

TAKING CONSCIENCE SERIOUSLY OR SERIOUSLY
TAKING CONSCIENCE?: OBSTETRICIANS,
SPECIALTY BOARDS, AND
THE TAKINGS CLAUSE

*Michael A. Fragoso**

INTRODUCTION

A young woman visits her local obstetrician. She tells him that she suspects, based on a home pregnancy test, that she is pregnant. Unwed and scared, she hesitated before seeing a doctor. The obstetrician examines her and tells her that she is, indeed, two months pregnant. The young woman says that she would like the pregnancy terminated and asks him if he will perform the procedure. The doctor, an observant Jew, informs her that had she visited sooner he might have been able to accommodate her request (as his particular religious beliefs do not attribute full human dignity to the embryo until it has gestated for forty days), but at this stage in the pregnancy he is unable to do so in good conscience, as that would involve the taking of human life. Furthermore, uncomfortable participating remotely in an abortion, the obstetrician does not refer the woman to a specific alternate obstetrician; he instead assures her that there are plenty of other nearby doctors who would be willing to perform the procedure and that she should ask around.

Some time goes by and the obstetrician receives a letter at his office giving him notice of a disciplinary hearing being held by the American Board of Obstetricians and Gynecologists (ABOG) in Dallas, Texas. The hearing involves allegations (made by the obstetrician who ultimately performed the abortion on the young woman) that he

* Candidate for Juris Doctor, Notre Dame Law School, 2012; A.B., Classics, Princeton University, 2006. I would like to thank Professor Dan Kelly for his excellent advice throughout the process of producing this Note. Likewise, I appreciate the helpful input and suggestions I received from Professor Carter Snead, Rich Collier, Nic Teh, Ashley Fragoso, Doctors Donna Harrison, Carmine Errico, and Michael Fragoso, as well as my tireless colleagues on the *Notre Dame Law Review*.

violated the ethical standards of the American College of Obstetricians and Gynecologists (ACOG). The letter says he did so by refusing to refer the patient “in a timely manner” to another provider while “deviating from standard medical practice.” He travels to Dallas to face the charges and is informed that ACOG ethical standards mandate performance or referral in all “standard” aspects of “reproductive healthcare” including the termination of pregnancy. The obstetrician objects that he did nothing wrong and that he was simply following his moral and religious convictions, as he always has. The board informs him that such personal scruples are no excuse and that his ethical duties as an obstetric specialist had been clearly defined in 2007 by the College in Ethics Opinion No. 385 (“Ethics Opinion”).¹ The board revokes his Certificate (the primary obstetric credential), thus terminating his status as a board certified obstetric surgeon.

The doctor returns home. Without his Certificate he loses his hospital admitting privileges making it too risky for him to see obstetric patients and driving down the demand for his services. Third party payers are also preparing to terminate their contracts with him, citing clauses mandating board certification, while both existing and potential patients are wary of seeing a specialist who is not board certified. Having spent a career as an obstetric specialist he is uncomfortable becoming a general practitioner, not having cultivated those skills for decades. After college, medical school, four years of residency, and decades as a practitioner, his once lucrative and socially beneficial medical practice is reduced to the value of his examination tables and filing cabinets.

While the facts are hypothetical, this scenario is entirely possible. In recent years there has been a growing fault line within the medical community on the rights of medical professionals to refuse participation in activities to which they have moral or religious objections. Typically the line runs through so called “reproductive health,” with religious medical practitioners refusing to participate in abortion, sterilization, or contraception on one side, and much of the medical and legal establishment on the other, demanding some level of cooperation in such procedures.

Since 2007 the obstetric specialty has been a particular focal point for conscience issues following the issuance of ACOG Ethics Opinion No. 385. In the Ethics Opinion, ACOG directed physicians

1 COMM. ON ETHICS, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, ACOG COMM. OP. NO. 385, *The Limits of Conscientious Refusal in Reproductive Medicine* (2007) [*hereinafter* ETHICS OPINION], available at http://www.acog.org/from_home/publications/ethics/co385.pdf.

who object to practices such as abortion on ethical grounds either to refer patients quickly to other physicians who would perform the procedure or, if that were not possible, to perform the procedure themselves.² These conclusions coincided with the promulgation of an annual ABOG Bulletin on obstetric certification noting that certification could be revoked for “violation of ABOG or ACOG rules and/or ethics principles or felony convictions.”³ The Bulletin for 2009 omitted the language about ACOG, but it was reintroduced in the most recent Bulletin for 2011.⁴ It thus became possible that refusal to perform or to refer for abortion could be grounds for revocation of a physician’s specialty certification in obstetrics.

Under current ACOG standards and ABOG rules our hypothetical obstetrician situation is one that could occur in the near future. How can he respond? Currently, he is able to contest the revocation of certification through the Office of Civil Rights of the Department of Health and Human Services (HHS).⁵ However regulations recently promulgated by HHS rescind the administrative authorization for such a course if enacted.⁶ He could try to pursue legal claims under various statutes, such as the Church Amendments⁷ or the Hyde-Weldon Amendment,⁸ protecting the conscience rights of healthcare professionals. Yet these statutes lack a clear channel for redress of grievances, particularly as the U.S. Court of Appeals for the Second

2 *See id.* at 1.

3 *See* William L. Saunders & Michael A. Fragoso, *Conscience Protection in Health and Human Services*, 10 ENGAGE: J. FEDERALIST SOC’Y PRAC. GROUPS, July 2009, at 115, 115 (quoting AM. BD. OF OBSTETRICS & GYNECOLOGY, BULLETIN FOR 2008: MAINTENANCE OF CERTIFICATION 10, ¶ 5.b (Nov. 2007)); *infra* Part I.B.

4 *See infra* Part I.A.

5 45 C.F.R. § 88.6 (2010). On January 11, 2011, the pro-life Alliance Defense Fund filed such a complaint with Health and Human Services on behalf of a nursing student seeking admission into Vanderbilt University Medical Center residency program, whose application required those interested in the “Women’s Health track” to agree to assist in the termination of pregnancies. *See* Press Release, Alliance Defense Fund, Vanderbilt University Illegally Requiring Nursing Residents to Sign Abortion Pledge (Jan. 11, 2011), *available at* <http://www.adfmedia.org/News/PRDetail/4511>. The disposition of the Office of Civil Rights toward such a claim was never determined, as Vanderbilt quickly relented on its own. *See* Press Release, Alliance Defense Fund, Vanderbilt University Abandons Illegal Policy That Forced Nursing Residents to Sign Abortion Pledge (Jan. 12, 2011), *available at* <http://www.adfmedia.org/News/PRDetail/4512>.

6 74 Fed. Reg. 10,207 (proposed Mar. 10, 2009) (partially codified at 45 C.F.R. pt. 88 (2011)).

7 42 U.S.C. § 300a-7 (2006).

8 Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, div. G, tit. V, § 508(d), 121 Stat. 1844, 2209.

Circuit held in November 2010 that the Church Amendments do not entail a private remedy.⁹

This Note suggests that constitutional takings doctrine can provide another colorable avenue of redress for a decertified obstetrician. While the question of physicians' conscience rights is typically discussed in the context of abortion rights and religious freedom, property interests are a neglected component to the question. Indeed, an obstetrician has vested property interest in his medical practice, which is compromised by efforts to regulate his conduct in a way that contradicts the autonomy to practice in good conscience on which he previously relied.

In revoking a Certificate based on newly promulgated and controversial ethical determinations, ABOG, acting pursuant to a public function, deprives a physician of a vested property interest (namely, the goodwill of his medical practice). This goodwill property interest is colorable in a takings context in some jurisdictions and ought to be from a broader normative perspective. Such a deprivation, in light of the novelty of the cause of revocation, would fail a doctrinal regulatory taking analysis due to the reasonable investment-backed expectations of the physician in arranging his practice. That is, he built his practice under the then sound expectation that he could invest time and money into it while both exercising conscientious objection to certain procedures and pursuing the best health interests of his patients according to his legitimate professional determinations.

Furthermore, in light of recent efforts at healthcare reform, this deprivation of obstetric property interests would yield perverse results in terms of both access to healthcare and reducing costs. Access to many types of medical care would be reduced through the reduction of the present and future supply of available obstetricians, while costs would potentially increase as a result of both increased scarcity due to the reduced supply of physicians and increased transition costs as physicians move in and out of obstetrics and other specialties.

After providing background on recent controversies regarding healthcare providers' conscience in Part I, this Note will explain why an ABOG decertification based on noncompliance with the Ethics Opinion could meet the criteria needed to constitute a regulatory taking. Part II examines whether or not ABOG meets the public function standards of the state action doctrine. Part III looks at the nature of a medical practice and its goodwill to see if (a) it is property in a consti-

9 See *Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695, 699 (2d Cir. 2010) ("What we do hold today is that [the Church Amendment] does not confer . . . a private right of action to enforce its terms.").

tutionally cognizable sense, and (b) whether it ought to be so. Part IV applies the current regulatory takings doctrine to the case of Certificate revocation. Part V addresses two related concerns: (a) the potential that conscience protection creates an “undue burden” on reproductive rights, and (b) the possible negative implications on the supply of obstetricians and its relation to broader policy interests in healthcare reform.

I. CONSCIENCE PROTECTION

The contours of physicians’ conscience rights and correlative professional obligations have been contested for decades. Indeed, the last half century has seen profound changes in both the practice of medicine¹⁰ and the state of law¹¹ that necessarily implicate the position of the physician *vis-à-vis* the patient and the procedures she may be asked to provide.

On one side of this debate has been the view that conscience is a morally constitutive aspect of human nature and thus to force *anyone* to violate his or her conscience is a profound moral wrong. In the case of physicians, this view requires both the conscientious adherence to the accepted standards of medical practice,¹² and to “a personal set of moral beliefs” based “in religious affiliation, personal preference, or moral reflection.”¹³ Such personal moral beliefs

center on how we value human life itself, its purposes, quality, destiny, and utility. Conflicts of belief in this realm are more

10 See Azgad Gold, *Physicians’ “Right of Conscience”—Beyond Politics*, 38 J.L. MED. & ETHICS 134, 136 (2010) (noting the change in recent decades in how patients view the practice of medicine, namely that “[t]he medical field became more ‘subjective’ than ‘objective,’ as reflected by the shift from measuring outcomes of treatments by ‘quality of life’ parameters rather than the traditional objective ‘morbidity’ and ‘mortality’ parameters”); see also Edmund D. Pellegrino, *The Physician’s Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 FORDHAM URB. L.J. 221, 223 (2002) (“For some, the ends and goals of medicine are no longer defined solely by physicians, but by social convention or the demands of patients or their families. On this view, the physician practices by virtue of a social contract, which grants her profession the privileges of freedom to practice in return for provision of those services that society requires or demands. What constitutes the practice of medicine is societally determined.” (footnote omitted)).

11 See, e.g., *Roe v. Wade*, 410 U.S. 113, 163 (1973) (“This means . . . that, for the [first trimester] of pregnancy . . . the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient’s pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State.”).

12 See Pellegrino, *supra* note 10, at 230.

13 *Id.* at 231.

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.¹⁴

As a result, “[c]onscientious objection implies the physician’s right not to participate in what she thinks morally wrong, even if the patient demands it.”¹⁵

Mainstream medical ethics expresses these principles through the basic tenet that physicians “have the right to refuse service to patients.”¹⁶ Furthermore, under a traditional understanding, “[h]ospital employees have the right to refuse to participate in performing an abortion, and a hospital cannot dismiss the employee for insubordination. An employee can abstain from assisting in an abortion procedure as a matter of conscience or religious conviction.”¹⁷

On the other side of this debate, there is a view that the principle of “patient autonomy” should be paramount, and what is conscientious objection to one person is burdensome refusal to another.¹⁸ Under this view, the demands of the patient win and conscientious objection is a coercive imposition on the rights of the patient.

In the past decade the debate over conscientious objection by physicians and other medical personnel has manifested itself in a vari-

14 *Id.*

15 *Id.* at 242. Dr. Pellegrino goes on to argue that patients indeed have a correlative right to have a physician “not presume the right to impose her will or conception of the good on the patient.” *Id.* The tension between these two potentially competing rights is relieved, in his view, through disclosure. “Individual physicians should prepare a leaflet outlining what they can, and cannot, in good conscience do. Patients should know in advance of a crisis that what they desire and believe to be morally acceptable may not be acceptable to the physicians they may be engaging.” *Id.* at 242–43 (footnote omitted).

16 BONNIE F. FREMGEN, *MEDICAL LAW AND ETHICS* 76 (2002).

17 *Id.* at 201.

