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MARYLAND’S CONSCIENCE CLAUSE: LEAVING A WOMAN’S RIGHT TO A HEALTH CARE PROVIDER’S CHOICE

MARIA CIRINCIONE*

INTRODUCTION

At thirty-five years of age, Lori Boyer found herself powerless and vulnerable in the emergency room of Good Samaritan Hospital in Lebanon, Pennsylvania after a man she knew raped her.1 These emotions seem obvious for a woman to experience after being raped,2 but Lori Boyer was forced to feel these same emotions for a second time by the emergency room physician who treated her when she came to the hospital for help.3 Why? Because her physician refused to provide her with emergency contraception as part of her post-rape treatment.4 After Lori requested the morning-after pill, her physician refused to write her a prescription and told her simply that it was against his religion to do so.5

Although Lori’s story was highlighted by the news media, she is just one example of the countless other women who have had the same emergency room experience after being raped.6 Some might even say that Lori was one of the luckier cases. She, at least, knew enough about the existence of emergency contraception7

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3. Erdely, supra note 1.
4. Id.
5. Id.
7. An estimated one in three women does not know about emergency contraception. Erdely, supra note 1.
to be able to ask her physician for treatment after having been raped. Like Lori’s
doctor, many physicians with conflicting beliefs about emergency contraception
may choose not to even mention the possibility. Thus, women with less knowledge
about emergency contraception may be denied information about their treatment
options and may never even know the difference. Lori was also fortunate because
she had the resources to find another physician on her own who was willing to
provide treatment before the effectiveness period for emergency contraception had
lapsed. Emergency contraception is only effective if administered within seventy-
two hours of intercourse and diminishes in effectiveness as time passes between
intercourse and treatment. Other women may not be as knowledgeable as Lori
and may learn about emergency contraception only after it is too late.

A “conscience statute” or “refusal clause” is a legislative provision that
protects a health care provider “who decline[s] to participate in certain health
services based on a religious or moral objection . . . .” These services commonly
include performing abortions, performing sterilizations, and even dispensing
contraception. Pennsylvania’s conscience statute, for example, permits private
institutions to refuse to provide abortions. Under the statute, an individual
provider at an institution, like Lori’s physician in Lebanon, Pennsylvania, could
claim protection from having to treat her with emergency contraception because he
believes that the use of contraception results in an abortion.

While Lori’s traumatic experience took place in a hospital in Pennsylvania, a
similar situation could just as easily occur in Maryland. Maryland’s conscience

8. In one survey published in the New England Journal of Medicine, eight percent of physicians
said they felt no obligation to present all options to their patients. Farr A. Curlin et al., Religion,
9. See Erdely, supra note 1 (“In many cases, women don’t even know a doctor is withholding
treatment.”). Jill Morrison, senior counsel for health and reproductive rights at the National Women’s
Law Center in Washington, D.C. stated that “in a crisis situation, like a rape, you often don’t think to
question your care. But unfortunately, now we can’t even trust doctors to tell us what we need to know.”
Id.
10. Id. After being denied access to emergency contraception by her treating emergency room
physician, Lori met with a rape counselor who was able to find another physician willing to prescribe
emergency contraception later that same day. Id.
11. See infra notes 163–66 and accompanying text (discussing the time period for effective
treatment with emergency contraception).
13. See infra Part I.A–B. (discussing the types of services that providers are protected from
performing in federal and state conscience legislation).
15. See Holly Teliska, Comment, Obstacles to Access: How Pharmacist Refusal Clauses
Undermine the Basic Health Care Needs of Rural and Low-Income Women, 20 BERKELEY J. GENDER L.
& JUST. 229, 235 (2005) (describing pharmacists who refuse to treat with emergency contraception
because their religious beliefs define the effect of emergency contraception as an abortion).
statute contains even broader protections for providers than Pennsylvania, as it allows any institution, public or private, and all individual providers to refuse to provide abortions.\(^{17}\) The Maryland conscience statute reads in relevant part:

- (a) (1) A person may not be required to perform or participate in, or refer to any source for, any medical procedure that results in artificial insemination, sterilization, or termination of pregnancy.
- (2) The refusal of a person to perform or participate in, or refer to a source for, these medical procedures may not be a basis for:
  - (i) Civil liability to another person; or
  - (ii) Disciplinary or other recriminatory action against the person.

- (b) (1) A licensed hospital, hospital director, or hospital governing board may not be required:
  - (i) To permit, within the hospital, the performance of any medical procedure that results in artificial insemination, sterilization, or termination of pregnancy; or
  - (ii) To refer to any source for these medical procedures.
- (2) The refusal to permit or to refer to a source for these procedures may not be grounds for:
  - (i) Civil liability to another person; or
  - (ii) Disciplinary or other recriminatory action against the person by this State or any person.\(^{18}\)

The language of the Maryland statute does not explicitly define a provider's duty to dispense or right to refuse to dispense emergency contraception in emergency rooms. Thus, ambiguities in the language of Maryland's conscience statute may put women in Maryland at risk for being denied access to emergency contraception when needed most.

Access to emergency contraception for emergency room patients is an important issue that deserves the attention of the Maryland legislature.\(^{19}\) The Maryland legislature could guarantee protection of a woman's right to access emergency contraception by amending the current conscience statute by limiting its scope to only abortion and/or sterilization procedures. Part I of this Comment begins with a brief history of federal and state conscience legislation in the United

\(^{17}\) MD. CODE ANN., HEALTH-GEN. § 20-214 (LexisNexis 2009).

\(^{18}\) Id.

and continues with a discussion of patient and provider rights in the context of relevant constitutional interpretations and physician responsibilities grounded in principles of medical ethics and Maryland case law. Part II provides a summary of general scholarly discourse on the conflict between patient and provider rights. Part III argues that Maryland's conscience legislation must be amended in three fundamental ways in order to prevent health care providers from being able to deny care to women in need of emergency contraception. Specifically, the Maryland legislature should (1) replace the phrase termination of pregnancy with abortion, (2) include a requirement that providers inform patients about emergency contraception as a treatment option if it is medically indicated, and (3) require a treating provider to either administer emergency contraception or to refer the patient to another provider who is willing to provide emergency contraception within the medically indicated time limit.

I. HISTORICAL BACKGROUND OF FEDERAL AND STATE CONSCIENCE CLAUSES

A. Federal Conscience Legislation

In the 1970s, Congress passed the first piece in a series of federal legislation aimed at protecting a health care provider's choice to refuse treatment because of conscience objections. The first federal conscience legislation came as a countermeasure to the Supreme Court's holding in the 1973 decision of Roe v. Wade. In Roe, the Court held that a woman possesses an individual right to bodily privacy, which includes the decision about whether to have an abortion. To counter the effects of the Roe decision, Congress passed the Church Amendment.

20. See infra Part I.A-B.
21. See infra Part I.C-D.
22. See infra Part II.
23. See infra Part III.
24. See infra notes 214-16 and accompanying text.
25. See infra notes 217-18 and accompanying text.
26. See infra pp. 197-98.
as part of the Health Programs Extension Act of 1973.\textsuperscript{31} The amendment protected individual providers from “perform[ing] or assist[ing] in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions . . . .”\textsuperscript{32} The Church Amendment restrictions apply to all recipients of funds\textsuperscript{33} under the Public Health Service (PHS) Act,\textsuperscript{34} the Community Mental Health Centers Act,\textsuperscript{35} and the Developmental Disabilities Services and Facilities Construction Act.\textsuperscript{36}

Beginning in 1996, Congress passed a series of legislative protections that expanded the scope of the original shield afforded to providers under the Church Amendment. Following the Church Amendment, the next major piece of conscience legislation\textsuperscript{37} was included in the Omnibus Consolidated Rescissions and Appropriations Act of 1996 (OBRA),\textsuperscript{38} which amended the PHS Act.\textsuperscript{39} The OBRA statute went beyond the provisions of the Church Amendment, as it prohibited discrimination against health care providers who refuse to provide abortion services and training for any reason and not just based on moral or religious grounds.\textsuperscript{40} Section 238n of the amended PHS Act also prohibits the federal government and any state or local government receiving federal funds from discriminating against an entity that refuses to provide arrangements and train for, undergo training for, or refer for abortions.\textsuperscript{41} In 1997, Congress shifted the focus of conscience legislation


31. § 401, 87 Stat. at 95–96.
33. Id. § 300a-7(b).
37. FEDER, supra note 30, at 2. There was a lull in legislation passed by Congress after the Church Amendment, with the exception of the adoption of the Danforth Amendment in 1988, which required neutrality in the case of abortion. \textit{Id}.
39. FEDER, supra note 30, at 2.
40. See 42 U.S.C. § 238n(a); FEDER, supra note 30, at 4.
41. 42 U.S.C. § 238n(a). The amendment also prohibits the federal government or state or local governments receiving federal assistance, from denying an entity accreditation or licensing, or from denying the entity financial assistance, services or benefits because the entity relies on accreditation
from protecting the beliefs of individuals and institutional providers to protecting the refusal rights of managed care providers funded by Medicaid and Medicare. This legislation was more expansive than previous federal conscience clause statutes that allowed providers to refuse the actual performance of abortion services because it allowed managed care providers to opt-out of counseling and referral services as well.

