, because their pointed "not suicide" language and "premises clauses" are, arguably, directly targeted against religious anti-PAD beliefs. *See supra* Sections III.B.–C.; *see also* Paulsen, *supra* note 7, at 1191 (asking whether "the Free Exercise Clause [is] about what government is *aiming at* with its laws (the non-discrimination rule reading) or about what it *hits* (the effects, or substantive right reading)," and concluding that history and structural interpretation strongly support the latter view).

223. *See* Paulsen, *supra* note 219 ("*Smith*'s reading of the Free Exercise Clause as a mere nondiscrimination rule is thus contrary to the best, most natural reading of the text; in tension with its logic and purposes; inconsistent with the premises that justify it; and at odds with much evidence of its original understanding. In a word, *Smith* is simply wrong.").

224. Hosanna-Tabor Evangelical Lutheran Church & Sch. v. Equal Emp't Opportunity Comm'n, 565 U.S. 171, 189–90 (2012).

225. *Id.* at 190.

tutionality of *Hosanna-Tabor* upon internal church decisions, the Court not only successfully sidestepped *Smith*, but it also broadened the ministerial exception significantly and solidified its constitutional foundation as firmly within the purview of both the Free Exercise Clause and the Establishment Clause.[226]

Justice Scalia's stated concern in *Smith* has been summarized formulaically: "Religious Pluralism plus Religious Liberty equals Anarchy."[227] Any society that requires a compelling government interest before permitting a restriction on religious liberty is "courting anarchy," according to Justice Scalia, and this courtship grows increasingly dire in proportion to that society's religious diversity.[228] As the tragic culmination, he envisioned "a system in which each conscience is a law unto itself."[229]

Abstract logic may have supported Justice Scalia's fears, but the past three decades have proven him wrong. The Religious Freedom Restoration Act enacted by Congress in response to *Smith* imposes the exacting "compelling interest" test on the government before permitting any burden (direct or indirect) on the free exercise of religion—and our society today, though more religiously pluralistic than ever before, remains far from the anarchy Justice Scalia fearfully anticipated.[230] Ironically, the greatest modern peril threatening to unravel our nation's moral fabric is not the overabundant free-for-all of claimed religious exemptions Justice Scalia sought to preclude; rather, it is arguably the precise opposite: the inability of conscientious religious institutions to claim the exemptions necessary to preserve a moral fabric that is unravelling all on its own.

As modern medicine continues to exponentially advance in scope and power, old questions continue to receive new answers: What is the role of biology in gender, and of gender in society?[231] What is the proper standard

226. *Id.* at 195–96. The majority opinion in *Our Lady of Guadalupe* does not mention *Smith*. 140 S. Ct. 2409 (2020).

227. Richard F. Duncan, *Free Exercise Is Dead, Long Live Free Exercise:* Smith, Lukumi *and the General Applicability Requirement*, 3 U. PA. J. CONST. L. 850, 853 (2001).

228. Emp't Div. v. Smith, 494 U.S. 872, 888 (1990).

229. *Id.* at 890.

230. RFRA § 2000bb–1(b), *supra* note 222. In 1997, the Supreme Court held that RFRA only applies to the federal government, propelling a wave of state RFRAs that essentially mirror the federal RFRA model. *See* City of Boerne v. Flores, 521 U.S. 507, 536 (1997); *see also State Religious Freedom Restoration Acts*, *supra* note 222 (outlining how twenty-one states have implemented state RFRAs).