18 See Rachel White-Domain, Comment, *Making Rules and Unmaking Choice: Federal Conscience Clauses, the Provider Conscience Regulation, and the War on Reproductive Freedom*, 59 DEPAUL L. REV. 1249, 1250 n.11 (2010) (noting that “the favored term among some supporters of reproductive rights [for conscience clauses] is ‘refusal clauses’”); see also Martha S. Swartz, “Conscience Clauses” or “Unconscionable Clauses”: *Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL’Y L. & ETHICS 269, 348 (2006) (“The widely accepted ethical principle that patients are *autonomous individuals* with the right to make the final decisions concerning their medical care, along with the corresponding principle that appears in all medical professionals’ codes of ethics that the ‘patient’s interest comes first’ leads to the following general rule: patient care decisions should be based on patient autonomy, as mediated by the clinician’s conclusion that the requested therapy (1) is not medically contraindicated (since it is both medically effective and not considered unethical within the profession’s generally accepted concept of ethical practice) and (2) is not illegal.” (emphasis added)).

ety of situations. These situations include (but are not limited to) pharmacists refusing to dispense drugs,¹⁹ nurses refusing to assist in abortions,²⁰ anesthesiologists refusing to participate in executions,²¹ Catholic hospitals refusing to provide emergency contraception²² or establishing guidelines against performing abortions,²³ Catholic organizations refusing to fund contraceptive coverage in healthcare plans,²⁴ and obstetricians refusing to perform abortions.²⁵

There are many aspects to this debate, the particulars of which go beyond the scope of this Note. The debate, however, is ongoing and is one in which competing moral and philosophical claims continue to yield distinct and competing conclusions.²⁶ It is in this theoretical

19 See, e.g., *Menges v. Blagojevich*, 451 F. Supp. 2d 992, 995 (C.D. Ill. 2006) (looking at the legal contours of a pharmacist firing due to an Illinois law requiring the provision of emergency contraception over the counter); Denise Hopkins & Marsha Boss, *Pharmacists' Right to Refuse to Dispense Prescriptions Based on Moral Grounds: A Summary of State Laws and Regulations*, 41 HOSP. PHARMACY 1176, 1177 (2006) (studying which state conscience protections apply to pharmacists); Catherine Grealis, Note, *Religion in the Pharmacy: A Balanced Approach to Pharmacists' Right to Refuse to Provide Plan B*, 97 GEO. L.J. 1715, 1720–23 (2009) (providing a history of the conflict over pharmacists' refusal to provide the emergency contraceptive drug, Plan B); Sarah Sturmon Dale, *Can a Pharmacist Refuse to Dispense Birth Control?*, TIME, June 7, 2004, at 22 (providing some of the political background to arguments over pharmacists' conscience rights).

20 See *Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695, 696 (2d Cir. 2010); *Shelton v. Univ. of Med. & Dentistry*, 223 F.3d 220, 222–23 (3d Cir. 2000).

21 See Press Release, Physicians for Human Rights, PHR Supports Refusal of California Anesthesiologists to Participate in Execution (Feb. 23, 2006), available at <http://physiciansforhumanrights.org/library/statement-2006-02-23.html>.

22 See *Catholic Charities, Inc. v. Superior Court*, 85 P.3d 67, 75 (Cal. 2004).

23 See Brigette Amiri, *Religious Doctrine Can't Trump Patients' Lives and Health*, ACLU BLOG Rts. (July 1, 2010, 2:02 PM), <http://www.aclu.org/blog/religion-belief-reproductive-freedom/religious-doctrine-cant-trump-patients-lives-and-health>.

24 See Patrick J. Reilly, *Look Who's Discriminating Now*, WALL ST. J., Aug. 14, 2009, at W11.

25 See, e.g., Jenny Hope, *Now NHS Doctors Refuse to Carry Out Late Abortions on Moral Grounds*, MAIL ONLINE (May 17, 2008), <http://www.dailymail.co.uk/news/article-566938/Now-NHS-doctors-refuse-carry-late-abortions-moral-grounds.html> (explaining how in the United Kingdom “[National Health Service] doctors are refusing to carry out late abortions, forcing hospitals to contract them out to private clinics and charities”).

26 See, e.g., President's Council on Bioethics, *Conscience in the Practice of Health Care Professions*, Transcripts (Sept. 11, 2008), (testimony of Robert P. George), <http://bioethics.georgetown.edu/pcbe/transcripts/sept08/session3.html> (“The [Ethics Opinion], in other words, in its driving assumptions, reasoning, and conclusions is not morally neutral. Its analysis and recommendations for action do not proceed from a basis of moral neutrality. It represents a partisan position among the

context that one must evaluate the efforts by ACOG, Congress, and HHS to establish workable policies on the issue.

A. *Abortion Referral and the American College of Obstetricians and Gynecologists*

Prior to November 2007, the American College of Obstetricians and Gynecologists had not taken a definitive stance on the issue of conscientious objection. The organization had established ethical guidelines relating to the permissibility of abortion, but these included an acknowledgement of “physician autonomy” in the right of obstetricians not to perform abortions.²⁷

ACOG’s relative neutrality regarding physician refusal to perform an abortion ended with the promulgation of its Ethics Committee Opinion #385 entitled “The Limits of Conscientious Refusal in Reproductive Medicine.”²⁸ The Ethics Opinion lays out a conception of conscience described as “the private, constant, ethically attuned part of the human character.”²⁹ Conscience expresses itself in phrases like “[i]f I were to do ‘x,’ I could not live with myself/I would hate myself/I wouldn’t be able to sleep at night.”³⁰ While conscience is a question

family of possible positions debated or adopted by people of reason and goodwill in the medical profession and beyond.”).

27 For a history of ACOG’s early efforts to address the abortion issue in the era of liberalized abortion starting in 1970, see Nancy Aries, *The American College of Obstetricians and Gynecologists and the Evolution of Abortion Policy, 1951–1973: The Politics of Science*, 93 AM. J. PUB. HEALTH 1810, 1810 (2003). Aries explains how ACOG’s Executive Board maintained a “conservative” approach to abortion provisions (essentially retaining for physicians the decision whether or not an abortion should be performed) even as New York began to liberalize its abortion laws in 1970. *See id.* at 1816. Those who favored liberal abortion access in the ACOG Committee on Professional Standards subsequently revised the *Standards for Obstetric-Gynecologic Hospital Services* in a way that “diverged from the college’s policy,” stating, “[i]t is recognized that abortion may be performed at a patient’s request, or upon a physician’s recommendation.” *Id.* (quoting *College Policy on Abortion and Sterilization*, ACOG NEWSLETTER 2 (Sept. 1970)). To solve this inconsistency the Executive Board polled the membership of ACOG finding that eighty-two percent supported the Committee standards, and “[w]ith the poll, those board members who supported a woman’s right to abortion found a method to liberalize the college’s policy without debate.” *Id.* The end result of the changes was that ACOG would support a liberalized legal abortion regime, while retaining physician “authority over whether or not to perform an abortion, how it was to be done, and what constituted a reimbursable medical indication.” *Id.* at 1818.

28 *See* ETHICS OPINION, *supra* note 1.

29 *See id.* at 2.

30 *Id.* (quotation marks omitted). *But see* President’s Council on Bioethics, *supra* note 26 (testimony by Alfonso Gomez-Lobo) (“Now, I find [the Ethics Opinion’s definition of conscience] incredible. I mean, it’s such a misunderstanding of what’s

of “moral integrity,”³¹ the Ethics Opinion ultimately concludes “there are clearly limits to the degree to which appeals to conscience may justifiably guide decision making.”³² This gives precedence, ultimately, to the principle of “patient autonomy.”³³ The Ethics Opinion then provides the following recommendations, inter alia, as to the ethical practice of obstetrics:

3. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.
4. Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.
5. In an emergency in which referral is not possible or might negatively affect a patient’s physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider’s personal moral objections.³⁴

In short, obstetric physicians who have a conscientious objection to performing an abortion or sterilization, or providing contraception must (1) provide notice to patients of this fact, (2) refer patients to other providers for such procedures if they are unwilling to provide them, and (3) perform the procedures themselves regardless of conscientious objection if referral is not feasible.

going on. It may be a consequence of that conscience that I cannot sleep at night, but conscience is a particular practical judgment as to whether what I’m going to do is morally right or morally wrong, which means whether I’m going to harm a human good or benefit a human good.”).

31 See ETHICS OPINION, *supra* note 1, at 2.

32 *Id.* at 2–3.

33 See *id.* at 3.

34 *Id.* at 5. The Ethics Opinion also notes:

In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients’ rights to health care services.

Id.

The Ethics Opinion has been widely criticized by anti-abortion scholars and practitioners.³⁵ Perhaps strongest among these criticisms is the view that the Ethics Opinion would have the effect of silencing dissent within the field of obstetrics and boxing out practitioners of a particular moral worldview.

If [the ACOG Ethics Committee's] advice were followed . . . [the obstetric] fields of medical practice would be cleansed of pro-life physicians whose convictions required them to refrain from performing or referring for abortions. The entire field would be composed of people who could be relied on either to agree with or at a minimum go along with their convictions, those of the report's authors, on this most profound of moral questions upon which reasonable people of goodwill disagree, yet must somehow find a way to live together in peace and discuss their differences with civility and mutual respect.³⁶

While not explicitly stated in the Ethics Opinion, the policies endorsed by it—in limiting conscientious objection and mandating complicity in abortion and related procedures—would make obstetrics an unappealing specialty for those who have moral objections to abortion.³⁷ This would force them out of the field, or preclude their entering into it.

35 See, e.g., AM. ASS'N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS, AAPLOG RESPONSE TO THE ACOG ETHICS COMMITTEE OPINION #385, TITLED "THE LIMITS OF CONSCIENTIOUS REFUSAL IN REPRODUCTIVE MEDICINE" (Feb. 6, 2008), available at <http://aaplog.octoberblue.com/wp-content/uploads/2010/02/aaplog-to-EthicsComm-Response-feb-6-pdf.pdf> ("We find it unethical and unacceptable that a small committee of ACOG members would pretend to provide the moral compass for 49,000 other members on one of the most ethically controversial issues in our society and within our medical specialty—and that without ever consulting the full membership.").

36 See President's Council on Bioethics, *supra* note 26 (testimony by Robert P. George).

37 As Dr. Pellegrino has noted:

For Catholics, Orthodox Jews, and [Muslims], the teachings of the Gospel, Torah, or Koran take precedence in their lives and indeed inspire their healing vocations. For these major religions, healing the sick is ultimately a religious act and it comes ultimately from God. To practice medicine that contravenes religious teaching would be to subvert conscience to secular society and its "values," to act hypocritically, and to violate moral integrity intolerably.

For Catholics this would also apply to the secular demand that those who must refrain from certain practice must refer physicians who will provide the disputed treatment or procedure would also be intolerable. 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. Respectfully, courteously, but definitively the religious physician must inform the patient of her objection while promising to care for the patient

This criticism is particularly sound as the exclusion of practitioners with pro-life moral or religious convictions is an outcome that has been endorsed by prominent medical ethicists in the context of providers' conscience debates. As Professor Julie Cantor argued in the *New England Journal of Medicine*, "[a]s the gate-keepers to medicine, physicians and other health care providers have an obligation to choose specialties that are not moral minefields for them. Qualms about abortion, sterilization, and birth control? Do not practice women's health."³⁸ Likewise, Oxford ethicist Julian Savulescu had opined in the *British Journal of Medicine*, "[i]f people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors."³⁹ These are well-credentialed individuals, affiliated with prestigious institutions, arguing in top-flight journals in favor of the purposeful exclusion of dissenting voices within the medical profession.

B. Specialty Certification in Obstetrics

The policies endorsed by the Ethics Opinion, in a sense, are merely an opinion by a committee of ethicists at ACOG. However, the policies can be enforced in the hands of ABOG because of its specialty certification power. This certification power incorporates the ethical norms of ACOG.

General medical licenses are regulated by the individual states.⁴⁰ The states decide who is and who is not entitled to practice medicine in general. As long as there has been professional medicine in America, however, there have also been attendant specialties.⁴¹ As the twentieth century progressed and "[a]s the number of physicians who limited their practice increased, many of them organized their own

until transfer or referral can be arranged by the patient, family, or social services.

Pellegrino, *supra* note 10, at 239–40 (footnotes omitted).

38 Julie D. Cantor, *Conscientious Objection Gone Awry—Restoring Selfless Professionalism in Medicine*, 360 *NEW ENG. J. MED.* 1484, 1485 (2009).

39 Julian Savulescu, *Conscientious Objection in Medicine*, 332 *BRIT. MED. J.* 294, 294 (2006).

40 See, e.g., *Medical Licensing Board of Indiana*, IN.GOV, <http://www.in.gov/pla/medical.htm> (last visited May 28, 2011) (providing information on obtaining a medical license in Indiana).

41 See GLENN GREENWOOD & ROBERT F. FREDERICKSON, *SPECIALIZATION IN THE MEDICAL AND LEGAL PROFESSIONS* 6–7 (1964) ("By the time the American medical profession began to develop, specialization had become accepted as proper in Europe.").

associations. These associations were independent of the American Medical Association and of each other.”⁴²

In addition to the development of *specialty associations* there was a proliferation of *specialty boards*.⁴³ These boards “are not associations of specialists, but are boards consisting of selected specialists who examine and certify applicants who wish to be recognized as specialists.”⁴⁴ A board’s function is to “(1) determine whether candidates have received adequate preparation, (2) provide a comprehensive test of ability and fitness of such candidates and (3) certify to the competence of those physicians who have satisfied their requirements.”⁴⁵ Certification by a specialty board confers with it a public recognition of training⁴⁶ and competence⁴⁷ that is crucial for physicians in their professional dealings with hospitals, insurers, and other employers.⁴⁸

In obstetrics, a specialist falls into one of six categories: ABOG Registered-Residency Graduate, Active Candidate, Diplomate, Expired Certificate, Retired Diplomate, and Revoked Certificate.⁴⁹ In order to have a Certificate revoked, there must be cause, which “may be due to, but is not limited to, licensure revocation or disciplinary restriction by any State Board of Medical Examiners, *violation of ABOG or ACOG rules and/or ethical principles*, or felony convictions.”⁵⁰ What is meant by “ABOG or ACOG rules and/or ethics principles” is not clarified further in the Bulletin. At the same time, the ACOG Ethics Committee has issued scores of opinions on all manner of ethical questions

42 *Id.* at 15.

43 *Id.* at 16.

44 *Id.*

45 *Id.* at 21. Currently the American Board of Medical Specialties (the national umbrella organization of medical boards) recognizes twenty four specialty boards. See *What Board Certification Means*, AM. BOARD MED. SPECIALTIES, http://www.abms.org/About_Board_Certification/means.aspx (last visited May 28, 2011).

46 See *How a Physician Becomes Board Certified*, AM. BOARD MED. SPECIALTIES, http://www.abms.org/Who_We_Help/Consumers/process.aspx (last visited May 28, 2011).