Since 1997 Congress has considered more expansive proposals for conscience protection, but has only passed these expansions as part of appropriations legislation and not as independent law. In 2003, legislators introduced two companion bills in the House and Senate “[t]o prohibit certain abortion-related discrimination in government activities.” Neither of these bills went beyond referral to committee, but both proposed to amend the PHS Act further by expanding the definition of “health care entity” to include “other health professional[s],” such as “hospital[s], . . . provider sponsored organization[s], . . . health maintenance organization[s], . . . health insurance plan[s], or any other kind of health care facility, organization or plan.” To circumvent opposition to these bills, supporters of the expansion inserted a conscience clause provision in the standards that require the entity to perform, refer for, provide for or refer for training for abortions. 

42. Just one year after the amendment to the PHS Act, Congress enacted the Balanced Budget Act of 1997. Pub. L. No. 105-33, 111 Stat. 251 (1997); FEDER, supra note 30, at 3. Congress enacted the legislation because of concerns that managed care providers would attempt to prevent doctors from informing patients about services not covered under their health plans. FEDER, supra note 30, at 3. Although the statute prohibited Medicare, 42 U.S.C. § 1395w-22(j)(3)(A), and Medicaid, 42 U.S.C. § 1396u-2(b)(3)(A), from preventing health care providers from discussing treatment options not covered by the plans, the legislation also allowed the managed care providers to refuse to cover costs associated with any service that the managed care provider is opposed to for moral or religious reasons. Id. § 1395w-22(j)(3)(B) (Medicare); id. § 1396u-2(b)(3)(B) (Medicaid). These services could include performing abortions, as well as providing abortion counseling and referrals. FEDER, supra note 30, at 3.

43. 42 U.S.C. § 1395w-22(j)(3)(B)(i) (Medicare); id. § 1396u-2(b)(3)(B)(i) (Medicaid); see also FEDER, supra note 30, at 3 (noting that the 1997 legislation may have a broader effect than the Church Amendment).

44. See infra notes 46–48 and accompanying text.

45. See infra notes 49–52 and accompanying text.


48. H.R. 3664 § 2(3); S. 1397 § 2(3); see also FEDER, supra note 30, at 4 (discussing the conscience clause provisions in H.R. 3664, S. 1397, and other legislation).
Consolidated Appropriations Act of 2005 called the Weldon Amendment. The Weldon Amendment successfully changed the definition of "health care entity" to the more expansive definition proposed by the failed companion bills and expanded the entities restricted by the legislation to include all recipients who receive funding from the Department of Health and Human Services (HHS), as well as the Departments of Labor and Education. Relative to previous laws, this legislation greatly expanded the list of entities protected under a conscience exception. Since the 2005 Weldon Amendment, Congress has inserted a conscience clause in every subsequent year's HHS appropriations act.

In 1997 the Supreme Court sparked significant implications for provider rights under state conscience legislation by striking down the Religious Freedom Restoration Act (RFRA) in City of Boerne v. Flores. In 1993, Congress had passed the RFRA, which prohibited the government from burdening religion with a law of general applicability unless the government could demonstrate such a burden was in furtherance of a compelling government interest and was the least restrictive means to further it. The RFRA was enacted in order to make the compelling interest test, previously established in Sherbert v. Verner, the controlling test for cases where free exercise of religion is burdened by a statute. In City of Boerne, the Court struck down the RFRA because its enactment exceeded Congress' enforcement power, and because the statute created "considerable congressional intrusion into the States' traditional prerogatives and general authority to regulate for the health and welfare of citizens." In so doing,
the Court reinstated its previous holding from *Employment Division v. Smith*, where the Court declined to apply the *Sherbert* balancing test to a law of general applicability. Based on the Court’s ruling in *City of Boerne*, it seems as though RFRA no longer stands as an obstacle in the way of states passing laws of general applicability, even if those laws indirectly burden religion. Thus, state legislation that guarantees access to types of care, but also may indirectly burden the religious beliefs of a provider through application, may still be constitutional, even without demonstrating a compelling government interest for the legislation.

**B. State Conscience Legislation**

Following in the footsteps of the federal government, states have also independently passed legislative conscience protections. As of February 1, 2010, almost every state had adopted a policy allowing health care providers to refuse to provide or participate in abortions, contraceptive services, or sterilizations. State conscience protections range in coverage over the types of health care entities protected and the types of health care services exempted. Some of the least expansive conscience protections can be found in Connecticut, New York, and West Virginia. In Connecticut and New York, the only protections afforded to health care providers apply to individual providers, and neither state provides a refusal protection for institutions or pharmacies. Furthermore, individual providers in Connecticut and New York may only refuse to provide abortions. West Virginia’s statute is also considerably narrow, providing no refusal

59. 494 U.S. 872, 884–85, 890 (1990) (holding that the Free Exercise Clause of the First Amendment did not prohibit application of Oregon’s drug laws to the ceremonial ingestion of peyote). In *Employment Division*, citizens were dismissed from jobs because of their illegal ingestion of peyote, which they used for sacramental purposes. *Id.* at 874. They were also denied unemployment benefits because they were discharged for work-related misconduct. *Id.*

60. *Id.* at 884–85. A law of general applicability does not specifically target religion but its non-religious application could indirectly burden religion. *See City of Boerne*, 521 U.S. at 535 (majority opinion) (discussing the impact of laws of general applicability on the practice of religion); *id.* at 537–39 (Scalia, J., concurring in part) (same).

61. *See GUTTMACHER INST., STATE POLICIES IN BRIEF: REFUSING TO PROVIDE HEALTH SERVICES 1* (2010), available at http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf (indicating that forty-six states allow some providers to refuse to provide abortions, thirteen allow some providers to refuse to provide services related to contraception, and seventeen allow some providers to refuse to provide sterilization services).

62. *See id.* at 2 (presenting data on abortion, contraception and sterilization, and on individual providers, institutions, pharmacies and pharmacists). For additional details, see infra note 227 and accompanying table.

63. *See GUTTMACHER INST., supra note 61, at 2. Some other states with relatively narrow conscience statutes include Iowa, Michigan, and Nebraska; each of these states has enacted statutes that only allow providers to refuse abortion services. *Id.*

64. *See, e.g., N.Y. CIV. RIGHTS LAW § 79-i* (McKinney 2009); *GUTTMACHER INST., supra note 61, at 2.

65. *GUTTMACHER INST., supra note 61, at 2.*
allowances for abortion or contraception, but permitting individual and institutional providers to refuse to provide or participate in sterilization procedures.\textsuperscript{66}

Some of the most expansive coverage for health care providers can be found in states like Mississippi and Arkansas. In Mississippi, both individual and institutional providers, including public and private entities, have the right to refuse to provide or participate in abortions, contraception, and sterilization procedures.\textsuperscript{67} Mississippi’s statute also explicitly provides protection to pharmacies and pharmacists.\textsuperscript{68} Arkansas is almost as expansive, except that it contains a broadly-worded refusal clause that may apply to pharmacies in allowing them to refuse to dispense contraception, but does not explicitly exempt pharmacies.\textsuperscript{69} Arkansas also only allows private institutions to refuse to provide contraception.\textsuperscript{70} Two other states with relatively expansive conscience statutes are Colorado and Washington. In Colorado, individual and institutional providers can refuse abortion services.\textsuperscript{71} An exception is also provided for contraception for individuals and private institutions, and possibly pharmacists and pharmacies because of the broad wording of the statute.\textsuperscript{72} In Washington, institutions and individuals can refuse to provide abortion and sterilization services as well as contraception.\textsuperscript{73}

Although Maryland’s conscience legislation also contains broad protections for health care providers, the statutory language is not as expansive as the statutes in states like Mississippi or Arkansas.\textsuperscript{74} As amended in 1991,\textsuperscript{75} the Maryland statute explicitly protects individual providers and hospitals that refuse to provide or participate in the “termination of [a] pregnancy.”\textsuperscript{76} The statute also allows individual providers and hospitals to refuse to provide or participate in artificial