231. *See, e.g.*, *Guidelines for Psychological Practice with Boys and Men*, AM. PSYCHOLOGICAL

for "healthy" sexuality?[232] What, if any, are the moral implications of genetically modifying human beings?[233] Perhaps the two most important questions in contemporary medical ethics deal with the extent and value of human existence: When does life begin? When does life end?[234] When the questions are life-or-death in consequence and metaphysical in scope, the authority we trust to answer them is colossally important.[235] The modern American legal system has refused to designate such an authority, instead delegating these fundamental moral questions to individual healthcare workers nationwide, who often possess little or no philosophical, ethical, or spiritual training.[236] In a dramatic reversal of Justice Scalia's bleak vision in

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ASS'N 1, 2 (Aug. 2018), https://www.apa.org/about/policy/boys-men-practice-guidelines.pdf ("Gender refers to psychological, social, and cultural experiences and characteristics associated with the social statuses of girls and women or boys and men . . . includ[ing] assumptions, social beliefs, norms, and stereotypes about the behavior, cognitions, and emotions of males and females."); *see also* GOODRICH, *supra* note 146, at 107–44; GEORGE, *supra* note 15, at 167–75.

232. *See, e.g.*, *FAQ on Health and Sexual Diversity—An Introduction to Key Concepts*, WORLD HEALTH ORG. 1, 1–2 (2016), https://www.who.int/gender-equity-rights/news/20170329-health-and-sexual-diversity-faq.pdf ("Sexuality . . . encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is influenced by the intersection of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors.").

233. *See, e.g.*, Ronald Bailey, *Genetically Modified Babies Are Ethically OK*, REASON (Nov. 26, 2019, 10:15 AM), https://reason.com/2019/11/26/genetically-modified-babies-are-ethically-ok/; Assoc. Press, *Chinese Researcher Claims Birth of First Gene-Edited Babies—Twin Girls*, STAT (Nov. 25, 2018), https://www.statnews.com/2018/11/25/china-first-gene-edited-babies-born/.

234. *See* George, *supra* note 37, at 419–20. Professor George captures the vast scope of modern conceptions of the value of human life:

> [S]ome people argue that there are human beings who are not yet persons—namely, those in the embryonic, fetal, and at least early infant stages of development—and other human beings who will never become, or are no longer, persons—the severely retarded, the seriously demented, those in permanent comas or persistent vegetative states. For people who hold this view, the question is not when does the life of a human being begin or end, but when does a human being qualify as a person, and therefore a creature with a serious right to life.

Id.; *see also* GEORGE, *supra* note 15, at 195 ("A common error is for people to convert the question of when a human life begins from a matter of biology to a matter of religious faith or personal belief.").

235. *See* GORSUCH, *supra* note 55, at 160–61 ("[I]f one's valuable humanness (and thus legal inviolability) turns on one's currently exercisable abilities for self-creation and self-expression, what specific traits and qualities must one exhibit? And how developed must they be before one qualifies for equal protection under the law?").

236. For a brief glimpse at the throng of inconsistent moral conclusions asserted by various physicians and bioethicists, see, e.g., Nejaime & Siegel, *supra* note 93, at 2566 (arguing against conscience claims because they "obstruct[] access to goods and services"); *Consensus Statement on Conscientious Objection in Healthcare*, PRACTICAL ETHICS (Aug. 29, 2016), http://blog.

Smith, we are now "courting anarchy" by refusing to afford religious healthcare institutions the conscience protections they require to fulfill their medical ministry according to their sincerely held religious beliefs.[237] Inadvertently, we have created the secular analogue of Justice Scalia's morally lawless nightmare: "a system in which each conscience is a law unto itself."[238]

V. CONCLUSION

The right to follow one's own conscience is foundational to the religious freedoms enshrined in the First Amendment, and this right is especially critical in the field of healthcare because any work involving the value of life inherently involves moral, conscientious, and even spiritual dimensions.[239] As the power and scope of the medical profession continue to expand in conjunction with the relentless advance of modern technology, the moral and ethical views espoused by healthcare workers and institutions will play an increasingly influential role in our society.[240] Now—before new and unforeseen technologies compound the ethical dilemmas—is the time for our country to decide its priorities when it comes to the competing claims of medical and religious autonomy.[241]