47 See *Board Certification & Your Career*, AM. BOARD MED. SPECIALTIES, http://www.abms.org/Who_We_Help/Physicians/career.aspx (last visited May 28, 2011) (“Certification by an ABMS Member Board has long been considered the gold standard in medical specialty certification. By pursuing board certification, you elevate yourself into the ranks of physicians committed to maintaining the highest possible standards for healthcare.”).

48 See *id.* (“Verifying board certification is not simply the province of hospitals. Insurers, healthcare organizations and even large employers not traditionally associated with healthcare are now interested in board certification as a marker of quality healthcare delivery.”).

49 AM. BD. OF OBSTETRICS & GYNECOLOGY, 2011 BULLETIN FOR BASIC CERTIFICATION IN OBSTETRICS AND GYNECOLOGY 6–8 (2010).

50 *Id.* at 7 (emphasis added).

facing obstetrics.⁵¹ Given the vagueness of ABOG's terms and the volume of ACOG Ethics Committee opinions, it is reasonable to infer that ACOG Committee opinions can affect ABOG ethics determinations.

Thus far ABOG has not revoked any Certificates for violation of the "ethical principles" espoused in the Ethics Opinion. Indeed, ABOG insists that such an outcome is not consistent with their practices.⁵² This argument, however, is unsatisfactory in many ways, not least of which is ABOG's failure to clarify any of the vagueness in the Bulletin as to which ethical criteria are encompassed by the referenced ABOG and ACOG rules.⁵³ Also telling is the fact that ABOG switched the enumerated causes for decertification between 2008 and 2009, removing the reference to ACOG in order to make it clear that the Ethics Opinion would not affect board certification while HHS was considering federal regulations on healthcare providers' conscience.⁵⁴ Yet by 2011 ABOG reinserted the ACOG reference in their Maintenance of Certification Bulletin, reestablishing the saliency of earlier concerns about decertification on conscience grounds.⁵⁵

51 See *Committee on Ethics Committee Opinions*, ACOG: AM. C. OBSTETRICIANS & GYNECOLOGISTS, http://www.acog.org/from_home/publications/ethics (last visited May 28, 2011).

52 See Letter from Norman F. Gant, Exec. Dir., ABOG, to Michael O. Leavitt, Sec'y, U.S. Dep't of Health & Human Servs., (Mar. 19, 2008), available at <http://www.aaplog.octoberblue.com/wp-content/uploads/2010/02/ABOGDrGant-to-Leavitt-Response3.19.08.pdf>.

53 See generally Michael Leavitt, *Physician Conscience*, LEAVITT PARTNERS (Aug. 7, 2008), <http://leavittpartners.com/blog/physician-conscience> ("Frankly, I found [ABOG's] response to be dodgy and unsatisfying. I sent another letter, more of the same."); see also Letter from the AAPLOG Board of Trustees to Norman F. Gant, Exec. Dir., ABOG (Apr. 7, 2008), available at <http://aaplog.octoberblue.com/wp-content/uploads/2010/02/AAPLOG-to-ABOG-Gant-20080407.pdf> (requesting clarification on certain ambiguous points made by Dr. Gant). But see Letter from Kenneth L. Noller, President, ACOG, to Fellows of the Am. Coll. of Obstetricians & Gynecologists (Mar. 26, 2008), available at <http://www.aaplog.octoberblue.com/wp-content/uploads/2010/02/Noller-to-Fellows-3-27-08.pdf> ("We want to be clear the Opinion does not compel any Fellow to perform any procedure which he or she finds to be in conflict with his or her conscience and affirms the importance of conscience in shaping ethical professional conduct.").

54 See Letter from AAPLOG to the Off. of Pub. Health & Sci., U.S. Dep't of Health & Human Servs., Re: Proposed Rescission of Provider Conscience Rule 74 Fed. Reg. 10,207 (Mar. 10, 2009), at 4 (Apr. 9, 2009), available at <http://downloads.frc.org/EF/EF09D50.pdf>.

55 See AM. BD. OF OBSTETRICS & GYNECOLOGY, *supra* note 49, at 7.

C. *Recent Legal Protections of Physicians' Conscience*

The Ethics Opinion by ACOG and the ABOG certification standards ignited a political controversy in the context of legal protections for physicians' conscience rights. It is worth tracing the historical and more recent statutory and regulatory conscience protections for healthcare providers.

1. Statutory Provisions

The first federal legislative protections⁵⁶ of physicians' conscience were enacted in the wake of *Roe v. Wade*⁵⁷ and are known as the Church Amendments.⁵⁸ The four Church Amendments (dating from 1973, 1974, and 1979) prohibit recipients of federal funds under the Public Health Services Act, Community Mental Health Centers Act, and Developmental Disabilities Services and Facilities Construction Act from performing or assisting in "any sterilization procedure or abortion, if his performance would be contrary to his religious beliefs or moral convictions."⁵⁹ The Church Amendments also ban discrimination against medical professionals who have "performed . . . a lawful sterilization procedure or abortion" or "refused to perform . . . such a procedure or abortion."⁶⁰

Later, Congress passed Public Health Services Act § 245, known as the Coats Amendment.⁶¹ The Coats Amendment was written in response to developments in medical education, whereby the Accreditation Council for Graduate Medical Education (ACGME) determined that obstetrics and gynecology residency programs ought to provide abortion training. It provides that the federal government and any state or local government receiving federal funding cannot discriminate against a broadly defined "health care entity" because it (1) refuses to receive, provide or require abortion training; (2) refuses to provide abortions; (3) refuses to provide referrals for abortions or abortion training; or (4) attended a training program that did or does not require attendees to perform abortions or require, provide, or refer for training in the performance of abortions or make arrangements for such training.⁶²

56 For an inexhaustive list (and critical analysis) of state legislative protections of medical conscience rights, see Swartz, *supra* note 18, at 270–73.

57 410 U.S. 113 (1972).

58 42 U.S.C. § 300a-7 (2006).

59 *Id.* § 300a-7(b).

60 *Id.* § 300a-7(c).

61 *Id.* § 238n.

62 *Id.*

The most recent legislative protection of physicians' conscience was the Hyde-Weldon Amendment of 2005, written by now-retired Florida congressman Dr. David Weldon as a rider on the Labor/HHS appropriation.⁶³ It reads:

None of the funds made available in this Act may be made available to a Federal agency or program, or to a state or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.⁶⁴

The Amendment defines "health care entity" as "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."⁶⁵

Taken together, the three sets of amendments provide fairly broad conscience protections for physicians in any context involving federal funds. Likewise, forty-six states (and the District of Columbia) have enacted legislative protections of physicians refusing to participate in abortion.⁶⁶

Nevertheless, the applicability of these federal amendments and state laws is unclear given the recently passed healthcare reform law, the Patient Protection and Affordable Care Act (PPACA).⁶⁷ As the PPACA contains its own revenue stream (not relying on general omnibus Congressional appropriations), the Hyde-Weldon and Church Amendments would not apply to it. Further, the Act was passed without a comprehensive conscience rider—although Senator Tom Coburn (an obstetrician) of Oklahoma proposed one.⁶⁸ The result is that the Act contains the potential to contravene established physicians' conscience protections in the area of reproductive health in its

63 Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, div. G, tit. V, § 508(d), 121 Stat. 1844, 2209.

64 *Id.*

65 *Id.*

66 Leonard J. Long, *Can Health Care Conscientious Objectors Thread the Needle?*, 13 QUINNIAC HEALTH L.J. 51, 66 (2009) (quoting HOLLY FERNANDEZ LYNCH, CONFLICTS OF CONSCIENCE IN HEALTH CARE 20 (2008)); see also Mark L. Rienzi, *The Constitutional Right to Refuse: Roe, Casey, and the Fourteenth Amendment Rights of Healthcare Providers* 40–41 & n.140 (Jan. 27, 2011) (unpublished manuscript), available at <http://ssrn.com/abstract=1749788> (cataloguing a series of representative state statutes).

67 Pub. L. No. 111-148, 124 Stat. 119 (2010).

68 S. Amend. 828 to S. Con. Res. 13, 111th Cong. (2009).

regulatory interpretation.⁶⁹ The PPACA is also silent as to any possible preemption of existing state conscience laws by new federal mandates or funding regulations.

2. Conscience Protection in Health and Human Services Regulations

While the Church Amendments have been in force since the 1970s, there were no regulations seeking to implement those statutory provisions or the subsequent conscience protections until January 2009.⁷⁰ These new conscience regulations were promulgated by the Department of Health and Human Services, at the direction of President George W. Bush's HHS Secretary, Michael O. Leavitt in the final days of the Bush administration.

The background of these regulations was the ACOG Ethics Opinion mandating performance of or referral for abortion and concern that ABOG would use these new ethical standards to revoke the certification of pro-life doctors. Upon learning about the Ethics Opinion, Secretary Leavitt wrote to the Executive Director of ABOG, Norman F. Gant, expressing his concerns that the Ethics Opinion and the ABOG Bulletin, when taken together, would result in decertifications on con-

69 See Helen Alvaré, *How the New Health Care Law Endangers Conscience*, PUB. DISCOURSE (June 29, 2010), <http://www.thepublicdiscourse.com/2010/06/1402> (“[W]hile §1303(b)(1) provides that abortion cannot be considered an ‘essential health benefit’ under the new law, it does nothing to exclude abortion from being included within other categories of mandated services such as ‘ambulatory patient services,’ ‘prescription drugs,’ or ‘preventive services.’ All of these categories the Secretary of HHS is authorized to populate under §1302(b). Nor does §1301(b)(1) provide that other procedures or services inimical to religious or moral convictions (e.g. sterilization, contraception, genetic testing, new reproductive technologies) may not be characterized by the Secretary as mandatory benefits under any one of these categories, including ‘essential health benefits.’”).

70 See 45 C.F.R. § 88 (2008). See generally Andre Draxton & Jessica Andrew, Note, *From Pre-School Aides to Presidents: Themes and Scenes of the Abortion Debate*, 11 J.L. & FAM. STUD. 457, 460 (placing the Bush-era conscience regulations in the broader context of executive efforts to combat judicial efforts to maintain the legality of abortion); Saunders & Fragoso, *supra* note 3, at 116–17 (describing the language of the Bush-era conscience regulations as well as some objections to them); O. Carter Snead, *Public Bioethics and the Bush Presidency*, 32 HARV. J.L. & PUB. POL’Y 867, 899 (2009) (“The highest profile action of the Bush Administration in [the physicians’ conscience] context was the issuance by HHS of a final rule that clarified and strengthened the protection of existing federal laws on healthcare provider conscience.”); Kim Worobec & Jennifer Gray, *HHS’ New Provider Conscience Regulations*, 21 HEALTH L., Apr. 2009, at 35, 35 (explaining the particular provisions of the Bush-era conscience regulations).

science grounds.⁷¹ There was disagreement between ABOG and Leavitt as to whether or not Leavitt's concerns were valid,⁷² and Secretary Leavitt's interactions with Dr. Gant were not particularly fruitful.⁷³ Accordingly Leavitt instructed HHS to begin considering a rule, a draft of which was leaked to the *New York Times*.⁷⁴ Thereafter the

71 See Press Release, U.S. Dep't of Health & Human Servs., HHS Secretary Calls on Certification Group to Protect Conscience Rights (Mar. 14, 2008), *available at* <http://www.hhs.gov/news/press/2008pres/03/20080314a.html> ("I am concerned that the actions taken by ACOG and ABOG could result in the denial or revocation of Board certification of a physician who—but for his or her refusal, for example, to refer a patient for an abortion—would be certified.").

72 See Julie Rovner, *Ob/Gyn Group: New Ethics Standards Misinterpreted*, NAT'L PUB. RADIO (Mar. 20, 2008), <http://www.npr.org/templates/story/story.php?storyId=88650797> (quoting Norman F. Gant, Executive Director of ABOG, claiming that Secretary Leavitt "took two and two and came up with five"); see also Letter from Norman F. Gant, *supra* note 52 (explaining to Leavitt what he allegedly got wrong).

73 See Leavitt, *supra* note 53. In a subsequent post, Leavitt clarified precisely what he viewed as the problematic "ideological basis of opposition to physician conscience," namely that "if a person goes to medical school they lose their right of conscience. Freedom of expression and action is surrendered with the issuance of a medical degree." Michael Leavitt, *Physician Conscience Blog II*, LEAVITT PARTNERS (Aug. 11, 2008), <http://leavittpartners.com/blog/physician-conscience-blog-ii>. In his view accomplishing this goal via professional certification was particularly abhorrent:

Obviously, some disagree with the federal law [protecting conscience] and would have it otherwise, so they have begun using the accreditation standards of physician professional organizations to define the exercise of conscience unprofessional and thereby make doctors choose between their capacity to practice in good standing and their right of conscience. In my view, that is simply unfair and a clear effort to subvert the law in favor of their ideology.

Id.

74 See Robert Pear, *Abortion Proposal Sets Condition on Aid*, N.Y. TIMES, July 15, 2008, <http://www.nytimes.com/2008/07/15/washington/15rule.html>. *But see* Leavitt, *supra* note 53 (responding to the leak, stating: "The Department is still contemplating if it will issue a regulation or not. If it does, it will be directly focused on the protection of practitioner conscience."). Secretary Leavitt's actions prior and subsequent to the leaking of the draft regulations caused a conflagration in the concerned precincts of politics and the pundit class, which is beyond the scope of this Note. For some commentary on that controversy at the time, see, for example, Rachel Walden, *ABOG Calls Out Secretary Leavitt Misrepresenting Certification Issue in Support of Proposed Regulation*, OUR BODIES, OURSELVES (Aug. 25, 2008, 9:01 AM), <http://www.ourbodiesourblog.org/blog/2008/08/abog-calls-out-secretary-leavitt-for-misrepresenting-certification-issue-in-support-of-proposed-regulation>, presenting a representative pro-choice view on the controversy, and Wendy Wright, *HHS Secretary Seeks Your Comments on Whether to Protect Pro-Life Doctors*, CONCERNED WOMEN FOR AMERICA (Aug. 12, 2008), http://www.cwalac.org/article_737.shtml, offering a pro-life defense of Secretary Leavitt's actions.

agency issued notice of a proposed rule,⁷⁵ and ultimately promulgated a rule protecting physicians' conscience rights, including protections against potential Certificate revocation.⁷⁶

These regulatory protections against an ABOG Certificate revocation on conscientious objection grounds are still in force. However, in 2009 HHS gave notice in the Federal Register that President Obama intended to rescind them in their entirety.⁷⁷ The new rules were published on February 23, 2011.⁷⁸ The new rule eliminated sections 88.2 through 88.5 (definitions, applicability, requirements and prohibitions, and certification, respectively) retaining the statement of purpose of the rule (section 88.1) and the designation of HHS's Office of Civil Rights as the department through which complaints are channeled (formerly section 88.6, now section 88.2).