\textsuperscript{66} W. VA. CODE ANN. § 16-11-1 (LexisNexis 2006); GUTTMACHER INST., supra note 61, at 2.
\textsuperscript{67} MISS. CODE ANN. § 41-107-5(1) (2009) (“A health-care provider has the right not to participate, and no health-care provider shall be required to participate in a health-care service that violates his or her conscience.”) (emphasis added); id. § 41-107-7(1) (“A health-care institution has the right not to participate, and no health-care institution shall be required to participate in a health-care service that violates its conscience.”) (emphasis added).
\textsuperscript{68} See id. § 41-107-3(b) (including pharmacists and pharmacy employees in the definition of health care providers).
\textsuperscript{69} See ARK. CODE ANN. § 20-16-304(4) (2005) (exempting physicians, pharmacists, and other health care providers, but not expressly including pharmacies).
\textsuperscript{70} Id. § 20-16-304(5).
\textsuperscript{71} COLO. REV. STAT. § 25-6-102(7), (9) (West 2008 & Supp. 2009).
\textsuperscript{72} Id.
\textsuperscript{73} WASH. REV. CODE ANN. §§ 70.47.160(2)(e), 9.02.150 (West 2009).
\textsuperscript{74} Unlike the conscience statutes in Mississippi and Arkansas, Maryland’s conscience statute does not permit a health care provider to refuse to offer contraception. Compare MISS. CODE ANN. § 41-107-5 (2009), and ARK. CODE ANN. § 20-16-304(4), with MD. CODE ANN., HEALTH–GEN. § 20-214 (2009). Maryland’s statute also does not contain a specific provision protecting pharmacists from refusing to dispense contraception. MD. CODE ANN., HEALTH–GEN. § 20-214.
\textsuperscript{75} 1991 Md. Laws, ch. 1.
\textsuperscript{76} MD. CODE ANN., HEALTH–GEN. § 20-214(a)–(b).
Because of its abortion and sterilization policies, and since the statute does not explicitly discuss a provider’s refusal rights regarding contraception, the Maryland statute could be classified as more neutral along the spectrum of state conscience statutes. However, because the statute does not mention emergency contraception specifically, its ambiguity opens the door for inconsistent provider interpretation. Thus, Maryland’s statute, despite its seemingly passive stance, could result in a broader application when it comes to emergency contraception. Part III of this Comment contains a discussion on the potential effects of ambiguities in Maryland’s conscience statute and recommendations for legislative reform.

C. Constitutional Interpretations of Patient Rights

The debate over legislative conscience protections should begin with a discussion about the scope of a provider’s right to refuse to supply services relative to the scope of a patient’s right to access specific treatments. Provider and patient rights have been explored in the context of constitutional rights to privacy and free exercise. Although this Comment does not attempt to achieve the proper balance between these opposing interests, a discussion about the Court’s interpretations of patient and provider rights is important in order to understand this Comment’s conclusions about changes to Maryland’s conscience statute.

In 1965 the Supreme Court confirmed a constitutional right to privacy in Griswold v. Connecticut. In Griswold, health care providers in Connecticut appealed their conviction as accessories for providing married couples with contraceptive advice and treatment. The trial court convicted them as accessories under a Connecticut statute that prohibited the use of “any drug, medicinal article

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77. Id.
78. Id.
79. See Id.
80. Some providers define emergency contraception as a treatment that terminates a pregnancy, and thus would include emergency contraception as a service they have a right to refuse under the statute. Yoder, supra note 28, at 977 (“Emergency contraception may or may not cause an abortion, depending on a person’s judgment as to when life begins.”).
81. Maryland’s conscience statute could be considered to take a passive stance on a physician’s right to refuse to dispense emergency contraception because it does not explicitly include emergency contraception as a service a provider can refuse, but also does not require a provider to dispense emergency contraception. See Md. Code Ann., Health-Gen. § 20-214(a)-(b).
82. See infra Part III.
85. 381 U.S. at 486.
86. Id. at 480.
or instrument for the purpose of preventing conception . . . ." 87 The Supreme Court reviewed the Appellant providers' constitutional challenge to the statute's prohibition against contraceptive use and concluded that an individual's right to privacy, although not explicitly named, is included in the First Amendment's "penumbra" of protections. 88 Additionally, the Court found that a law forbidding access to contraception would "invade the area of protected freedoms" under the Constitution. 89 In Eisenstadt v. Baird, 90 the Court expanded a right to access contraception free from governmental intrusion to all women, not just to married couples. 91 Thus, under the Supreme Court's holdings in Griswold and Eisenstadt, a statute that forbids access to contraception violates a woman's constitutional right to privacy.

In 1973 the Court strengthened and extended an individual's right to bodily privacy as a guarantee of substantive due process in the case of Roe v. Wade. 92 Based on a line of precedents, 93 the Court concluded that personal privacy is a "fundamental" right, 94 which includes the right to access abortion. 95 Limiting this right somewhat, the Court stated that regulation over "fundamental rights" may only be justified by a "compelling state interest." 96 Thus a state cannot limit a

87. Id. The medical providers convicted in Griswold were directly convicted under a second statute that punished "[a]ny person who assists, abets, counsels, causes, hires or commands another to commit any offense . . . ." Id.

88. Id. at 483. More "peripheral" rights of the First Amendment include "[t]he right to educate [one's] child in a school of the parents' choice . . . [,] the right to study . . . any foreign language" in school, and the right to associate with other people. Id. at 482.

89. Id. at 485.
90. 405 U.S. 438 (1972).
91. Id. at 453.
92. 410 U.S. 113 (1973). The Appellants brought the action in this case for an injunctive relief from a Texas abortion law that the Appellants claimed was unconstitutional. Id. at 117-18. The Court held that the Texas statute, which prohibited abortions at all stages of pregnancy except to save the life of the mother, was unconstitutional. Id. at 164. The Court also created three distinct time periods during which the appropriateness of state regulation of a mother's abortion decision was determined. Id. at 164-65. The decision to continue the pregnancy would be left to the mother and mother's physician during the first trimester. Id. at 164. After the first trimester and until viability of the unborn child, the state could regulate abortion procedures related to the mother's health. Id. Finally, after the point of viability, the state may proscribe abortion, except in cases where medically appropriate in order to preserve the life or health of the mother. Id. at 164-65.
93. Id. at 152-53 (citing, e.g., Griswold v. Connecticut, 381 U.S. 479, 484-85 (1965), and Eisenstadt, 405 U.S. at 453-54).
94. Id. at 152-55 (citing, e.g., Palko v. Connecticut, 302 U.S. 319, 325 (1937), and Eisenstadt, 405 U.S. at 453-54).
95. Id. at 153 ("Th[e] right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action . . . or . . . in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.").
woman’s right to privacy without a compelling government interest in doing so. In the context of patient and provider rights, this limitation is compounded by the Court’s holding in Boerne, which reaffirmed a state’s right to enact religion-neutral laws that indirectly burden religion without a compelling state interest.97 Based on the Roe98 and Boerne99 holdings, patient rights seem to be favored by the Court for state statutory protection.

In 1992 the Supreme Court reaffirmed the Roe decision in Planned Parenthood of Southeastern Pennsylvania v. Casey.100 The Court unequivocally upheld the core holding in Roe, stating that “[n]o evolution of legal principle has left Roe’s doctrinal footings weaker than they were in 1973.”101 While maintaining the constitutional right established in Roe, the Planned Parenthood Court replaced the “compelling state interest” test with the “undue burden standard.”102 The new standard prohibits state regulation of a woman’s right to an abortion that “has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion . . .”103

D. Professional Responsibilities Grounded in Medical Ethics and Maryland Case Law

Patient and provider rights have also been explored in the context of established principles of medical ethics. According to the American Medical Association’s (AMA) Principles of Medical Ethics, patients must give informed consent before a provider can begin treatment.104 The AMA describes informed consent as “more than simply getting a patient to sign a written consent form.”105 Informed consent “is a process of communication between a patient and physician that results in the patient’s authorization or agreement to undergo a specific medical

99. City of Boerne, 521 U.S. at 536.
101. Id. at 857. The Court went on to say that “[n]o development of constitutional law since the case was decided has implicitly or explicitly left Roe behind as a mere survivor of obsolete constitutional thinking.” Id.
102. Id. at 876.
103. Id. at 877. The Court elaborated further by stating that a law designed to further the state’s interest in protecting a fetal life that imposes an undue burden on the woman’s decision would be unconstitutioanal. Id.
According to the AMA, in order to achieve informed consent, physicians should disclose alternative treatments and the risks and benefits to the alternatives. Thus, statutory and constitutional requirements aside, physicians have an affirmative ethical obligation to inform a patient of all possible treatment alternatives available, including those that the physician may not personally believe are in the patient's best interest or that the physician does not personally support.