The PAD legalization movement in the medical field is accelerating: nine jurisdictions have already embraced PAD, and its popularity continues to grow among Americans.[242] The tireless pro-PAD groups driving this movement are expanding in influence and funding, and their increasingly tense, even antagonistic, relationship with conscientious anti-PAD groups (most notably, the Catholic Church) shows no signs of relenting, conceding,

practicalethics.ox.ac.uk/2016/08/consensus-statement-on-conscientious-objection-in-healthcare/ (arguing that healthcare workers claiming conscience exemptions "should be required to compensate society and the health system for their failure to fulfil their professional obligations"); Martha S. Swartz, *"Conscience Clauses" or "Unconscionable Clauses": Personal Beliefs Versus Professional Responsibilities*, 6 YALE. J. HEALTH POL'Y, L. & ETHICS, 269, 278 (2006) (arguing that "health care professionals should be admonished that conscientious objections based on personal beliefs, as opposed to professional ethics, will entail consequences").

237. Emp't Div. v. Smith, 494 U.S. 872, 888 (1990).

238. *Id.* at 890.

239. *See supra* Section IV.B.1.

240. *See supra* Section IV.C.

241. *See* GEORGE, *supra* note 15, at 97–110.

242. *See supra* notes 39–41 and accompanying text.

or seeking common ground.[243] The new PAD Acts sweeping the nation do not incidentally impact the field of conscience—the tactical vocabulary and "premises clauses" embedded in every single state PAD Act betray an underlying intent to undercut all conscientious opposition from the outset.[244]

Fortunately, the solution presents itself in the powerful fortification of religious liberty represented in the 2012 *Hosanna-Tabor* decision, and expounded in the 2020 *Our Lady of Guadalupe* decision, in the form of the ministerial exception.[245] Religious liberty jurisprudence has long recognized the necessity, under the Religion Clauses of the First Amendment, of allowing religious institutions to hire and fire their own "ministers," because these unique employees teach, represent, and even personify the religious mission of the institution.[246] Importantly, the Court took the critical step of recognizing that certain employees of religious institutions "personify [the] beliefs"[247] of the institution even when they lack the formal title, training, or overtly ministerial role that the misleading phrase "ministerial exception" implies.[248]

In light of its centuries-old and world-renowned commitment to healing the sick, the Catholic Church's healthcare employees necessarily personify its beliefs and, in the language of Chief Justice Roberts, "carry out [its] mission."[249] These medical ministers are functional, if not literal, representatives of Catholic doctrine, and the Church must therefore be permitted to manage them according to *Hosanna-Tabor*'s understanding of the ministerial exception.[250] For the government to intervene and second-guess the Church's identification of its own ministers would be an unconstitutional violation of the Church's religious autonomy to select its leaders and define its own beliefs and practices.

Ironically, the ethical free-for-all Justice Scalia feared in *Employment Division v. Smith* is taking place in the secular, rather than the religious, sphere. We have avoided trusting any single religious institution with the

243. *See supra* Section III.A.
244. *See supra* Sections III.B. and III.C.
245. *See supra* Section IV.A.
246. *See supra* Section IV.A.
247. Hosanna-Tabor Evangelical Lutheran Church & Sch. v. Equal Emp't Opportunity Comm'n, 565 U.S. 171, 188 (2012); *see supra* Section IV.A.
248. *See supra* Section IV.A.
249. *Hosanna*-Tabor, 565 U.S. at 196; *see supra* Section IV.B.1.
250. *See supra* Section IV.B.2.

task of conscientiously weighing our proposed medical developments; instead, we have delegated this immensely important responsibility to thousands of individual doctors across the nation. The inevitable result is that each individual healthcare worker has become a "law unto himself."[251]

As the tension continues to escalate between conscientious religious healthcare organizations and pro-PAD advocacy groups, the ministerial exception is the best option for protecting institutional free exercise of religion.[252] In the coming decades, as this tension continues to manifest in the courts, the right to conscience in the field of healthcare must supersede any competing claims.

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251. Emp't Div. v. Smith, 494 U.S. 872, 890 (1990); *see supra* Section IV.C.

252. *See supra* Section IV.C.

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