Thus, currently, there are a number of statutory and regulatory protections for physicians' conscience rights that might ostensibly protect obstetric specialists from having their Certificates revoked. However, the statutory protections are somewhat indeterminate in scope,⁷⁹ and the regulatory protections have recently been in flux. Even if currently effective, albeit in a weakened form, the regulations are still easily rescindable or further alterable.

If these statutory and regulatory protections are rescinded or otherwise ineffective, physicians might be able to raise a number of constitutional objections (under either the U.S. Constitution or state constitutions) to protect their freedom of conscience. Physicians also might have a constitutionally cognizable claim to conscience rights (under Free Exercise of Religion) that would presumably preclude Certificate revocation.⁸⁰ Alternatively, they might have a due process

75 73 Fed. Reg. 50,274 (proposed Aug. 26, 2008) (to be codified at 45 C.F.R. pt. 88).

76 See 45 C.F.R. § 88.4(a)(3) (2009) ("For the purposes of granting a legal status to a health care entity (including a license or certificate), or providing such entity with financial assistance, services or benefits, fail to deem accredited any postgraduate physician training program that would be accredited but for the accrediting agency's reliance upon an accreditation standard or standards that require an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether such standard provides exceptions or exemptions")

77 74 Fed. Reg. 10,207 (proposed Mar. 10, 2009).

78 45 C.F.R. § 88 (2011).

79 See, e.g., *Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695, 697–98 (2d Cir. 2010) (calling into question the available private legal channels for healthcare providers whose consciences are violated).

80 See, e.g., Nora O'Callaghan, *Lessons from Pharaoh and the Hebrew Midwives: Conscientious Objection to State Mandates as Free Exercise Right*, 39 CREIGHTON L. REV. 561, 565

claim against Certificate revocation.⁸¹ I contend that physicians also might have a legitimate claim against the revocation of their Certificate insofar as it constitutes a taking of their vested property interests in their medical practices.

II. MEDICAL BOARD AS A STATE ACTOR

In order for an obstetrician to have a cognizable takings claim under the Fifth Amendment (or the Fourteenth Amendment's Due Process Clause if the taking involves a state actor), the alleged taking must satisfy the state action doctrine. That is, in order for there to be a takings claim, the property in question must "be taken in a way in which the state's involvement is judged significant."⁸² This requirement is in keeping with longstanding constitutional doctrine, which states: "[N]othing in the language of the Due Process Clause itself requires the State to protect the life, liberty, and property of its citizens against invasion by private actors. The Clause is phrased as a limitation on the State's power to act . . ."⁸³ At first glance, it seems that a decertification by ABOG would not be a state action. After all, ABOG is "an independent non-profit organization" and not a government body or agency.⁸⁴ Yet private actors can be subject to constitutional scrutiny if they are serving a "public function."⁸⁵

There are many modes of evaluating the applicability of this public function exception, and ABOG would most likely come under entanglement doctrine. Under entanglement (or "joint participa-

(2006) ("I argue that *conscientious objection* claims by religious believers are very close to the core of religious liberty, are in line with the history and tradition of American understandings of the proper limits of free exercise rights, generally present less danger to the community, and should receive a different kind of constitutional analysis compared to claims of those seeking *civil disobedience* religious liberty rights.").

81 See T.W. Cousens, Annotation, *Suspension or Expulsion from Professional Association and the Remedies Therefor*, 20 A.L.R.2d 531 (1952) (explaining traditional causes of action against professional associations on internal procedural grounds); see also Rienzi, *supra* note 66, at 46–69 (offering an argument for conscientious refusal by physicians under substantive due process jurisprudence).

82 BRUCE A. ACKERMAN, *PRIVATE PROPERTY AND THE CONSTITUTION* 146 (1977); see also *id.* ("[T]he takings clause . . . is understood to constrain only state action and not analogous conduct attempted by private parties.").

83 *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 195 (1989).

84 *About Us*, AM. BOARD OBSTETRICS & GYNECOLOGY, <http://www.abog.org/about.asp> (last visited May 28, 2011).

85 See, e.g., *Marsh v. Alabama*, 326 U.S. 501, 506 (1946) ("Thus, the owners of privately held bridges, ferries, turnpikes and railroads may not operate them as freely as a farmer does his farm. Since these facilities are built and operated primarily to benefit the public and since their operation is essentially a public function, it is subject to state regulation.").

tion”) a private actor can be subject to the constitutional restrictions applicable to state action if the state “insinuated itself into a position of interdependence” with a private actor in such a way that the state “must be recognized as a joint participant in the challenged activity.”⁸⁶

At a conceptual level an action by ABOG would seem to involve joint participation with the states and federal government, especially as the action relates to the consequences of decertification. For example, one of the primary consequences of decertification is the revocation of hospital admitting privileges because hospitals often predicate those privileges on certification.⁸⁷ A number of large and important hospitals are public institutions.⁸⁸ Likewise, for public and private hospitals alike, the government is an increasingly active financier of maternity services, with Medicaid (the principal federal medical safety net, administered by the states) paying for more than forty percent of births.⁸⁹ The vast majority of non-Medicaid maternity coverage is provided by private third-party payers, such as insurance and HMOs, which the federal government already regulates heavily—a situation that will only increase due to the recent Patient Protection and Affordable Care Act,⁹⁰ especially as it relates to maternity coverage.⁹¹ In the event that a decertification adversely affects either public or private third party reimbursement, it thus affects the healthcare provider in a way that requires comingled state action.

This analysis encounters problems, however, in that it involves *reverse* entanglement. Under a classic entanglement scenario, such as *Burton v. Wilmington Parking Authority*, a private actor is acting under color of state authority (e.g. a private restaurant is discriminating

86 *Burton v. Wilmington Parking Auth.*, 365 U.S. 715, 725 (1961) (noting this in the context of a Delaware restaurant that refused to serve African Americans, while occupying space in a building owned by the Wilmington Parking Authority).

87 See *infra* note 161 and accompanying text.

88 See, e.g., *About HHC*, N.Y. CITY HEALTH & HOSPS. CORP., <http://www.nyc.gov/html/hhc/html/about/about.shtml> (last visited May 28, 2011) (noting that the New York City Health and Hospitals Corporation, run by the City of New York, serves 1.3 million New Yorkers each year).

89 USHA RANJI ET AL., *STATE MEDICAID COVERAGE OF PERINATAL SERVICES I* (2009) (“Today, Medicaid pays for more than four in ten births nationwide, and in several states, covers more than half of total births.”).

90 Pub. L. No. 111-148, 124 Stat. 119 (2010).

91 See Adam Sonfield, *The Potential of Health Care Reform to Improve Pregnancy-Related Services and Outcomes*, 13 GUTTMACHER POL’Y REV. 13, 15 (2010) (“Most notably, maternal and newborn care is one of only 10 types of health care services explicitly required by law to be included in what will become widely known as the ‘essential health benefits package.’ That package of services . . . will be covered for all enrollees in all plans sold in the new [insurance] exchanges, as well as in any new individual and small group policies sold outside of the exchanges.”).

while it occupies property in a government-owned parking garage). When the relationship is reversed—and the actions of a government actor (e.g. a public hospital or the state Medicaid authority) implicate the actions of a private entity with whose requirements they are complying (e.g. ABOG)—current doctrine does not maintain that the private actor becomes entangled in such a way as to make its policy constitutionally justiciable.⁹²

Furthermore, in the rare cases that these state action questions have been heard as they relate to healthcare providers—involving disputes over hospital accreditation—the courts have been reluctant to consider the accrediting authority a state actor.⁹³ Thus, while the constitutional status of a medical board like ABOG has not been adjudicated, under current doctrine it is unlikely that ABOG, if it were to

92 In dealing with a suit against the NCAA by a basketball coach, the Supreme Court framed the issue in this way:

The mirror image presented in this case requires us to step through an analytical looking glass to resolve the case. Clearly [University of Nevada, Las Vegas's] conduct was influenced by the rules and recommendations of the NCAA, the private party. But it was UNLV, the state entity, that actually suspended [Coach Jerry] Tarkanian. Thus the question is . . . whether UNLV's actions in compliance with the NCAA rules and recommendations turned the NCAA's conduct into state action.

Nat'l Collegiate Athletic Ass'n v. Tarkanian, 488 U.S. 179, 193 (1988). Justice Stevens, writing for the Court, held that the NCAA's conduct in sanctioning Tarkanian was not state action even though it resulted in actions that affected him adversely by UNLV, a state actor. *See id.* at 199.

93 *See McKeesport Hosp. v. Accreditation Council for Graduate Med. Educ.*, 24 F.3d 519, 524 (3d Cir. 1994) (finding that the Accreditation Council for Graduate Medical Education was not a state actor when it was sued by a hospital for discrediting the hospital's residency even though the Pennsylvania State Board of Medicine had authorized the Council to serve as the state's "accrediting body"). *But c.f.* *St. Agnes Hosp. v. Riddick*, 748 F. Supp. 319, 326 (D. Md. 1990) (noting general paucity of compelling authority on the question of medical accreditation councils constituting state actors). It is worth noting that *St. Agnes* was the second decision by the Maryland District Court on the topic, having previously found that

[ACGME] belittles the connection between the ACGME, the state, and the issues in this action. The state, through its statutes and regulations, has given to the ACGME the authority to determine which residency programs shall be accredited, and thus to determine, in part, how a person must be trained in order to qualify for a physician's license in the state of Maryland.

St. Agnes Hosp. v. Riddick, 668 F. Supp. 478, 480 (D. Md. 1987). Following *Tarkanian*, however, the District Court backtracked on its definitive determination of entanglement. Regardless, the issue in *St. Agnes*—the removal of residency accreditation from a Catholic hospital for refusal to teach abortions—was probably mooted by the Coats Amendment. *See supra* note 61 and accompanying text.

decertify a practitioner, would be entangled with state action in the provision of medicine.

Nevertheless, a departure from the prevailing reverse entanglement doctrine is justifiable when one distinguishes the fundamental issues at hand in an ABOG decertification—the practice of medicine—and those in *National Collegiate Athletic Association v. Tarkanian*. ABOG rules for certification apply across the country in various contexts often involving close concert with state and federal actors. Tarkanian's due process claim against the NCAA as a state actor, on the other hand, was essentially bootstrapped, relying on the happenstance that he was a coach at a state university rather than a private one. ABOG is more pervasively and consistently entangled with state action than the controlling *Tarkanian* case, warranting a possible expansion of reverse entanglement.

Guidance can be found in similarly situated private medical associations at common law. A number of jurisdictions have determined that such associations provide sufficient public goods that they are held to higher level of scrutiny in their membership decisions given their "public functions."⁹⁴ The most well known such extension of public authority into the practice of medicine was *Falcone v. Middlesex County Medical Society*.⁹⁵ *Falcone* involved a dispute over whether a certain Dr. Falcone, a physician licensed to practice by the State of New Jersey, ought to have been admitted into the Middlesex County Medical Society. The Medical Society refused his admittance because he was a doctor of osteopathy (DO) rather than an allopathic physician (MD). In resolving the dispute, the New Jersey Supreme Court concluded:

Through its interrelationships, the County Medical Society possesses, in fact, a virtual monopoly over the use of local hospital facilities. As a result it has power, by excluding Dr. Falcone from membership, to preclude him from successfully continuing in his practice of obstetrics and surgery and to restrict patients who wish to engage him as an obstetrician or surgeon in their freedom of

94 See Note, *The Antidiscrimination Principle in the Common Law*, 102 HARV. L. REV. 1993, 1997 (1989) ("Similarly, when a professional society such as the American Medical Association accredits a medical school, or affects a hospital's decisions of whom to employ, it too assumes a 'public' function. As in the traditional duty-to-serve cases, the business or association cannot exclude a member of the public absent a 'reasonable' or nonarbitrary basis." (footnotes omitted)). But see Zechariah Chafee, Jr., *The Internal Affairs of Associations Not for Profit*, 43 HARV. L. REV. 993, 1010–14 (1930) (espousing an older view that expulsion from a private association, like a club, is an action without cognizable legal remedy).

95 170 A.2d 791 (N.J. 1961).

choice of physicians. Public policy strongly dictates that this power should not be unbridled but should be viewed judicially as a fiduciary power to be exercised in reasonable and lawful manner for the advancement of the interests of the medical profession and the public generally⁹⁶

In other words, because of the monopolistic power held by the County Medical Society, and its service to the public good,⁹⁷ it was not free to discriminate against duly licensed physicians on the “arbitrary” grounds of whether a medical or osteopathic association accredited their graduate schools. This departure from the previous general posture of judicial noninterference with the affairs of private associations has been followed by nine other states.⁹⁸

ABOG likewise occupies a unique position in its certification power, through which it provides a unique public service. As has been seen, the states license doctors, but the states leave it up to the independent specialty organizations, recognized by the American Board of Medical Specialties, to credential specialty practitioners.⁹⁹ This credentialing forms the basis for establishing competency on both the supply and demand sides of the medical profession. On the supply side, credentialing allows hospitals and third-party payers to base their hiring, privilege, and reimbursement decisions on objective baseline criteria of training and competence as determined by the boards. On the demand side, credentialing allows patients with lay knowledge to rely on the considered opinion of the board when evaluating the basic competency of a given specialist. Thus, with the proliferation of medi-

96 *Id.* at 799; *see also* Greisman v. Newcomb Hosp., 192 A.2d 817, 825 (N.J. 1963) (extending the *Falcone* doctrine to include also private hospitals).