Physicians also have an ethical duty to refer patients to another provider if doing so would be in the best interest of a patient. As a viable treatment to preventing an unwanted pregnancy, emergency contraception counts as a treatment option that a physician has an ethical obligation to discuss with a patient facing a potential pregnancy.

Maryland courts have adopted a reasonableness standard, rather than the professional medical standard, for obtaining informed consent, and thus require full disclosure of alternative treatments in order for a physician to obtain a patient's informed consent. The landmark case on informed consent is the decision of the Maryland Court of Appeals in Sard v. Hardy. One of the central issues in the case was whether the physician violated the doctrine of informed consent when he failed to disclose alternative treatment options to the patient. The court

106. Id.
107. Id. Patients should also be given "an opportunity to ask questions to elicit a better understanding of the treatment or procedure, so that he or she can make an informed decision to proceed or to refuse a particular course of medical intervention." Id.
108. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 76 (1982), available at http://www.bioethics.gov/reports/past_commissions/making_health_care_decisions.pdf ("Since the judgment about which choice will best serve well-being properly belongs to the patient, a physician is obliged to mention all alternative treatments, including those he or she does not provide or favor, so long as they are supported by respectable medical opinion."); Am. Med. Ass'n, supra note 105; see also Rachel Benson Gold, Conscience Makes a Comeback in the Age of Managed Care, GUTTMACHER REP., Feb. 1998, at 1, 2, http://www.guttmacher.org/pubs/tgr/Ol/1/grOlOlOl.pdf (discussing private health plans and the "incompatib[ility] with . . . basic [medical] principles" of such plans that "gag physicians from discussing a woman's options on the grounds of corporate conscience").
109. AM. MED. ASS'N, supra note 104, at 591 ("Physicians should always make referral decisions based on the best interests of their patients. . . .").
110. Sarah Tomkowiak, Reconciling Principles and Prescriptions: Do Pharmacist Refusal Clauses Strike the Appropriate Balance Between Pharmacists' and Patients' Rights?, 2007 U. ILL. L. REV. 1329, 1335 ("Emergency contraception] reduces a woman's chance of experiencing an unintended pregnancy by up to eighty-nine percent. It is estimated that the use of [emergency contraception] could prevent approximately 1.7 million unintended pregnancies and eight hundred thousand abortions each year.").
111. 379 A.2d 1014 (1977). A patient and her husband accused the treating physician of negligently performing a bilateral tubal ligation on the patient, and of failing to disclose the fail-rates of the operation as well as alternative options for treatment. Id. at 1017. In failing to disclose this information, the plaintiffs alleged, the physician had failed to obtain the patient's informed consent for the sterilization surgery. Id. After undergoing the sterilization procedure, the patient became pregnant despite believing that she was sterile. Id. at 1019.
112. Id. at 1017.
recognized the doctrine to mean "that a physician, treating a mentally competent adult under non-emergency circumstances, cannot properly undertake to perform surgery or administer other therapy without the prior consent of his patient."\textsuperscript{113} In applying the doctrine, the court stated that "unless a person has been adequately apprised of the material risks and therapeutic alternatives incident to a proposed treatment, any consent given, be it oral or written, is necessarily ineffectual."\textsuperscript{114} The court affirmatively adopted a "general or lay standard of reasonableness set by law and independent of medical custom,"\textsuperscript{115} over the professional standard of care set by medical custom.\textsuperscript{116} The reasonableness standard requires the physician to disclose any information the patient requires in order to make an "intelligent decision" about treatment.\textsuperscript{117} Thus, "the scope of the physician's duty to inform is to be measured by the materiality of the information to the decision of the patient."\textsuperscript{118} Under the reasonableness standard adopted by Maryland's highest court, a physician should be required to disclose emergency contraception as a treatment option to emergency room patients who are at risk of becoming pregnant in order to legally receive informed consent for treatment.

II. THE CONFLICT BETWEEN PATIENT AND PROVIDER RIGHTS

Many scholars have addressed the difficult issue of where to draw the line between a patient's right to access and a provider's right to refuse treatment for moral or religious reasons. The extent of patient and provider rights in the context of state regulation is a difficult question to answer because medical services fall into an intermediate category between secular and sectarian activity.\textsuperscript{119} Religious

\textsuperscript{113} Id. at 1019. Additionally, the reference to "non-emergency situations" is likely referring to cases where a physician need not act with haste to save a patient's life or avoid further injury to the patient. See id. at 1022 (referencing exceptions to a physician's duty to obtain informed consent when "an emergency of such gravity and urgency exists that it is impractical to obtain the patient's consent").

\textsuperscript{114} Id. at 1019 n.3. The court went on to affirm that a physician's duty to disclose includes disclosure of alternative treatment options, id. at 1020, and that "[t]he law does not allow a physician to substitute his judgment for that of the patient in the matter of consent to treatment." Id.

\textsuperscript{115} Id. at 1021–22.

\textsuperscript{116} Id. at 1022.

\textsuperscript{117} Id.

\textsuperscript{118} Id.

\textsuperscript{119} Kathleen M. Boozang, Deciding the Fate of Religious Hospitals in the Emerging Health Care Market, 31 Hous. L. REV. 1429, 1477–78 (1995). Medical services fall under an intermediate category of activity that is not completely secular, but not purely spiritual. Id. Whether the state considers sectarian health care services as activity within the practice of religion is important because such a perception would make that activity subject to certain exemptions from civil laws. See id. at 1476 (noting the possibility that states may view sectarian health care as part of the practice of religion). Purely secular activities are subject to the regulation of the state and purely religious activities are exempt from laws that interfere with the religious institution's religious beliefs. Id. at 1477. However those activities that fall into the intermediate category create an ambiguity as far as regulation. Id. For a discussion of the Supreme Court's interpretations of medical services as an intermediate category of activity that the state may regulate, see id. at 1475–80.
providers have used constitutional guarantees as well as federal and state conscience legislation to support their right to refuse certain treatments. As discussed above, patient rights have also been confirmed and protected under constitutional guarantees. However, state conscience legislation varies greatly from state to state, and thus patient and provider protections are not consistently applied throughout the country. Many commentators have asserted other arguments about how conscience conflicts could be improved through state legislative reform. These assertions apply to many of the health care spheres touched by the issue of conscience protections, including religious institutions, pharmacies, and contraception in general. All of these arguments ultimately attempt to outline the proper balance between patient and provider rights.

Religious institutions are one sphere of the health care industry touched by the issue of conscience protections. There is a tension between patients seeking specific health care services and institutional health care providers that refuse to provide such services on religious or moral grounds. Kathleen Boozang, Professor of Law at Seton Hall University School of Law, addressed this tension and raised the question of “whether federal and state laws should continue to protect a hospital’s ability to establish institutional policies according to its religious or moral beliefs.” Boozang asserted that legislatures should institute reforms “that offer[] both protection to the sectarian health care provider and ensure[] patient access to care.” Boozang proposed that legislatures should provide access to services through alternative secular providers or require sectarian institutions to provide unrestricted access to legally guaranteed treatment. Alternatively, Boozang also suggested that “[l]egislatures might institute innovative market reforms by encouraging cooperative delivery arrangements between secular and sectarian providers . . . .”

120. Id. at 1480.
121. See supra Part I.C.
122. See supra Part I.B (discussing variances in state conscience legislation).
123. See infra notes 127–54 and accompanying text.
124. Many scholars have proposed reforms to conscience protections regarding religious institutions, pharmacies and pharmacists, and contraception itself. See, e.g., Boozang, supra note 119 (religious institutions); Grimes, supra note 27 (pharmacies and pharmacists); Tomkowiak, supra note 110 (contraception).
125. This Comment asserts that one state in particular, Maryland, should amend its current conscience legislation in order to provide stronger protections for women seeking access to emergency contraception in emergency rooms. See infra Part III.
127. Id. at 1438.
128. Id. at 1493.
129. Id. at 1431.
130. Id. at 1438–39.
Boozang’s argument requires state legislative action in order to achieve a proper balance between provider and patient rights. This proposed resolution would allow religious institutions to maintain loyalty to their beliefs but would also allow patients to receive the type of care to which they are entitled. In order to achieve the proper balance, Boozang’s argument places the burden on policy makers to create an inventive solution through legislation.