97 *See Falcone*, 170 A.2d at 799 (“It must be borne in mind that the County Medical Society is not a private voluntary membership association with which the public had little or no concern. It is an association with which the public is highly concerned and which engages in activities vitally affecting the health and welfare of the people.”).

98 *See Hottentot v. Mid-Maine Med. Ctr.*, 549 A.2d 365, 368 n.4 (Me. 1988). The Maine Supreme Court declined to follow the *Falcone* doctrine, in line with the posture of the Massachusetts Supreme Judicial Court. *Id.* at 368–69. I rely on *Falcone* with some trepidation, as New Jersey state action decisions are noted for their promiscuous and anomalous application of public functions to private actors in order to effectuate policy ends. *See, e.g., Cox v. Athens Reg’l Med. Ctr.*, 279 Ga. App. 586, 593 (2006) (declining to extend *Doe v. Bridgeton Hosp. Ass’n, Inc.*, 366 A.2d 641, 645 (N.J. 1976) which held that private, nonprofit, nonsectarian hospitals are “quasi-public institutions” required to provide their facilities for “elective” abortion). Nevertheless, *Falcone* predates the subsequent more ambitious rulings by the New Jersey Supreme Court and the fact that the *Falcone* doctrine has been followed by numerous other jurisdictions is notable.

99 *See supra* notes 41–48 and accompanying text.

cal specialty fields, quacks and incompetents are kept out of the supply pool of providers for the benefit of both the specialties themselves, and also, presumably, for the public at large.¹⁰⁰ As the boards manage the credentialing, the state is freed from having to expend its resources by expanding its licensing protocols to cover specialties as well.

Thus, while existing caselaw would probably not implicate ABOG as a state actor, a decertified physician has a plausible claim that ABOG and other specialty boards are state actors, given the extent of the reverse entanglement and the public function such boards serve as regulators of the medical practice. Indeed—not without some irony—influential legal commentary has marshaled the “public function” of the medical profession (through the “monopoly” power afforded to it by the state) as a factor that limits providers’ conscience rights.¹⁰¹ Presumably this public function cuts both ways, affecting not just the physicians who practice in monopoly but also the boards that oversee it.

III. IS THERE A PROPERTY INTEREST IN MEDICAL PRACTICE?

The Takings Clause of the Fifth Amendment of the U.S. Constitution states, “nor shall private property be taken for public use, without just compensation.”¹⁰² This Clause provides the basis of the doctrine of regulatory takings, namely that “changes in legislation or regulation can trigger takings liability, at least in some instances.”¹⁰³ Or, in other

100 See AM. BD. OF OBSTETRICS & GYNECOLOGY, *supra* note 49, at 38 (“Individuals who are certified as Diplomates by the Corporation acquire no property right or vested interest in their certification or in their Diplomate status, the duration, terms, and conditions of which may be extended, reduced, modified or otherwise changed as determined by the Board of Directors, in its absolute discretion *to assure greater protection of the public*, to recognize knowledge and skills deemed to require further evaluation or to accommodate legal requirements.” (emphasis added)).

101 See R. Alta Charo, *The Celestial Fire of Conscience—Refusing to Deliver Medical Care*, 352 NEW ENG. J. MED. 2471, 2473 (2005) (“And it is here that licensing systems complicate the equation By granting a monopoly, [the states] turn the profession into a kind of public utility, obligated to provide service to all who seek it. Claiming an unfettered right to personal autonomy while holding monopolistic control over a public good constitutes an abuse of the public trust”). It is worth noting that Charo’s *Celestial Fire* is the first source cited by the Ethics Opinion. See ETHICS OPINION, *supra* note 1, at 5 n.1.

102 U.S. CONST. amend. V. As the Takings Clause relates to nonfederal actors it is through the Due Process Clause of the Fourteenth Amendment, which prohibits states from “depriv[ing] any person of life, liberty, or property without due process of law.” *Id.* amend. XIV.

103 DAVID A. DANA & THOMAS W. MERRILL, PROPERTY: TAKINGS 229 (2002).

words, “[t]he general rule at least is that while property may be regulated to a certain extent, if regulation goes too far, it will be recognized as a taking.”¹⁰⁴ Incumbent upon both the traditional takings formulation and the established regulatory taking doctrine is that what is taken is a *property* interest.

In the case of ABOG decertification, the question then becomes, does the revocation of an obstetric Certificate constitute the taking of property in such a way that it implicates the Fifth (and Fourteenth) Amendment? It clearly is not a taking of real property, as in a “pure taking” (e.g. the condemnation of a house to build an interstate highway), but it does entail a significant loss of value in a medical practice. I will look at a descriptive question: What kind of property interest is contained in a medical practice? I will then examine the underlying normative question: How *ought* takings doctrine apply to the nonreal property interests found in a medical practice?

A. *Is a Medical Practice Property?*

The decertification of an obstetrician involves property interests in the goodwill of the physician’s medical practice. Obviously, the real property associated with a medical practice is not affected: A decertified obstetrician retains the lease or ownership interest in the building that houses her practice. Moreover, even assuming that there may be a property interest in the obstetrician’s professional degree, the professional degree is not affected.¹⁰⁵ What is changed is the “personal goodwill,” which (described in a corporate context) “exists when the shareholder’s reputation, expertise, or contacts gives the corporation its intrinsic value. It is most likely to be found in closely held businesses, especially those that are technical, specialized, or professional in nature or have few customers and suppliers.”¹⁰⁶ The lost property interest is thus in the *practice* itself, the medical services provided by the obstetrician and the business interest those services have accrued over the years.

104 Pa. Coal Co. v. Mahon, 260 U.S. 393, 415 (1922).

105 See Margaret F. Brinig, *Property Distribution Physics: The Talisman of Time and Middle Class Law*, 31 FAM. L.Q. 93 (1997) (looking at the role of academic degrees and increased spousal earning power in marital dissolution from a property perspective).

106 Darian M. Ibrahim, *The Unique Benefits of Treating Professional Goodwill as Property in Corporate Acquisitions*, 30 DEL. J. CORP. L. 1, 1 (2005). The type of personal goodwill found in the case of an obstetric decertification is “professional goodwill.” See *id.* at 9 (“Personal goodwill is often found in professional businesses. These businesses are able to offer unique services due to the advanced education and special skills of their owners. In this context, personal goodwill is often referred to as ‘professional goodwill.’” (footnotes omitted)).

In the case of a joint practice, the obstetric partner's equity share in the partnership would not necessarily be implicated by his decertification. Nevertheless, the value he brings to the partnership would be reduced, as would his professional standing. Thus the total profitability of the partnership would still be reduced. If all the partners in a multipractitioner obstetric practice were to face decertification, then it would be comparable to the situation discussed in the introductory hypothetical: A total inability of the practice as a whole to achieve its medical (and business) purpose—namely the practice and provision of obstetric medicine.

Professional goodwill as a form of property most often appears in the context of marital dissolutions. In the dissolution context it is seen as a cognizable form of property, although its value is necessarily difficult to quantify.¹⁰⁷ For example, in *In re Marriage of Fortier*¹⁰⁸ a Court of Appeals in California noted that such goodwill in a medical practice during marital dissolution is different from the expected earnings of the physician; rather, such goodwill is a cognizable asset to be divided at time of divorce.¹⁰⁹ Likewise, in *In re Marriage of Hull*,¹¹⁰ the Supreme Court of Montana held “that the goodwill of a professional anesthesiology practice may be a marital asset subject to property division in a marriage dissolution.”¹¹¹ The Supreme Court of Montana relied primarily on an earlier decision by the Supreme Court of Washington, *In the Matter of the Marriage of Fleege*.¹¹² In *Marriage of Fleege* the court held that “[t]he value of goodwill to the professional spouse, enabling him to continue to enjoy the patronage engendered

107 See Martin J. McMahon, Annotation, *Valuation of Goodwill in Medical or Dental Practice for Purposes of Divorce Court's Property Distribution*, 78 A.L.R.4th 853 (1990) (“In the divorce cases that involved sole practitioner physicians . . . some courts, in determining the value of goodwill for purposes of property distribution, have held or implied that straight capitalization . . . capitalization of excess earnings . . . fair market value . . . personal characteristics of the physician . . . factors pertaining to the practice or business . . . and other or unspecified factors and methods . . . were applicable.”).

108 109 Cal. Rptr. 915 (Ct. App. 1973).

109 *Id.* at 918 (“Therefore, since community goodwill may be evaluated by no method that is dependent upon the post-marital efforts of either spouse, then, as a consequence, the value of community goodwill is simply the market value at which the goodwill could be sold upon dissolution of the marriage, taking into consideration the expectancy of the continuity of the practice.”).

110 712 P.2d 1317 (Mont. 1986).

111 *Id.* at 1321.

112 588 P.2d 1136 (Wash. 1979).

by that goodwill, constitutes a community asset and should be considered by the court in distributing the community property.”¹¹³

On the other hand, in the context of eminent domain or physical takings, goodwill is generally excluded from the just compensation—like other consequential damages such as attorney’s fees.¹¹⁴ California, where most of the cases involving the “taking” of goodwill have arisen, is an exception in that in 1975 it passed and signed into law section 1263.510 of the California Code of Civil Procedure.¹¹⁵ That provision explicitly mandates that “[t]he owner of a business conducted on the property taken, or on the remainder if the property is part of a larger parcel, shall be compensated for loss of goodwill if the owner proves [four conditions].”¹¹⁶ Even here, though, the property claim is an ancillary one, as one of the conditions upon which the compensation is predicated reads, “[t]he loss is caused by the taking of the property or the injury to the remainder.”¹¹⁷ Thus, while California has recognized a compensable property interest in goodwill, it is not one that stands *alone* as a constitutionally cognizable claim.¹¹⁸

States have some space in which to shape the definition of private property as it relates to goodwill. On the federal level, the U.S. Supreme Court has taken “important steps toward developing a federal constitutional definition of private property” but such steps

113 *Id.* at 1140.

114 See RICHARD A. EPSTEIN, *TAKINGS* 51–52 (1985). Epstein does not agree with this rule: “The injustice—for such it is—of the current rule is widely recognized in the decided cases and the academic literature. But this broad academic consensus on the basic point has not been matched by a judicial willingness to overturn established doctrine.” *Id.* at 53 (footnote omitted); see also *City of Oakland v. Pac. Coast Lumber & Mill Co.*, 153 P. 705, 707 (1915) (“It is quite within the power of the Legislature to declare that a damage to that form of property known as business or the good will of a business shall be compensated for; but, unless the Constitution or the Legislature has so declared, it is the universal rule of construction that an injury or inconvenience to a business is *damnum absque injuria* and does not form an element of the compensating damages to be awarded.”).

115 CAL. CIV. PROC. CODE § 1263.510 (West 2010).

116 *Id.*; see also *Cmty. Redevelopment Agency of L.A. v. Abrams*, 543 P.2d 905, 908 (Cal. 1976) (en banc) (refusing to compensate lost goodwill in a relocated pharmacy because the relocation was forced before the legislature changed the law to allow goodwill compensation).

117 CAL. CIV. PROC. CODE § 1263.510.

118 See, e.g., *Chhour v. Cmty. Redevelopment Agency of Buena Park*, 53 Cal. Rptr. 2d 585, 587 (Ct. App. 1996) (explaining how the “judicial stinginess” of not recognizing goodwill as constitutionally protected property was remedied in California by the revision to the Code of Civil Procedure); *Redevelopment Agency of Emeryville v. Arvey Corp.*, 5 Cal. Rptr. 2d 161, 162 (Ct. App. 1992) (noting that the jury in *Arvey’s* eminent domain litigation had awarded him \$225,000 in lost goodwill compensation).

remain “tentative” and not “complete.”¹¹⁹ As such, “[t]he Supreme Court has said that in most cases it must defer to state definitions of what constitutes property for purposes of the federal Constitution’s property guarantees.”¹²⁰

Probably most important for evaluating an ABOG decertification, then, would be the state definition of property in Texas as ABOG’s certification process contains Texas choice-of-law provisions.¹²¹ Currently Texas law protects “private real property,” defined as “an interest in real property recognized by common law, including a groundwater or surface water right of any kind, that is not owned by the federal government, this state, or a political subdivision of this state,” from uncompensated takings.¹²² A change in Texas’s property definition to include goodwill (perhaps as California has done, but ideally as an independent cause of action) would greatly increase the chances of an ABOG conscience decertification affecting a cognizable property right.

B. *Should a Medical Practice Be Property?*

We have seen that the main property interest in a medical practice at stake in an obstetric decertification is professional goodwill, and that the justiciability of professional goodwill in a takings context is murky, at best. Given the paucity of examples of goodwill being treated as a constitutionally cognizable form of property, we ought to ask, should it count as such? I conclude that it ought to count as a recognizable property interest under at least three theoretical approaches to the issue.

1. Richard Epstein’s View

In his influential book, *Takings: Private Property and the Power of Eminent Domain*, Richard Epstein argues that distinctions must be

119 DANA & MERRILL, *supra* note 103, at 68. Dana and Merrill identify clearly the requirements that property be made of “discrete assets” and contain a “right to exclude”—and propose a third prong, that the property be “exchangeable on a stand-alone basis.” *Id.* at 68–81.

120 POLLY J. PRICE, *PROPERTY RIGHTS* 137 (2003).

121 *See* AM. BD. OF OBSTETRICS & GYNECOLOGY, *supra* note 49, at 38 (“In any dispute of any kind with the [ABOG] or any Person or Entity, such Person or Entity shall be subject to suit, if at all, only in the County and State where the [ABOG] maintains its principal place of business and its headquarters, which is currently Dallas, Dallas County, Texas. Each Person or Entity shall be required and agrees to consent to the exclusive jurisdiction and venue of courts located in Dallas, Texas and laws of the State of Texas for the resolution of any and all such disputes.”).

122 TEX. GOV’T CODE ANN. § 2007.002 (West 2008).

made when approaching loss of goodwill. Regardless of one's views on Epstein's broader (and controversial) argument, his discussion of goodwill is pertinent here.

Epstein argues that “[t]he economic loss of goodwill as such . . . is *never* the touchstone of actionability.”¹²³ This is because loss of goodwill in and of itself can come from various sources—among them, in a commercial context, “because the owner’s performance has slipped or because his competitors have outdone him or because tastes have changed”¹²⁴—which are perfectly reasonable causes for diminution of goodwill. “[F]orce,” on the other hand, is the “forbidden mean[s] . . . that is always decisive on the normative question of entitlement, be it against a private defendant or against the state.”¹²⁵ Epstein offers a hypothetical example of such a “forced” destruction of goodwill: a neighbor who barricades a business next door without trespassing on the business owner’s land.¹²⁶

When goodwill is destroyed by force, Epstein argues, the property owner is owed compensation just as she is for the taking of any other form of property. In his view, “[f]ar from being vague, goodwill is something that can be owned, transferred, protected against interference by (at the very least) deliberate force and misrepresentation by third parties, and, of course, taxed.”¹²⁷ Thus, “[w]hat possible warrant is there then for denying it the status of private property under the Constitution?”¹²⁸ As such, in precluding the presence of goodwill in a constitutional takings context, “a court must give some independent normative account of private property which explains why, and how, it is permissible to import into the Constitution meanings wholly at variance with both ordinary and legal conceptions.”¹²⁹ Epstein thus finds even statutory fixes, like that of California,¹³⁰ insufficient as they do not protect goodwill to the extent the Constitution ought to; California in particular “gives no principled reason why the loss of goodwill is compensable only when coupled with dispossession.”¹³¹

123 EPSTEIN, *supra* note 114, at 81.

124 *Id.*; *see infra* Part V.

125 EPSTEIN, *supra* note 114, at 81–82.

126 *See id.* at 80–81.

127 *Id.* at 83.

128 *Id.*

129 *Id.* at 84. Epstein does not think that courts have done so. *See id.* at 82 (noting that “[t]he intellectual case for compensation of goodwill generally enjoys much scholarly support” (citing Gideon Kanner, *When Is “Property” Not “Property Itself”: A Critical Examination of the Bases of Denial of Compensation for Loss of Goodwill in Eminent Domain*, 6 CAL. W. L. REV. 57 (1969))).

130 *See supra* notes 115–16 and accompanying text.

131 EPSTEIN, *supra* note 114, at 86.

Epstein's view that the taking of goodwill ought to be compensable as a matter of constitutional property protection would apply in the case of an obstetric decertification. The eradication of goodwill in the case of the decertified obstetrician is not due to economically efficient causes, e.g. incompetence, competition, population shifts, etc.,¹³² but rather due to an external organization's interference with the obstetrician's ability to practice—not unlike the hypothetical neighbor barricading the entrance to a place of business.¹³³ This eradicated goodwill would then be compensable in and of itself, without a requisite dispossession first (as required by California).¹³⁴

2. Liberty and Decisional Property Rights

Why do we protect private property and do those reasons implicate obstetric goodwill? This broader normative question involves the purposes underlying the constitutional property rights protected by the Fifth Amendment.¹³⁵ At its most basic level “[p]roperty is seen as a bulwark which protects material wealth, liberty, and autonomy.”¹³⁶

132 See *infra* Part IV.

133 See *supra* note 126 and accompanying text.

134 Because Epstein is describing pure state action, it is unclear what the remedy would be under his system for a private entity acting in a public function as ABOG could be. This perhaps points to another potential ground for action, namely that ABOG would be liable to the decertified physician under private law for tortious interference in his practice. That is beyond the scope of this Note, however.

135 I do not argue that this set of considerations should necessarily have interpretive force in a constitutional context, as that is a separate question of constitutional interpretation which cannot be resolved here. Compare RONALD DWORKIN, *TAKING RIGHTS SERIOUSLY* 135–36 (1977) (arguing that difficult constitutional questions should refer to the “*concepts*” underlying “vague” clauses—“like legality, equality, and cruelty”—and not “*conceptions*” of them; or in other words that we should focus on what a clause “means,” not what I, or the Founders, or Ronald Dworkin *say* it means (emphasis added)), and STEPHEN BREYER, *ACTIVE LIBERTY* 76–84 (2005) (evaluating competing interpretations of the Equal Protection Clause—“one color-blind, one purposive”—in the context of affirmative action in college and law school admissions), with Robert H. Bork, *The Constitution, Original Intent, and Economic Rights*, 23 *SAN DIEGO L. REV.* 823, 832 (1986) (“For the subject of economic rights . . . we must turn away from the glamor [sic] of abstract philosophic discourse and back to the mundane and difficult task of discovering what the Framers were trying to accomplish with the Contract Clause and the Takings Clause.”).

136 LAURA S. UNDERKUFFLER, *THE IDEA OF PROPERTY* 1 (2003); see also JEDEDIAH PURDY, *THE MEANING OF PROPERTY* 9 (2010) (noting in a historical survey that among “jurists and reformers” of the eighteenth century “property promised to integrate the most important qualities of personal freedom, the signal value of the modern world”).

In this sense property is seen as a right to a thing (in rem),¹³⁷ which carries with it what can be termed decisional rights—namely the owner of the thing has the right to decide what she does or does not do with the thing.¹³⁸ Incumbent upon such rights are duties, duties which protect the interests of the right-bearer.¹³⁹

Thus, in a sense, the protection of private property in law is a burden upon the other (typically, all others) to respect the decision-making authority of the right-holder *vis-à-vis* his property. In so doing, the broader liberty and autonomy of the right-holder are respected—not merely the narrow right to the “thing.” This respect applies particularly to the goodwill property of the obstetrician facing decertification: The protection of the obstetrician’s goodwill gives her the right to practice medicine as she sees fit in keeping with the dictates of her conscience, and imposing a duty on others (here ABOG) not to interfere with that decisional right.

3. Liberty and In Personam Property Rights

A contemporary approach to property rights implicates similar overarching goals of protecting liberty and in some ways serves to clarify them as they relate to goodwill. This contemporary approach to property understands property as a “bundle of sticks” or a “bundle of rights” with no one stick or right being essential for calling some interest “property.”¹⁴⁰

While the distinction between a right to the thing and the “bundle of rights” view is not always a clear one—or at least the distinction

137 See generally Thomas W. Merrill & Henry E. Smith, *What Happened to Property in Law and Economics?*, 111 *YALE L.J.* 357, 360–66 (2001) (presenting an account of the “traditional” (in rem) approach to property law).

138 See UNDERKUFFLER *supra* note 136, at 17 (positing a “particular land-based power” of the property owner—“the right of a title holder to use his land in the way that he, in his discretion, desires”—and referencing *Lucas v. S.C. Coastal Council*, 505 U.S. 1003 (1992)); see also JEREMY WALDRON, *THE RIGHT TO PRIVATE PROPERTY* 47 (1988) (“Ownership, as we have seen, expresses the abstract idea of an object being correlated with the name of some individual, in relation to a rule which says that society will uphold that individual’s decision as final when there is any dispute about how the object should be used.”).

139 See J.E. PENNER, *THE IDEA OF PROPERTY IN LAW* 13 (1997) (“The essential claim [Joseph] Raz makes is that a person is the bearer of a right when a duty is imposed *in order* to serve or protect *his interest*.” (citing Joseph Raz, *On the Nature of Rights*, 93 *MIND* 194, 195 (1984))).

140 PRICE, *supra* note 120, at 138 (“The Supreme Court generally considers property not to be limited to objects that a person may possess but to be anything to which a bundle of rights attaches . . .”).

is not entirely essential for understanding one or the other¹⁴¹—looking at the specific interests held by the owner starts to bring forward a fairly definite series of rights or powers.¹⁴² One helpful (but inexhaustive) list of these rights and powers includes “claim-rights to possess, use, manage, and receive income; the powers to transfer, waive, exclude, and abandon; the liberties to consume or destroy; immunity from expropriation; the duty not to use harmfully; and liability for execution to satisfy a court judgment.”¹⁴³ Such a mode of evaluating the reality of ownership seems compatible with Epstein’s justification for protecting goodwill—given that he cites its transferability, ability to be protected, and its ability to be taxed as ways of understanding how it is property.¹⁴⁴

Applying obstetric goodwill to the list above, we see that the ownership of it includes possession (it is the physician’s goodwill), use and management (she decides when to work), receipt of income (income is the basis for private medical practice), power to transfer (a practice can be sold), power to exclude (one practitioner does not need to admit another to her practice, nor does she need to see every patient), right to abandon (obstetricians retire), immunity from expropriation, the duty not to use harmfully (you cannot practice bad medicine), and liability for execution to satisfy a court judgment (practice goodwill can be divided by a court as a marital asset). Thus, although practice goodwill is not a tangible thing to be grasped, it has adhering to it a “bundle of rights” that can make it property in a cognizable sense, for, “[i]f a person has all of these incidents [described above], or most of them, with respect to a certain thing, then he or she owns it.”¹⁴⁵

141 See WESLEY NEWCOMB HOHFELD, *FUNDAMENTAL LEGAL CONCEPTIONS* 28 (Walter Wheeler Cook ed., Yale Univ. Press 2000) (1919) (“Sometimes [‘property’] is employed to indicate the physical object to which various legal rights, privileges, etc., relate; then again—with far greater discrimination and accuracy—the word is used to denote the legal interest (or aggregate of legal relations) appertaining to such a physical object.”).

142 See *id.* at 51 (“Many examples of legal powers may readily be given. Thus, X, the owner of ordinary personal property ‘in a tangible object’ has the power to extinguish his own legal interest (rights, powers, immunities, etc.) through that totality of operative facts known as abandonment; and—simultaneously and correlatively—to create in other persons privileges and powers relating to the abandoned object,—e.g., the power to acquire title to the latter by appropriating it. *Similarly*, X has the power to transfer his interest to Y” (footnote omitted)).

143 STEPHEN R. MUNZER, *A THEORY OF PROPERTY* 22 (1990) (citing A.M. Honoré, *Ownership*, in *OXFORD ESSAYS ON JURISPRUDENCE* 107 (A.G. Guest ed., 1961)).

144 See *supra* note 127 and accompanying text.

145 MUNZER, *supra* note 143, at 220.

Some of the rights that adhere to obstetric goodwill, in particular the rights to use and exclude, implicate the basic liberty purpose of protected property seen above. At issue in the case of an abortion-related ABOG decertification is the right of an obstetrician to use his medical practice in a manner consistent with, among other things, his conscience and his professional estimation of his patient's health in order to exclude others from demanding its use in a manner contrary to those considerations. Thus, preserving his right to property—and those “sticks” in the attendant “bundle”—preserves not the *thing* but his freedom of action with the thing as it applies to other people. Incidentally, this freedom of action also coincides with traditional standards of physician autonomy in medical ethics,¹⁴⁶ making these rights all the more essential to a proper understanding of medical goodwill, and all the more necessary to protect.

IV. REGULATORY TAKINGS

If ABOG's public functions constitute state action, and if the physician's certification and attendant professional goodwill constitute a constitutional property interest, the question remaining is whether decertification constitutes a taking.

A. *Background on Regulatory Taking*

Takings doctrine has its origins in the Fifth Amendment to the U.S. Constitution, which states, “nor shall private property be taken for public use, without just compensation.”¹⁴⁷ In its “pure form” takings doctrine applies to the issue of physical takings.¹⁴⁸ In this context there are two primary components to doctrine under the Takings Clause: That the government must provide “just compensation” for a taking, and that the taking must be “for public use.” Takings doctrine applies to actions by the federal government through the Fifth Amendment and to actions by state governments either through the Fourteenth Amendment¹⁴⁹ or under the auspices of state constitutions.¹⁵⁰

146 See *supra* Part III.B.2.

147 U.S. CONST. amend. V.

148 See EPSTEIN, *supra* note 114, at 50.

149 See *Chi., Burlington & Quincy R.R. Co. v. City of Chi.*, 166 U.S. 226 (1897).

150 See DANA & MERRILL, *supra* note 103, at 2 (“The Supreme Court generally has employed the same standards in assessing takings claims without regard to whether the action is brought against the federal government under the Fifth Amendment or against a State under the Fourteenth. In addition, all state constitutions (except North Carolina's) include takings clauses . . .”).

Although originally restricted to eminent domain and physical takings, the Supreme Court's takings doctrine has since expanded to counteract other regulatory encroachments on private property in the exercise of state police power.¹⁵¹ The seminal case in this regard, *Pennsylvania Coal Co. v. Mahon*,¹⁵² involved a Pennsylvania law that restricted the mining of anthracite coal in such a way as to "destroy previously existing rights of property and contract."¹⁵³ While he noted that "[g]overnment hardly could go on" if forced to pay for every alteration to property values due to "change in the general law," Justice Holmes nevertheless concluded that the police power must have its limits, otherwise "the contract and due process clauses are gone."¹⁵⁴

B. Analysis of Regulatory Takings

The takings doctrine potentially implicated by the loss of goodwill due to a decertification by ABOG is an ad hoc regulatory taking.¹⁵⁵ The doctrinal framework has its roots in *Pennsylvania Coal*, but the Supreme Court articulated the modern standard in *Penn Central Transportation Co. v. New York*.¹⁵⁶ There, in concluding that a historical preservation law did not constitute a taking, the Supreme Court enunciated a three-part test for a regulatory taking: (1) the extent of the diminution of value of the property in question; (2) the reasonable investment-backed expectations of the owner; and (3) "the character of the governmental action."¹⁵⁷

151 See *id.* at 4 ("Although originally confined to exercises of eminent domain, the Supreme Court eventually extended the Takings Clause beyond that context. . . . [T]he Court recognized that sometimes a police power regulation has an impact functionally equivalent to an exercise of eminent domain.").