Other commentators have specifically focused on the need for state legislative reform in order to ease the tension between customers seeking access to contraceptive treatment and pharmacists refusing to provide access. At least one argument asserts that state statutes lacking a clear indication of a pharmacist’s exact refusal rights are particularly problematic when it comes to a woman’s right to access a popular form of emergency contraception, Plan B. In 2006 the Food and Drug Administration (FDA) approved over-the-counter access for women age 18 and over, and then lowered the age to 17 in 2009. One commentator asserted that the “dual status” of emergency contraception as a prescription and over-the-counter drug is cause for state legislatures to adopt reforms to conscience statutes. This argument asserts that, without statutory clarification, the FDA’s

131. Id. at 1515–16.
132. Id. at 1516. Boozang advocates for a cooperative effort between the state, non-sectarian health care providers, and sectarian health care providers to create a solution that will provide patients with access to a complete range of services, and also protect the beliefs of religious facilities. Id.
136. Grimes, supra note 27, at 1421. The same argument that emergency contraception’s dual status creates a need for statutory reform also includes the assertion that state statutes that were ambiguous before the dual status change have become even more problematic after the policy change. Some states with narrow statutes that are particularly ambiguous, like Georgia’s, GA. CODE ANN. § 16-12-142(b) (2007), could actually be construed to give broader protections to pharmacists because of the change to dual status. Grimes, supra note 27, at 1420. Mississippi’s statute, on the other hand, is broad enough to protect pharmacists from having to dispense to both underage women with a prescription and of-age women without a prescription. Id. at 1419. The language in the Mississippi statute that describes a pharmacist’s right includes “prescribing, dispensing or administering . . . .” MISS. CODE ANN. § 41-107-3(a) (2009). Before the FDA policy change, Georgia’s general conscience statute was too narrow to protect pharmacists from refusing to dispense emergency contraception on moral or religious grounds. Grimes, supra note 27, at 1420. However, Georgia’s statute contains a clause that states that “[n]othing in this subsection shall be construed to authorize a pharmacist to refuse to fill a prescription for birth control medication . . . .” GA. CODE ANN. § 16-12-142(b) (emphasis added). Since the policy change allows some customers to request emergency contraception with a prescription and some without a
change in policy will create complications for delivery of emergency contraception.\(^3\) Although the change in federal regulation applies to pharmacists and not to emergency rooms, the argument for clearer state legislation to remedy federal ambiguities for pharmacists is parallel to the argument that states should clarify conscience statutes that govern how emergency contraception is dispensed in emergency rooms.

Another interpretation advocates for legislative changes that would protect the rights of pharmacists from dispensing emergency contraception because some may believe emergency contraception causes an abortion.\(^{138}\) This interpretation contains the assertion that specific statutory protections are essential, but that these protections are necessary primarily for the protection of pharmacist beliefs.\(^{139}\) The argument hinges on the assumption that the use of emergency contraception results in an abortion, and not merely the prevention of a pregnancy.\(^{140}\) The argument also relies on the fact that the Supreme Court has determined that a woman’s right to an abortion does not include a government duty to make abortions more accessible\(^{141}\) and that governments have “generally [not] been required to subsidize the exercise of fundamental rights . . . .”\(^{142}\) Thus, this argument concludes that a refusal to provide emergency contraception is not a violation of a patient’s constitutional rights.\(^{143}\) Countering this argument is the interpretation that patients have a constitutional right to access emergency contraception.\(^{144}\)

The argument for stronger provider protections also relies on the premise that the use of emergency contraception constitutes an abortion, despite the fact that this prescription, the statute’s language could be construed as implicitly allowing a pharmacist to refuse to dispense emergency contraception to customers \(\text{without}\) a prescription. Grimes, supra note 27 at 1420. Thus the argument asserts that states with ambiguities that do not properly clarify a pharmacist’s refusal for emergency contraception, particularly given the FDA policy change for Plan B, must reform their conscience legislation to prevent the difficulties associated with the ambiguity. \(\text{Id.}\) at 1421.

\(^{137}\) The kinds of complications asserted by this argument were in reference to when the dual status hinged on age 18, \(\text{Id.}\) at 1417, but are equally as applicable now that the age has been lowered to 17. Some of these complications include enforcement difficulties and a barrier to popular support of the FDA’s mandated change to dual status. \(\text{Id.}\) Since the availability of Plan B is not necessarily known by all customers who may need access, many under-age women seeking the pill will likely feel embarrassed and confused after they learn at the pharmacy that they are unable to get Plan B without a prescription. \(\text{Id.}\) Enforcement problems could occur since older friends and boyfriends of underage women would be willing to help younger women gain access without a prescription. \(\text{Id.}\)

\(^{138}\) See, e.g., Yoder, supra note 28, at 975 (describing one pharmacist’s view that life begins at conception, and his reluctance to dispense emergency contraceptives).

\(^{139}\) \(\text{Id.}\) at 1025.

\(^{140}\) See \(\text{Id.}\) at 975.

\(^{141}\) See \(\text{Id.}\) at 983 (citing Beal v. Doe, 432 U.S. 438, 445–46 (1977)).

\(^{142}\) \(\text{Id.}\) at 988; see, e.g., Maher v. Roe, 432 U.S. 464, 466 (1977) (holding that a state regulation that limited Medicaid benefits to medically necessary, first trimester abortions did not impinge a woman’s fundamental right).

\(^{143}\) Yoder, supra note 28, at 1003.

\(^{144}\) See supra Part I.C.
conclusion is not accepted by the medical community or constitutional precedent. As explained above, the Supreme Court has consistently held that women have the right to make their own family planning decisions. Further, there is no Supreme Court precedent on which to base a classification of emergency contraception as an abortifacient. Even commentators in favor of stronger provider protections acknowledge that the Court has never declared when life officially begins and that a conclusion about emergency contraception as an abortifacient is not substantiated by a Supreme Court opinion. The same proponents for stronger provider protections also acknowledge that the right to use contraception “appears to be broader in scope than the right to abortion.” While Griswold laid the foundation for a right to bodily privacy, Eisenstadt declared that individuals have “the right...to be free from unwarranted governmental intrusion into...the decision whether to bear or beget a child.” Part III of this Comment contains a discussion on prevailing rights and the assertion that Maryland’s state statute should be reformed to guarantee patient rights to emergency contraception.

Another argument suggests that state statutes permitting refusal of contraception for pharmacists go beyond the original intent of refusal clauses. The original purpose of conscience legislation was to allow doctors and nurses who actually performed abortions to refuse to perform these procedures if they had a moral or religious objection. Since a pharmacist’s role is only to help patients make use of their medications and not to directly select treatment for patients, legislation that allows pharmacists to refuse to provide access to treatment runs against the original purpose of conscience clauses. This argument is equally applicable to emergency room physicians who would be providing rape victims access to oral emergency contraceptives.

III. MARYLAND’S CONSCIENCE CLAUSE SHOULD BE AMENDED IN THREE FUNDAMENTAL WAYS

A woman’s access to emergency contraception in Maryland emergency rooms is an important issue deserving the attention of Maryland legislators. For women,

145. See infra note 214.
146. See supra Part I.C.
147. Yoder, supra note 28, at 986.
148. Id. at 987.
151. See infra Part III.
152. Tomkowiak, supra note 110, at 1340.
153. Id. Although conscience clauses initially applied to abortions only, many states have expanded their clauses to include other types of treatment such as assistive reproductive technology, human embryonic or fetal research, in vitro fertilization, and stem cell research. Id. at 1339–40.
154. Id. at 1340.
this issue is of particular importance because women bear the greatest burden if rights to access are not protected. However, although women have the most to lose from legislation lacking protections to access, the unique consequences of an unplanned pregnancy, especially from rape or incest, will also greatly affect a woman’s family as well as the greater Maryland community. Justice Blackmun described these unique consequences in his explanation in *Roe* for why women are guaranteed a constitutional right to privacy that includes the decision to terminate a pregnancy. Furthermore, *Griswold* and its progeny demonstrate the Court’s stance that a law forbidding a woman’s access to contraception, and even to abortion, would be an infringement on a woman’s guaranteed right to privacy and family planning.

Maryland’s legislature should prohibit health care providers from denying patients access to emergency contraception in hospital emergency rooms. Many scholars have advocated for a balance between a provider’s right to refuse services that conflict with its religious doctrine and a patient’s right to access those services. This Comment is in general agreement with those scholars who argue that both provider and patient rights must be protected through legislative means. This Comment asserts, however, that without explicit legislative protections that guarantee access to emergency contraception, Maryland’s conscience statute could produce a state-sanctioned *practical denial* of access to emergency contraception. Thus, because of constitutional guarantees to privacy and the

155. Justice Blackmun stated:

The detriment that the State would impose upon the pregnant woman by denying th[e] choice [to have an abortion] altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.


156. *Id.* at 153 (“This right of privacy . . . is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.”).

157. *See supra* Part I.C.

158. *See supra* Part II.