152 260 U.S. 393 (1922).

153 *Id.* at 413.

154 See *id.*

155 Regulatory takings can also be of a categorical nature. Current Supreme Court doctrine for a categorical regulatory taking requires either a permanent physical presence in the property in question, see *Loretto v. Teleprompter Manhattan CATV Corp.*, 458 U.S. 419, 421 (1982), or a complete destruction of all value of the property, see *Lucas v. S.C. Coastal Council*, 505 U.S. 1003 (1992). The facts of an ABOG decertification do not implicate either test for a categorical taking.

156 438 U.S. 104 (1978).

157 *Id.* at 124; see also *Connolly v. Pension Benefit Guar. Corp.*, 475 U.S. 211, 225 (1986) (applying the three-part test to a nonphysical taking).

1. Extent of Diminution

Justice Brennan, writing for the majority in *Penn Central*, found that the extent to which the regulation in question interfered with a property value was a factor to be considered in a takings analysis. Justice Brennan noted that diminution of value alone could not constitute a taking when the regulation is “reasonably related to the general welfare.”¹⁵⁸ Nevertheless, citing *Pennsylvania Coal*, he maintained that an analysis of Penn Central’s takings claim required the Court to “consider whether the interference with appellants’ property is of such a magnitude that ‘there must be an exercise of eminent domain and compensation to sustain [it].’”¹⁵⁹ The Court concluded that even with the restrictions on building, Penn Central would still be able to profit from Grand Central Terminal (as they had for years) and so any diminution of value claims were not well supported.¹⁶⁰

In the case of an ABOG decertification there would clearly be a diminution of an obstetric practice’s goodwill value. While it would certainly vary from case to case as to the particular extent of the diminution, the adverse effect decertification would have on hospital staff and admitting privileges alone would in most cases constitute a severe—if not total¹⁶¹—reduction of the value of a solo obstetric practice as it renders close to valueless the particular expertise of the professional.¹⁶² Likewise, decertification would reduce the effectiveness and professional desirability of a given obstetrician in a partnership practice—even if her partners retained their Diplomate status and admitting privileges—by reducing her professional reputation and thus her professional goodwill,¹⁶³ thereby reducing the total value of

158 *Penn Cent.*, 438 U.S. at 131 (“Appellants concede that the decisions sustaining other land-use regulations, which, like the New York City law, are reasonably related to the promotion of the general welfare, uniformly reject the proposition that diminution in property value, standing alone, can establish a ‘taking’ . . .”).

159 *Id.* at 136 (alteration in original) (quoting *Pa. Coal*, 260 U.S. at 413).

160 *Penn Cent.*, 438 U.S. at 136 (“So the law does not interfere with what must be regarded as Penn Central’s primary expectation concerning the use of the parcel. More importantly, on this record, we must regard the New York City law as permitting Penn Central not only to profit from the Terminal but also to obtain a ‘reasonable return’ on its investment.”).

161 See, e.g., BYLAWS OF THE MED. STAFF, MEM’L HOSP. OF SOUTH BEND § 3.1-1(c) (2009) (“An applicant [to the Medical Staff] must be board certified and/or subspecialty certified by the American Board of Medical Specialties (ABMS) . . .”); see also Michael Leavitt, *Physician Conscience III*, LEAVITT PARTNERS (Aug. 21, 2008), <http://leavittpartners.com/blog/physician-conscience-blog-iii> (“Physician certification is a powerful instrument. Without it, a doctor cannot practice the specialty.”).

162 See Ibrahim, *supra* note 106, at 7–10 (surveying various types of goodwill).

163 See *id.* at 11.

the practice. Decertification can also affect adversely the ability of a practitioner to be reimbursed by third parties, such as health insurers, thus driving down the available supply of paying patients and revenues from insurance reimbursement.¹⁶⁴ This would yield a very significant loss of practice value on the part of a decertified obstetrician, thus clearly meeting the diminution prong of the analysis.

2. Investment-Backed Expectations

The Court in *Penn Central* concluded that diminution of value claims must also be evaluated in the context of the reasonable investment-backed expectations of the property owners. That is, how do the given regulations interfere with the prospective economic activity of the claimant?¹⁶⁵ Indeed, the Court noted that in previous cases it had found that interference in economic activities not sufficiently connected to reasonable expectations was not justiciable in a takings context.¹⁶⁶ Justice Brennan clarified, however, that this factor was an issue in *Pennsylvania Coal* for, in that case, the Kohler Act frustrated the reasonable investment expectations of the claimants to the anthracite coal mining rights.¹⁶⁷ By contrast, in *Penn Central*, Brennan concludes,

[Grand Central Terminal's] designation as a landmark not only permits but contemplates that appellants may continue to use the property precisely as it has been used for the past 65 years: as a railroad terminal containing office space and concessions. So the law does not interfere with what must be regarded as Penn Central's primary expectation concerning the use of the parcel.¹⁶⁸

164 See, e.g., *Sources Used for Horizon NJ Health Provider Directory*, HORIZON NJ HEALTH, http://www.horizonnjhealth.com/misc/pdnjh_glossary.html (last visited May 28, 2011) ("We check specialty board certification before a physician joins our network and at least every three years after that or more often according to state or federal requirements.").

165 See *Penn Cent.*, 438 U.S. at 124 ("The economic impact of the regulation on the claimant and, particularly, the extent to which the regulation has interfered with distinct investment-backed expectations are, of course, relevant considerations.").

166 See *id.* at 124–25 ("A second are the decisions in which this Court has dismissed 'taking' challenges on the ground that, while the challenged government action caused economic harm, it did not interfere with interests that were sufficiently bound up with the reasonable expectations of the claimant to constitute 'property' for Fifth Amendment purposes.").

167 See *id.* at 127.

168 *Id.* at 136.

Thus, the Court held that preventing further construction on the Grand Central parcel did not frustrate any reasonable investment-backed expectations of the owners.

An obstetrician has the expectation in building his practice that he will be able to do so in a manner consistent with his conscientious beliefs and his legitimate, autonomous practice of medicine. ABOG decertification, based upon the ethical norms of the Ethics Opinion, frustrates both of these expectations. An obstetrician practicing today would be practicing medicine as a result of numerous personal and financial investments dating back (in most cases) decades: from the cost of college and medical school, to reduced earning power during a lengthy postgraduate residency, to capital invested either in establishing a solo practice or in buying equity in an existing practice. Also involved are significant opportunity costs, as this time and money were spent in the pursuit of the goal of practicing obstetrics and not any variety of other potential, lucrative fields such as business, law, or other types of medicine. In the case of a practicing obstetrician who neither performs nor refers for abortion, these considerable investments would have been made relying on the traditional canons of medical ethics¹⁶⁹ and traditional legal protections of physicians' consciences.¹⁷⁰ Thus, a regulatory action by ABOG against a practicing obstetrician who violates the new proposed norms of ethical behavior would not only constitute a severe diminution of the value of his medical practice but it would do this contrary to the expectations based on reasonable (and previously established) rules on which the obstetrician had relied in investing time, talent, and capital for many years.

A decertification on conscience grounds can be easily distinguished in this context from a decertification for incompetence (or felony conviction or whatever other established grounds for decertification might be given). No one becomes an obstetrician relying on the ability to practice incompetently. Likewise, specialty boards clearly have the authority to maintain their membership in line with certain established standards of professional competence. Those standards, however, neither encompass the abrogation of practitioners' conscience rights nor the imposition of a particular controversial conception of a given patient's health and wellbeing.

The physician's autonomy in achieving the medical best interests of his patient is otherwise accepted by ACOG's Committee on Ethics. For example, if a healthy patient requests an "elective" cesarean section while exhibiting no factors that might indicate one medically,

169 See *supra* notes 16–17 and accompanying text.

170 See *supra* Part I.C.1.

must her obstetrician comply? The answer invariably relies on the physician's studied (and autonomous) application of his professional knowledge to the situation at hand with an eye toward maximizing the positive health outcomes of the patient. Here, that could mean either that her health outcomes would be better served by a cesarean section, or that they would not—not that these considerations must simply yield to the patient's desires. ACOG supports this view, saying in a Committee on Ethics Opinion,

If the physician believes that cesarean delivery promotes the overall health and welfare of the woman and her fetus more than vaginal delivery, he or she is ethically justified in performing a cesarean delivery. Similarly, if the physician believes that performing a cesarean delivery would be detrimental to the overall health and welfare of the woman and her fetus, he or she is ethically obliged to refrain from performing the surgery.¹⁷¹

ACOG does not present any arguments distinguishing this accepted exercise in physicians' autonomy from any parallel decision by an obstetrician that abortion is "detrimental to the overall health and welfare of the woman and her fetus." Thus, an obstetrician should be justified in relying on such considerations of professional autonomy in arranging his professional practice.

3. Character of Government Action

It is also necessary to look at the "character" of the government action. As Justice Brennan wrote in *Penn Central*, "[i]n deciding whether a particular governmental action has effected a taking, this Court focuses rather both on the character of the action and on the nature and extent of the interference with rights in the parcel as a whole" ¹⁷² Among the salient considerations in evaluating the character of government actions are problems of arbitrariness¹⁷³ and discrimination.¹⁷⁴ Also, harkening back to *Pennsylvania Coal*, the Court acknowledged that the equity of any distribution of benefits and

171 COMM. ON ETHICS, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, AGOG COMM. OP. NO. 395, SURGERY AND PATIENT CHOICE (2008), available at http://www.acog.org/from_home/publications/ethics/co395.pdf.

172 See *Penn Cent.*, 438 U.S. at 130–31.

173 See *id.* at 132–33 ("But, in any event, a landmark owner has a right to judicial review of any Commission decision, and, quite simply, there is no basis whatsoever for a conclusion that courts will have any greater difficulty identifying arbitrary or discriminatory action in the context of landmark regulation than in the context of classic zoning or indeed in any other context.").

174 See *id.* at 132 ("[C]ontrary to appellants' suggestions, landmark laws are not like discriminatory . . . zoning").

burdens generated by the regulation are salient concerns when evaluating the character of the action.¹⁷⁵ The Court, however, acquiesced to the fact that “legislation designed to promote the general welfare commonly burdens some more than others.”¹⁷⁶ It concluded that the thirty one historical districts and over four hundred individual landmarks sufficiently dispersed the burdens of the regulation so as to make the character of the action permissible.¹⁷⁷

Evaluating the character of such an action by ABOG is somewhat more difficult than evaluating diminutions of value and investment-backed expectations. On one hand, an ABOG decertification of a pro-life obstetrician might be construed as a regulation for the general welfare—the ostensible good health of women seeking certain reproductive health services—and one that affects all obstetric specialists. Given ABOG’s established procedures, arbitrariness may not be a pressing concern.¹⁷⁸ Likewise, the burdens of decertification seem to apply to all obstetricians who do not follow the generally applicable rules.¹⁷⁹

The rules themselves, however, are problematic in terms of discrimination and equitable dispersal of benefits. Given that an ABOG decertification on conscience grounds would be grounded in the ethical norms set out in the Ethics Opinion, its stated purposes are what should control any putative regulatory action by ABOG. The Ethics Opinion makes it abundantly clear that, with respect to this provision, its concern is only ostensibly the obstetric specialty as a whole, and the focus is actually on those obstetricians who have conscientious objections to procedures such as abortion.¹⁸⁰ Similarly, the benefits of the Ethics Opinion would be less widespread than they might seem. The

175 See *id.* at 133 (“It follows, [claimants] argue, that New York City’s law is inherently incapable of producing the fair and equitable distribution of benefits and burdens of governmental action which is characteristic of zoning laws and historic-district legislation and which they maintain is a constitutional requirement if ‘just compensation’ is not to be afforded.”).

176 *Id.*

177 See *id.* at 134.

178 See AM. BD. OF OBSTETRICS & GYNECOLOGY, *supra* note 49, at 7 (explaining that some procedural avenues are available in a Certificate revocation).

179 One might say, to paraphrase Anatole France, that the Ethics Opinion, in its “majestic equality[,] . . . forbid[s]” pro-life and pro-choice alike from refusing to perform abortions. ANATOLE FRANCE, *THE RED LILY* 95 (Winifred Stephens trans., John Lane Co. 1908) (1894).

180 “[S]ome providers claim a right to refuse to provide certain services, refuse to refer patients to another provider for these services, or even decline to inform patients of their existing options” ETHICS OPINION, *supra* note 1, at 1 (emphasis added).

concern of the Ethics Opinion is access to abortion services. However, in compelling all obstetricians potentially to perform abortions, the Ethics Opinion neglects to benefit (and indeed burdens) women who, out of religious, moral, or medical conviction would prefer to see an obstetrician who does not perform abortions.¹⁸¹ The Ethics Opinion does not provide any compelling reason why one segment of the population (those who seek abortions) should be preferred and benefited over another (those who actively avoid abortions).

V. ADDITIONAL CONSIDERATIONS

I now turn to certain additional considerations that may be relevant in a property-based analysis of physicians' conscience claims.

A. An "Undue Burden" on Reproductive Freedom?

While this Note examines an ABOG abortion ethics decertification from a property rights perspective, given the broader reproductive-rights context in which such an action would take place, any court adjudicating such a case would need at least to consider the permissibility of a decertification in the broader context of reproductive freedom.