159. Due to the time-sensitive nature of emergency contraception, an emergency room doctor’s refusal could result in three scenarios where a patient is unable to benefit from treatment because the effectiveness period would have lapsed before they could find an alternative provider. *See infra* Part III.A. These scenarios demonstrate a practical denial of access because a patient would not have another opportunity to prevent a pending pregnancy after the effectiveness of emergency contraception expires. Such a statute constitutes the kind of burdensome government obstacle and a form of government intrusion that the Supreme Court has held to be unconstitutional. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992) (“An undue burden is an unconstitutional burden.”).
irreversible consequences that denied access can produce, Maryland’s legislature should reform the state conscience statute in three fundamental ways in order to explicitly protect a woman’s right to access emergency contraception in emergency rooms in Maryland. The Maryland legislature should (1) replace the phrase termination of pregnancy with abortion,160 (2) include a requirement that providers inform patients about emergency contraception as a treatment option if it is medically indicated,161 and (3) require a treating provider to either administer emergency contraception, or to refer the patient to another provider who is willing to provide emergency contraception within the medically indicated time limit.162

A. Maryland’s Conscience Statute Is Problematically Ambiguous

Ambiguous state legislation that lacks affirmative guarantees of access to emergency contraception will create the opportunity for a practical denial of access because of the time-sensitive nature of emergency contraception. First, the effectiveness of emergency contraception is limited by a very finite period of time after intercourse has occurred.163 Although emergency contraception can be effective if taken within 120 hours of intercourse, it is most effective if taken within the first twelve to twenty-four hours after intercourse,164 and should be taken within seventy-two hours.165 If taken after a fertilized egg has implanted into the uterine wall, emergency contraception is entirely ineffective.166 Thus, if a provider’s refusal makes it practically impossible for a patient to access emergency contraception elsewhere in time for the treatment to be effective, the conscience statute permitting this refusal will have effectively denied that patient access to treatment altogether.

Two other scenarios that demonstrate how an emergency room physician’s refusal could result in a practical denial of access to treatment are when patients live in rural or impoverished areas, and when a physician refuses to either inform a patient about the treatment or refer a patient to another willing provider. In many rural or impoverished areas, a patient may not have the resources to travel to another physician or facility that does not share the same objections as the first

160. See infra notes 214–16 and accompanying text.
161. See infra notes 217–18 and accompanying text.
162. See infra pp. 197–98.
164. Tomkowiak, supra note 110, at 1336.
166. Tomkowiak, supra note 110, at 1336.
emergency room where the patient was denied. In fact, protocol in many areas requires that rape victims transported by emergency vehicles be taken to the closest hospital available, regardless of ideological affiliation. Thus, a rape victim without the means to go elsewhere may not make it to another provider in time to benefit from the effects of emergency contraception. Finally, ambiguous legislation, which does not specifically require a provider to at least inform a patient of emergency contraception as an existing treatment option, will likely cause a practical denial of treatment. If a patient is unfamiliar with emergency contraception and a treating emergency room physician purposely neglects to inform her, the ambiguous law will have practically denied that patient treatment if she does not somehow learn about the option before the drug's effectiveness expires.

All three of the practical denial scenarios are magnified in effect when the patient is a victim of rape or incest and is taken to an emergency room for treatment. Rape victims can be confused, frightened, or in an incapacitated state. Victims of incestual rape are often young and may not be accompanied by a guardian who is knowledgeable about emergency contraception. Both of these typical candidates for emergency contraception may be lacking the resources, social support, and knowledge of treatment options to be able to overcome a practical denial of access to treatment that they have a right to receive.

Ambiguities in Maryland's conscience statute could cause the practical denial of access to emergency contraception and would, therefore, violate a woman's constitutional rights to such access. In Griswold, the Supreme Court stated that a law forbidding access to contraception would be a violation of a woman's right to

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167. Erdely, supra note 1 ("[Y]ou don't need to be in a rural area to have limited access, . . . all you need to be is poor.").
168. Michael Hirsley, Bishop Reignites Ethics Struggle: Catholic Hospital Told to Deny Morning-After Pill to Victims of Rape, CHI. TRIB., Feb. 25, 1994. Therefore, rape victims can be taken to the emergency department of a hospital that refuses to administer emergency contraception. See id.
169. See supra notes 1–11 and accompanying text (discussing Lori Boyer's story and the potential for less fortunate scenarios for other women with less knowledge and resources).
170. See Erdely, supra note 1 (noting that many women who are denied emergency contraception are not even aware they had the option to receive it).
171. See Hirsley, supra note 168 ("[T]he urgency of information given about the pill might not be understood by the traumatized victim, particularly within the [seventy-two] hours in which the pill should be taken.").
172. Lori Boyer was traumatized both physically and emotionally by her attack and still suffered from those injuries while being treated in the emergency room. See supra notes 1–8 and accompanying text.
174. See id. (discussing the backlash victims of incest experience from their own family members and the young age of victims); supra note 171 and accompanying text.
bodily privacy. While it is true that a state law that permits a provider to refuse to provide emergency contraception does not explicitly forbid a patient access to treatment on its face, the application of that law may sanction a practical denial of access because of the time-sensitive nature of emergency contraception. Thus, the application of Maryland's statute may effectively forbid access to treatment, which, under Eisenstadt, patients are entitled to obtain free from government intrusion. Further, even if we assume—a albeit incorrectly—that emergency contraception constitutes abortion, the application of Maryland's statute may also fail the test set forth in Roe and Planned Parenthood. Since the Maryland statute sanctions a potential denial of access, the statute could constitute an unconstitutional "effect of placing a substantial obstacle in the path of a woman seeking an abortion . . . ." Finally, under the AMA's Code of Medical Ethics, as well as the standard adopted by Maryland's courts for obtaining informed patient consent, Maryland's statute should at least require emergency room providers to inform patients of emergency contraception as a treatment option and refer patients if providers are morally opposed to treating with emergency contraception.

Ambiguities in the Maryland conscience statute make its application problematic. As a general matter, Maryland's conscience statute does not explicitly guarantee access to emergency contraception. So, while Maryland's statute does not explicitly deny access on its face, any one of the three practical denial scenarios mentioned above could become a reality as a result of the statute's application. The Maryland conscience statute has three main ambiguities. First, the statute lacks a definition for the phrase termination of pregnancy. This ambiguity leaves the door open for providers to apply their own definition for the phrase, which may include the use of emergency contraception. Second, the statute does not provide an affirmative requirement for providers to inform a patient about emergency contraception as a treatment option. Finally, the statute permits a provider to refuse to refer a patient to another provider who would be willing to give the patient access to treatment.

176. See supra notes 163–66 and accompanying text.
179. Planned Parenthood, 505 U.S. at 877.
180. See infra Part III.B.
182. Id. § 20-214(a)(1), (b)(1)(i).
183. Id. § 20-214.
184. Id. § 20-214(b)(1). Although this component of the statute is not technically an ambiguity since the statute explicitly permits providers to refuse to refer patients to other willing providers, I classified
Maryland’s Conscience Clause

The first troubling component of the Maryland statute is that it does not contain an official definition for abortion, and instead references the ambiguous phrase termination of pregnancy.\(^{185}\) Such ambiguity leaves open the door for health care providers to apply their own definitions and tests for abortions,\(^{186}\) which may include emergency contraception.\(^{187}\) Many religious institutions and providers, like the Catholic Church,\(^{188}\) view emergency contraception as an abortifacient because they subscribe to the belief that conception begins at fertilization.\(^{189}\) Since emergency contraception will prevent fertilization, those providers who subscribe to this definition may be opposed to treating a patient with emergency contraception.\(^{190}\) The ambiguity creating this obstacle could be partially cured by amending the current statute to include a definition for abortion in conformity with the medical community’s definition.\(^{191}\) Incorporating an official definition for abortion in the statute would help to eliminate a basis for providers using imprecise analyses to determine whether using contraception would result in an abortion.

The second troubling aspect of the Maryland statute is its failure to include an obligation for physicians to inform a patient about emergency contraception as a treatment option for preventing pregnancy.\(^{192}\) Without a provision that requires a physician to inform patients about emergency contraception, a patient’s treating physician could purposely neglect to inform her of the option.\(^{193}\) Standards of medical ethics and Maryland case law command that a physician receive informed

this component as an ambiguity for the purposes of a discussion on possible recommendations for the Maryland legislature.

185. Id. § 20-214(a)(1), (b)(1)(i).

186. Catholic hospitals often use an imprecise process to determine whether ovulation has occurred in order to make a decision about whether to administer emergency contraception to a patient. Hirsley, supra note 168. Even a bishop in Chicago found the process used for determining ovulation “scientifically inappropriate and unreliable.” Boozang, supra note 119, at 1451 (referencing comments made by Bishop John Meyers in Chicago).

187. The Catholic Church, and some other religious conservative groups, define conception as the moment of fertilization. Teliska, supra note 15, at 235. Therefore, since emergency contraception can prevent a pregnancy by preventing implementation of a fertilized egg, providers who subscribe to the Catholic Church’s definition of conception could interpret the effect of emergency contraception to be abortion. Id.

188. Id.

189. Id. Emergency contraception comes in pill form and contains a high dose of the same hormones used in oral contraceptives. Tomkowiak, supra note 110, at 1335. The physical results that occur after emergency contraception is taken are not disputed. Id. at 1336. The treatment inhibits ovulation, fertilization, and implementation of the fertilized egg. Yoder, supra note 28, at 979.


191. The medical community, the Food and Drug Administration, and the AMA have concluded that emergency contraception is a form of contraception and not abortion because of the treatment’s undisputed effects. Karissa Eide, Comment, Can a Pharmacist Refuse to Fill Birth Control Prescriptions on Moral or Religious Grounds?, 42 CAL. W. L. REV. 121, 125 (2005); Yoder, supra note 28, at 979.


193. See supra notes 6–11 and accompanying text.
consent from a patient before administering treatment. Yet, a woman cannot give informed consent about treatment without having full information about her treatment options. Even assuming arguendo that emergency contraception is an abortifacient, constitutional jurisprudence and medical ethics standards guarantee patients at least the right to learn about the treatment option from their providers and a right to access that is not effectively barred because of protections granted to providers by the state. Thus, the statute should be amended to include a requirement that physicians inform patients about emergency contraception in order to preclude physicians from claiming exemption under the currently ambiguous statute.

The third troublesome aspect of the Maryland statute is the exception granted to providers from being required to refer patients they refuse to treat. The current statute explicitly permits a provider to refuse to refer a patient for “termination of pregnancy.” Since the Maryland statute provides this exception, but does not include a duty to refer the patient elsewhere, such a denial arguably constitutes a government-created undue burden to accessing emergency contraception, which is a clear violation of a woman’s constitutional rights. Additionally, an explicit protection from having to refer patients to other willing providers conflicts with the AMA’s Principles of Medical Ethics, which obligates a physician to refer a patient if it is in her best interest. Despite a provider’s rights to personally object to specific types of treatment, a provider does not have the right to effectively restrict a patient’s treatment options—a position that even advocates for stronger provider rights have adopted by including mandatory referral clauses in their suggestions about reforms to emergency contraception legislation.

194. See supra Part I.D (discussing the requirement that patients be aware of all viable treatment options in order to make an informed decision and give informed consent for a treatment option).
195. The Supreme Court has clarified the scope of a woman’s right to include a freedom from unduly burdensome government interference with achieving an abortion. Yoder, supra note 28, at 983–84 & nn.39–43. While the government “is not responsible for removing obstacles” to a woman’s access that it did not itself create, id. at 984, a practical denial of access to emergency contraception because of a government-granted exception would in fact create an obstacle in the path of a woman to receive care. In many cases, permitting a provider to refuse access to a patient would prove to be a complete practical denial of access. See supra note 159 and accompanying text. Thus, even assuming arguendo that treating a patient with emergency contraception would result in an abortion, women are still entitled to be informed about abortion as a treatment option, and thus informed about emergency contraception.
198. See supra note 109 and accompanying text (discussing a provider’s ethical obligation to refer a patient to another provider if it is in a patient’s best interest).
199. See supra note 108 and accompanying text (describing a physician’s obligation to mention viable alternative treatments even if the physician is opposed to those alternatives).
200. See Yoder, supra note 28, at 1020, 1023–24 (discussing proposed legislation for pharmacist rights of conscience).
B. Recommendations for the Maryland Legislature

The Maryland legislature should amend the current statute to specifically address an emergency room patient’s practical ability to receive information and access to emergency contraception. While a woman’s right to access is important in different life scenarios, the immediate urgency associated with a patient’s treatment in an emergency room gives rise to a specific need for legislative protections. Because of the time sensitivity surrounding effective treatment with emergency contraception, the dire consequences associated with a denial of treatment, and the delicate state of the typical patient in need of contraceptive treatment in emergency rooms, the issue of a woman’s constitutionally guaranteed choice to use contraception must be protected by unambiguous legislation in Maryland.

Several states have already enacted statutory provisions that address the issue of emergency contraception for patients. Some states have addressed the need for

201. In 2001, Maryland came close to enacting legislation expanding protections for a woman accessing emergency contraception in hospital emergency rooms. See Susan Reimer, People Should Know About Emergency Contraception, BALT. SUN, Feb. 26, 2002, at 1E. The Maryland House of Delegates reviewed a bill in 2001 that would have required hospitals to either provide emergency contraception to rape and incest victims or refer them to a provider who would. H.D. 1224, 2001 Leg., 415th Sess. (Md. 2001). The bill never passed a committee vote, Reimer, supra, but in support of the bill, one delegate stated that “[t]he type of health care that a crime victim receives should not depend on what hospital she stumbles into after she’s raped . . . .” Id. After the 2001 bill failed, the House reviewed a somewhat weaker bill in 2002 that would have required all hospitals to at least give rape and incest victims information about emergency contraception. H.D. 930, 2002 Leg., 416th Sess. (Md. 2002). The 2002 version was withdrawn after committee hearing. Md. Gen. Assembly, Bill Info—2002 Regular Session: House Bill 930 (Dec. 12, 2002), http://mlis.state.md.us/2002rs/billfile/HB0930.htm.

202. See supra notes 163–66 and accompanying text.

203. See supra notes 155–56 and accompanying text.

204. See supra notes 171–74 and accompanying text.

205. See supra Part I.C.

206. Amending Maryland’s statute would not impose a duty on the state to make abortions more accessible. One commentator opposed to a statute protecting a woman’s right to access contraception, stated that such a statute would impose “an affirmative duty on the [state] . . . to provide abortions or to make them more accessible,” which the Court has found to be impermissible. Yoder, supra note 28, at 983. However, an amendment to the Maryland legislation to protect women’s access would not impose an additional duty on the state; instead, less ambiguous language would enable patients to avoid situations of practical denial of access, which Griswold and its progeny confirmed would violate a woman’s right to bodily privacy. See supra Part I.C (discussing Supreme Court precedent under Griswold, Roe, and Planned Parenthood).

207. Connecticut, Massachusetts, Minnesota, and New Jersey are some of the states that require emergency rooms to provide emergency contraception to patients who request it. CONN. GEN. STAT. ANN. § 19a-112e (West Supp. 2009); MASS. GEN. LAWS ANN. ch. 111, § 70E(g) (West Supp. 2009); MINN. STAT. ANN. § 145.4712 (West Supp. 2009); N.J. STAT. ANN. § 26:2H-12.6c (West 2007); see also Ctr. for Reproductive Rights, Emergency Contraception for Rape Survivors, http://reproductiverights.org/en/document/emergency-contraception-for-rape-survivors (last visited Feb. 25, 2010) (listing all of the states that have enacted legislation requiring emergency rooms to provide emergency contraception to patients who request it). Some states have also enacted legislation requiring
providers to at least inform patients about emergency contraception as an option. For example, Colorado’s statute calls for licensed health care facilities to amend their protocols to include “informing the [rape] survivor in a timely manner of the availability of emergency contraception as a means of pregnancy prophylaxis ...”\textsuperscript{208} Illinois’s statute also requires hospitals treating sexual assault survivors to develop a protocol to ensure “that each survivor ... will receive medically and factually accurate and written and oral information about emergency contraception ...”\textsuperscript{209} Illinois’s statute does not exempt providers who are morally opposed to emergency contraception from providing information to the patient about emergency contraception as a treatment option.\textsuperscript{210} Massachusetts has gone even further and enacted a provision that specifically protects female rape victims of childbearing age.\textsuperscript{211} Every female rape patient of childbearing age at a state-licensed hospital\textsuperscript{212} has the right “to receive medically and factually accurate written information prepared by the commissioner of public health about emergency contraception; to be promptly offered emergency contraception; and to be provided with emergency contraception upon request.”\textsuperscript{213} Maryland should take steps to amend its current conscience statute to provide the kinds of protections afforded in states like Massachusetts.

In order to correct the ambiguities and shortcomings in Maryland’s conscience statute, the legislature should amend the law’s language in three fundamental ways. The legislature should first replace \textit{termination of pregnancy} with the term \textit{abortion} and provide a definition for abortion in conformity with the standards set by the medical community.\textsuperscript{214} The phrase \textit{termination of pregnancy} is

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\textsuperscript{208} COLO. REV. STAT. ANN. § 25-3-110(2) (West 2008 & Supp. 2009). However, Colorado’s statute still includes a provision that exempts providers who are morally opposed to emergency contraception from being required to inform patients about emergency contraception as a treatment option. \textit{Id.} § 25-3-110(3)(a).