While the full jurisprudence of abortion and reproductive freedom, stretching back to *Doe v. Bolton*,¹⁸² *Roe v. Wade*,¹⁸³ *Eisenstadt v.*

181 A Gallup Poll recently found that forty-seven percent of the country identifies as "pro-life" (versus forty-five percent identifying as "pro-choice"). *Abortion*, GALLUP <http://www.gallup.com/poll/1576/abortion.aspx> (last visited May 28, 2011). It is not unreasonable to suppose that a very substantial percentage of those so identifying are women, and that many of those women would prefer to have a physician practicing in the intimate sphere of their lives relating to abortion and childbirth to share their convictions. Likewise, imagine an older woman having her first (and probably only) child deciding, as a matter of personal medical preference, to see a physician who in his autonomous practice of medicine does not view abortion as a valid standard of medical care because such a physician might prioritize the healthy delivery of the baby at all costs, in keeping with the desires of the hypothetical mother, even at the expense of taking risks with her health a pro-choice obstetrician might not. The ability for women to choose between alternative (if not competing) approaches to medical care does not seem to be an irrelevant concern, and the Ethics Opinion would severely constrain such an ability by forcing all obstetricians to comply with one conception of obstetric care—namely one that condones abortion. *See, e.g., Treatment Philosophy*, GIANNA, <http://www.giannahealth.org> (last visited May 28, 2011) (explaining why the New York City Gianna Center for Women's overtly Catholic approach to reproductive medicine can yield distinct and potentially desirable reproductive health outcomes—here solutions to infertility).

182 410 U.S. 179 (1973).

183 410 U.S. 113 (1973).

Baird,¹⁸⁴ and *Griswold v. Connecticut*,¹⁸⁵ is beyond the scope of this Note, the 1992 Supreme Court decision *Planned Parenthood of Southeastern Pennsylvania v. Casey*¹⁸⁶ presents salient questions regarding the so-called “undue burden” test. According to the plurality in *Casey*, “[n]umerous forms of state regulation might have the incidental effect of increasing the cost or decreasing the availability of medical care, whether for abortion or any other medical procedure.”¹⁸⁷ It continues, “[o]nly where State regulation imposes an undue burden on a woman’s ability to make this decision does the power of the state reach into the heart of the liberty protected by the Due Process Clause.”¹⁸⁸

Noting that past “undue burden” standards have lacked consistency, the Court attempts to clarify its meaning, explaining, “[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”¹⁸⁹ As to the “effect” analysis, the plurality states “a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman’s choice cannot be considered a permissible means of serving its legitimate ends.”¹⁹⁰

Abortion rights advocates have long insisted that access to physicians willing and able to perform abortions is a serious concern in certain communities. In some parts of the country (particularly the upper midwest), doctors willing to perform abortions are sufficiently rare that abortionists are sometimes flown in to service the local population.¹⁹¹ It is presumably such situations that the Ethics Opinion has in mind when it notes,

184 405 U.S. 438 (1972).

185 381 U.S. 479 (1965).

186 505 U.S. 833 (1992).

187 *Id.* at 874 (plurality opinion).

188 *Id.*

189 *Id.* at 877.

190 *Id.* But see *id.* at 985 (Scalia, J., dissenting) (“The shortcomings of *Roe [v. Wade]* did not include lack of clarity: Virtually all regulation of abortion before the third trimester was invalid. But to come across this phrase in the joint opinion—which calls upon federal district judges to apply an ‘undue burden’ standard as doubtful in application as it is unprincipled in origin—is really more than one should have to bear.”).

191 See Jack Hitt, *Who Will Do Abortions Here?*, in *THE ETHICS OF ABORTION* 45, 45 (Robert M. Baird & Stuart E. Rosenbaum eds., 3d ed. 2001) (“At one point last year, [the abortion doctor] was touching down in Minnesota, North Dakota, Wisconsin, and Indiana. In the trade, these new frequent-flier docs are called ‘circuit riders.’

[c]onscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide.¹⁹²

One could therefore argue that in certain (rare) populations a physician's refusal to perform an abortion (without adequate alternative provisioning for the procedure in place) would effectively prevent a woman from being able to procure one without traveling a long distance at considerable expense. A court might consider this a "substantial obstacle" depending on the circumstances, and thus qualifying as an "undue burden."

Yet, *Casey's* undue burden test applies to state action, which, in the context of this analysis, is potentially implicated by the decertifying body (ABOG), not the claimant obstetrician. It seems no small stretch to hold that the *Casey* standard *requires* state action in order to fend off an undue burden to reproductive rights; that is, that the Constitution requires ABOG to act against obstetricians who would not perform abortions in underserved populations. Such a posture would contradict the long-standing holding of the Supreme Court that the right to abortion is "negative" and not "positive."¹⁹³

On the other hand, it is unlikely that any decertification would be litigated on property rights grounds alone, with claimants also making claims based, *inter alia*, on various statutory provisions and regulations.¹⁹⁴ Undue burden questions could potentially complicate conscience claims derived from the Hyde-Weldon Amendment or its corresponding regulations, as these provisions rely on government regulation of medical practice in the manner envisioned by *Casey*.¹⁹⁵ In this respect, there is a potential advantage of a property-based conscience claim by a decertified physician: It shifts the state action

They are proof of two things: that the medical infrastructure undergirding the right to an abortion is strained to the breaking point and that the practical reality of abortion is retreating into a half-lighted ghetto of pseudonyms, suspicion, and fear[.]."

192 ETHICS OPINION, *supra* note 1, at 5.

193 See, e.g., *Harris v. McRae*, 448 U.S. 297, 316 (1980) (holding that the constitutional right to abortion does not implicate a constitutional entitlement to abortions through federal health expenditures). But see Maureen Kramlich, *The Abortion Debate Thirty Years Later: From Choice to Coercion*, 31 *FORDHAM URB. L.J.* 783, 783–84 (2004) (presenting the legal efforts following *Roe* to change the basic question of abortion rights "from 'choice' to 'access'").

194 See *supra* Part I.C.1–2.

195 See Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, div. G, tit. V § 508, 121 Stat. 1844, 2209.

inquiry from the government protecting his conscience to the professional body violating it. His claim is thus freed from its reliance on federal and state legislation and thus possible negative treatment at the hands of *Casey*. Even if a decision upholding his property—and thus conscience—rights has the prospective effect of “burdening” women seeking abortions, this would be due to his private actions and choices and not government regulations.

B. ABOG Decertification and Physician Shortages

Another consideration is the effect of ABOG decertification on the supply of physicians and, in particular, obstetric specialists. The enforcement of obstetric ethics norms that would require the performance of, or referral for, abortions would effectively exclude from the practice of obstetric medicine to a substantial percentage of the population that either identifies as pro-life in such a way as to refuse complicity in abortion or otherwise would prefer not to perform abortions or participate in the abortion process.¹⁹⁶ While the precise percentage is unknown, the effect itself is not: By erecting a new barrier to entry into the practice of obstetric medicine—a pro-choice approach to abortion—ABOG decertification for conscientious objection would reduce the supply of obstetric physicians. A reduced supply, coupled with a static or increased demand, will result in a shortage of obstetricians.

Our shortage of physician is already a problem, affecting some communities more severely than others, and is expected to grow worse. The shortage will be more problematic even without any of the supply reductions that are likely to occur as a result of decertifying existing obstetricians who refuse to perform abortions and deterring future obstetricians who will choose a different career or specialty rather than violate their consciences. While physician shortages have been most acute in the field of primary care,¹⁹⁷ they are predicted to

196 Some opponents of conscience rights for healthcare providers see the exclusion of these populations from medical practice as a desirable goal. *See supra* notes 38–39 and accompanying text.

197 *See* Andy Kroll, *The Doctor Can't See You Now*, MOTHER JONES (Oct. 5, 2009), <http://motherjones.com/politics/2009/10/doctor-cant-see-you-now> (“If primary-care medicine in the US were a patient, its diagnosis would be grim. The first responders to illness and pain, who can spot and treat chronic conditions in their early stages, primary-care doctors are in greater demand each year. In 2006, just more than 250,000 primary-care doctors practiced in the US—by some estimates, that was about several thousand to more than 7,000 less than the demand.”).

grow in both primary care¹⁹⁸ and specialties¹⁹⁹ and have already been felt in obstetrics.²⁰⁰ Though the causes of these current and probable shortages are manifold, crowding out pro-life individuals from obstetric practice would surely exacerbate this problem. The nature and extent of this disruption would be a salient concern for any court adjudicating a decertification.

Furthermore, such potential reductions in the supply of obstetricians should be of particular concern, given the underlying objectives of current healthcare reform measures. As President Obama's Office of Management and Budget noted, "[t]he Administration will explore all serious ideas that, in a fiscally responsible manner, achieve the common goals of constraining [healthcare] costs, expanding access, and improving quality."²⁰¹ A reduction in the supply of obstetricians will, by definition, restrict access and presumably increase costs as the supply diminishes. Likewise, even if an obstetrician decides to recertify in another specialty or practice generally, such a restructuring further disrupts the supply of physicians by imposing transition costs as the obstetrician retrains and opportunity costs given the obstetrician's potential to continue practicing in his or her chosen specialty. These outcomes are not consistent with stated goals of constraining costs, increasing access, and improving quality.

198 See Veronica Nett, *Health Reform May Cause State Doctor Shortage, Council Says*, CHARLESTON GAZETTE, July 15, 2010, <http://wvgazette.com/News/201007150896> (reporting that the effects of federal healthcare reform will cause demand for primary care to outstrip supply in West Virginia).

199 See ASS'N OF AM. MED. COLLS., PHYSICIAN SHORTAGES TO WORSEN WITHOUT INCREASES IN RESIDENCY TRAINING I (2010), available at https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf ("[B]y 2020 our nation will face a serious shortage of both primary care and specialist physicians to care for an aging and growing population. According to the [Association of American Medical Colleges] Center for Workforce Studies, there will be 45,000 too few primary care physicians—and a shortage of 46,000 surgeons and medical specialists—in the next decade.").

200 See Megan Miller, *Solution for Garrett OB/GYN Shortage, at Least Temporarily*, CUMBERLAND TIMES-NEWS, Mar. 11, 2010, <http://times-news.com/local/x1745491135/Solution-for-Garrett-OB-GYN-shortage-at-least-temporarily> (reporting on a severe malpractice-based shortage in obstetric specialists in rural Garrett County, Maryland); Rita Rubin, *Putting a Face on Malpractice Insurance Debate*, USA TODAY, Mar. 5, 2003, http://www.usatoday.com/news/health/2003-03-04-malpractice-debate_x.htm (noting that the increasing costs of malpractice insurance are forcing some obstetrician-gynecologists to abandon the obstetric sides of their practices).

201 OFFICE OF MGMT. & BUDGET, A NEW ERA OF RESPONSIBILITY 27 (2009), available at <http://www.gpoaccess.gov/usbudget/fy10/pdf/fy10-newera.pdf>.

CONCLUSION

The conscience rights of physicians, obstetricians in particular, have become a point of legal and political contention in recent years. This debate will likely extend into at least the near future given the indeterminacy and fluctuation in current statute and regulations as well as the funding and mandate changes in recent healthcare reform legislation. Central to these conflicts are the American Board of Obstetricians and Gynecologists and the American College of Obstetricians and Gynecologists. The latter still adheres to an ethical opinion mandating that obstetric specialists perform or refer for abortions, regardless of their conscientious objections, while the former just recently reaffirmed the use of “ethics rules” from the College in evaluating whether or not to maintain the certification of a specialist.

If ABOG were to decertify an obstetrician for not performing or referring for an abortion, as indicated by current ACOG guidelines, it is possible that the obstetrician would have a plausible claim against ABOG for taking the goodwill property that constituted the obstetrician’s medical practice. Such a claim would almost certainly be in addition to the wide array of potential (but largely untested) legal claims based on a combination of statutory provisions, executive regulations, and other constitutional provisions, including, the Free Exercise Clause of the First Amendment.

In the hypothetical presented at the outset, we are now able to say with greater certainty what the hypothetical obstetrician’s takings claim would look like. Under the traditional test for regulatory takings, his argument would be strong: His medical practice would be nearly valueless, representing a high diminution of value; the diminution would be contrary to his investment-backed expectations, expectations previously endorsed within medical ethics, to be able to practice in a manner consistent with one’s conscience and the action would have been inequitable and prejudicial against a particular segment of the specialty—pro-life practitioners.

It is less clear that ABOG is a joint participant in state action and that goodwill property meets the constitutional definition of property for a takings claim. While finding that ABOG is implicated in state action would be an extension of current doctrine, it would not be one without justification, given the degree of entanglement between private medical actors and all levels of government, as well as the longstanding view that the medical profession—including its boards and societies—serve a public function. Likewise, while federal courts have yet to address whether a medical practice constitutes “property” for constitutional purposes, many states have recognized goodwill as

property. Indeed, nothing prevents a state from designating goodwill as a cognizable property interest, and any such determination at the federal level would not be inconsistent with either current takings doctrine or a well-ordered conception of property.

Regardless of the merits of the claim, a property-based analysis of obstetricians' conscience rights highlights an underappreciated reality: that a practicing physician's interest in business goodwill—encompassing the professional expectations on which the practice was built as well as the exclusionary and decisional rights the practice involves it—demands a robust protection of the right to conscientious objection and legitimate professional autonomy. Furthermore, this property perspective highlights the high transition costs inherent in a regime of decertification on conscience grounds—including loss of goodwill, physicians practicing outside their established specialties, and crowding out potential obstetricians on the supply side. The result of such decertification without adequate protection of conscience or property would be to diminish the supply of obstetricians to increase the costs of medical care, both of which are orthogonal to the accepted goals of healthcare reform to increase access and lower costs.