\textsuperscript{209} 410 ILL. COMP. STAT. ANN. § 70/2.2(b) (West 2005 & Supp. 2009)

\textsuperscript{210} \textit{See id.}

\textsuperscript{211} MASS. GEN. LAWS ANN. ch. 111, § 70E(o).

\textsuperscript{212} The Massachusetts statute uses the term \textit{facility} to describe the treatment centers where patient rights apply and broadly defines the term to include: hospitals, clinics, infirmaries, institutions for care of unwed mothers, rest homes, and charitable homes for the aged, licensed or subject to licensing, by the Department of Public Health. \textit{Id.} § 70E.

\textsuperscript{213} \textit{Id.} § 70E(o).

\textsuperscript{214} The FDA, AMA, and general medical community have adopted a definition for conception that begins at the time that a fertilized egg implants into the uterine wall. Eide, \textit{supra} note 191, at 125 (“[B]ecause the medical community equates conception with implantation, even if the fertilized egg passes through the uterus without implanting, contraceptives do not cause an abortion because conception has not yet occurred.”); Yoder, \textit{supra} note 28, at 979.
ambiguous because of definitional disputes, \(^{215}\) and thus lends itself to an inconsistent application across the state of Maryland. The statute's definition of abortion should reference the implantation of a fertilized egg as the moment of conception and should explicitly except emergency contraception from the definition of abortion as a form of contraceptive treatment. \(^{216}\) Although providers may continue to subscribe to their own definitions for abortion and to their own opinions about the effects of emergency contraceptive treatment, a clear and decisive definition for abortion, which excludes emergency contraception, will help to alleviate the imprecise analyses religious providers conduct to determine whether they inform a patient about and offer emergency contraception as an option.

Second, the legislature should amend the current Maryland conscience statute to include a requirement that providers inform patients about abortion as a treatment option if it is a medically indicated. Since a patient must be aware of all available treatment options in order to give her informed consent for the option selected, \(^{217}\) the Maryland statute should require providers to discuss emergency contraception as an available option, even if the provider refuses to provide the treatment himself. Emergency contraception is an effective treatment for patients that present in an emergency room within seventy-two hours of intercourse. \(^{218}\) Thus, legislation should require a treating provider to discuss emergency contraception as an available treatment option if a patient presents within the seventy-two-hour window of effectiveness.

Lastly, if a patient requests treatment with emergency contraception, the reformed Maryland conscience statute should require a treating provider to either administer emergency contraception, or to refer the patient to another provider who is willing to provide emergency contraception within the medically indicated time limit. At its strongest, this requirement will ensure that women requesting treatment are able to access it during treatment in a hospital emergency room. At its weakest, this requirement will ensure no woman is unable to access emergency contraception through a government-created practical denial.

If a provider chooses not to treat a patient with emergency contraception the statute should require the provider to refer the patient to another facility where the patient can access emergency contraception in conformity with treatment time restrictions. If the refusing provider can refer the patient to another provider within the same institution, doing so would sufficiently satisfy the statutory referral requirement. If no other provider in the same institution is willing to administer the

\(^{215}\) See supra notes 186–87 and accompanying text (discussing religious conservatives as one group that adheres to a definition for abortion that includes emergency contraception).

\(^{216}\) Both recommendations are in conformity with the medical community’s adopted definitions and standards. See supra note 214.

\(^{217}\) See supra Part I.D (discussing the AMA’s ethical requirement and Maryland case law requirement that physicians receive a patient’s informed consent).

\(^{218}\) See supra notes 164–66 and accompanying text.
treatment, the refusing provider should be required to refer the patient to another provider outside of the institution who will administer treatment in conformity with treatment time restrictions. If the patient requires transportation in order to receive treatment by an alternative provider, the refusing provider should be required to provide transportation and the corresponding costs should be included as part of the patient's treatment costs accrued at her initial place of treatment. These requirements would counter the devastating effects a provider's refusal to refer can have on a patient and allow a provider to avoid a financial burden in order to refer a patient. Additionally, these requirements would balance a provider's desire not to be directly involved with the act of administering treatment, with a patient's right to avoid a government-sanctioned, burdensome obstacle to access because of a provider's refusal.

A statutory provision requiring an emergency department to transfer a patient in order to receive emergency contraceptive treatment is not unreasonable since the obligation would be analogous to the transfer requirements under the federal Emergency Medical Treatment and Labor Act (EMTALA). Pursuant to EMTALA, a hospital emergency department has an obligation to treat a patient with an emergency condition until the patient's emergency condition is stabilized, or the hospital must transfer the patient to another emergency department so long as the transfer can be done according to the safety requirements dictated by the statute. The statute defines an "emergency medical condition" to include:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in... placing the health of the individual... in serious jeopardy [or]... serious impairment to bodily functions....

Although it is debatable whether an imminent pregnancy meets this definition, the urgency associated with the seventy-two-hour window that a patient has to prevent an unwanted pregnancy is obvious. Further, stabilized means "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility...." In the case of a rape victim in the emergency room, stabilization could include reducing or eliminating the probability of the patient becoming pregnant as a result of the rape. Thus, the same arguments for patient care under EMTALA apply to a

221. The requirements of this section are enforceable against "participating" hospital emergency departments, id. § 1395dd(d), which is one "that has entered into a provider agreement under section 1395cc" of Title 42, id. § 1395dd(e)(2).
222. Id. § 1395dd(b)(1).
223. Id. § 1395dd(e)(1)(A).
224. Id. § 1395dd(e)(3)(B).
state statute that requires a hospital's emergency department to provide treatment to diminish the risk of pregnancy or to transfer the patient to another emergency department with the capability to perform stabilization treatment.

CONCLUSION

Access to emergency contraception in emergency rooms is an important issue in Maryland. Prior Supreme Court precedent indicates that a woman should be free to access emergency contraception without state-created obstacles that could possibly bar her from accessing treatment in time for it to be effective. Standards of medical ethics and Maryland case law require a physician to discuss emergency contraception as a treatment option in order to receive informed consent from a patient before making treatment decisions. In emergency rooms, where rape victims and other women seeking urgent care go for treatment, access to emergency contraception is more important than ever. Currently, ambiguities in the Maryland statute allow too much flexibility for providers in emergency rooms to refuse to provide or even inform patients about emergency contraception. This kind of state-sanctioned refusal serves as the kind of government obstacle the Supreme Court has forbidden in upholding a woman's right to bodily privacy.

The Maryland legislature should act to eliminate the ambiguities in Maryland's conscience legislation and explicitly protect a woman's right to access emergency contraception in Maryland emergency rooms. In order to do so, the Maryland legislature should adopt the medical community's definition for abortion that excludes emergency contraception. The new Maryland conscience statute should also provide explicit protections to patients receiving emergency room care. Physicians should be required to inform patients of emergency contraception if treatment in each particular case is medically indicated. Finally, physicians should be required to treat patients that request access to emergency contraception or to refer them to another provider who is willing to administer treatment within the effective time period of emergency contraception. These changes to the current statute will sufficiently protect a woman's right to access emergency contraception free from a state-sanctioned denial in Maryland's emergency rooms.

225. See supra Part I.C.
226. See supra Part I.D.
### Table 1: Policies Allowing Providers to Refuse\(^{227}\)

<table>
<thead>
<tr>
<th>State</th>
<th>Abortion</th>
<th>Contraception</th>
<th>Sterilization</th>
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<td>Individual Providers</td>
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Note: Unless indicated, the right to refuse applies to all institutions—private, religious, and public.

\(\$\) Temporarily enjoined; law not in effect pending the outcome of litigation.

\(\Psi\) An expansion of the state’s abortion refusal clause is temporarily enjoined pending the outcome of litigation; the prior law is in effect.

\(\ast\) A broadly worded refusal clause may apply.

\(\dagger\) Pharmacists have a duty to dispense valid prescriptions and can only refuse to dispense a prescription, including contraceptives, when their employers approves the refusal and the woman can still access her prescription in a timely manner.

\(\ddagger\) State law requires pharmacies to fill valid contraceptive prescriptions.

\(\Phi\) Pharmacies have a duty to fill valid prescriptions.

\(\Omega\) The policy in Washington requires pharmacies to dispense valid prescriptions and to deliver FDA-approved drugs, such as Plan B. Only the plaintiffs in an ongoing court case are exempt from the policy with regard to emergency contraception.
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<th>Contraception</th>
<th>Sterilization</th>
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