ASSISTED SUICIDE, FORCED COOPERATION, AND COERCION: REFLECTIONS ON A BREWING STORM

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INTRODUCTION

Because government funds to institutions and individuals finance a significant amount of medical care in the United States, the prospect of conditions or "strings" attached to that funding is an ever-present specter. Furthermore, the fact that institutions and individuals require licenses to provide medical care also raises these possibilities as the brave new world of medicine poses far more moral dilemmas than anticipated even a brief time ago.[1]

This has led many institutions and individuals to refrain from various activities, believing that to do so would constitute direct or material cooperation in an evil activity. Their ability to avoid participation in these activities is a matter of grave and growing concern. Likewise, the possibility of conditions imposed on individuals and institutions as

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1 Kevin H. Theriot & Ken Connelly, *Free to Do No Harm: Conscience Protections for Healthcare Professionals*, 49 ARIZ. ST. L.J. 549, 551–52 (2017) ("[T]he swift pace of scientific advancement and the expansion of medical capabilities have greatly increased the chances that a growing number of medical practitioners will face a crisis of conscience sooner rather than later in carrying out their vocation."); *id.* at 579 ("[M]edical advancements and scientific knowledge will likely continue to bring new and unforeseen challenges to conscience, and government involvement in healthcare will likely bring more countervailing imperatives and less accommodation."). For a historic overview of conscience protections in the health care arena, see generally Lynn D. Wardle, *Protection of Health-Care Providers' Rights of Conscience in American Law: Present, Past and Future*, 9 AVE MARIA L. REV. 1 (2010).

a requirement for financial support or necessary licenses may threaten their ability to act in accord with their beliefs on the morality of various medical interventions.

Much of today's most contentious and high-profile discourse about unconstitutional conditions and coercion in the medical arena centers on issues pertaining to gender and reproduction.[2] Not yet receiving as much attention is the ability of institutions and individuals to resist involvement in assisted suicide—even though this is "among the most controversial topics in the United States today. It is such a contentious issue because it extends beyond politics, delving into matters of personal autonomy and morality. Quite literally, it is a matter of life or death."[3] Now that assisted suicide is legal in a growing number of jurisdictions, a storm may be brewing. Precisely because that storm is not yet as fierce here as it is in other areas, steps to ensure strong conscience protections must be taken today so that the specter of coercion does not arise tomorrow.[4]

The broader debate on unconstitutional conditions is beyond the scope of this Article.[5] Instead, what follows are reflections that focus on a narrow, related issue: the protection of conscience rights in the specific context of assisted suicide.[6] Certainly, the parameters of

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2 *See, e.g.*, Kay L. Levine, Jonathan Remy Nash & Robert A. Schapiro, *Protecting State Constitutional Rights from Unconstitutional Conditions*, 56 U.C. DAVIS L. REV. 247 (2022); Griffith v. El Paso Cnty., No. 21-CV-00387-CMA-NRN, 2023 WL 2242503, at *12 (D. Colo. Feb. 27, 2023).

3 Anthony W. Joyce, Note, *Prosecuting Fatal Speech: What Minnesota's* State v. Final Exit Network *Means for Assisted-Suicide Laws Across the Country*, 71 OKLA. L. REV. 1229, 1229 (2019).

4 For excellent commentary on the assisted suicide debate in the specific context of institutions, see Zachary R. Carstens, Note, *The Right to Conscience vs. The Right to Die: Physician-Assisted Suicide, Catholic Hospitals, and the Rising Threat to Institutional Free Exercise in Healthcare*, 48 PEPP. L. REV. 175 (2021).

5 For in-depth analysis of unconstitutional conditions more broadly, see generally Kathleen M. Sullivan, *Unconstitutional Conditions*, 102 HARV. L. REV. 1413 (1989); Lynn A. Baker, *The Prices of Rights: Toward a Positive Theory of Unconstitutional Conditions*, 75 CORNELL L. REV. 1185 (1990); Peter A. Clodfelter & Edward J. Sullivan, *Substantive Due Process Through the Just Compensation Clause: Understanding* Koontz*'s "Special Application" of the Doctrine of Unconstitutional Conditions by Tracing the Doctrine's History*, 46 URB. LAW. 569 (2014); Charles R. Bogle, Note, *"Unconscionable" Conditions: A Contractual Analysis of Conditions on Public Assistance Benefits*, 94 COLUM. L. REV. 193 (1994); Cass R. Sunstein, *Why the Unconstitutional Conditions Doctrine is an Anachronism (with Particular Reference to Religion, Speech, and Abortion)*, 70 B.U. L. REV. 593 (1990).

6 Andrew S. Kubick, *An "Oath Unviolated": Realizing the Joy of Medicine Through the Free Exercise of Conscience*, CATHOLIC J. ON RELIGIOUS FREEDOM & HEALTHCARE, Winter 2021–2022, at 1 ("[T]here is a pervasive assault on the rightful exercise of medical conscience that disturbs the joy of medicine and disrupts the plans of future physicians who refuse to forfeit their morals to attain their license."); Soledad Bertelsen, *Conscientious Objection of Health Care Providers: Lessons from the Experience of the United States*, 3 NOTRE DAME J. INT'L &

unconstitutional conditions doctrine will be shaped by the current discussions of that doctrine in the medical contexts of abortion, reproduction, and gender.[7] However, these brief reflections argue that, today, attention must be paid to developing robust conscience protections in the context of assisted suicide, even though it has not yet come to a head in quite the same way.

In reflecting on this question, it is vital to protect *both* individual providers *and* institutions from legal coercion. Only by doing so today will they be able to mount vigilant defenses against future attempts to impose unconstitutional conditions in this arena. These reflections do not propose how best to do so. Instead, they are intended to raise questions and sound an alarm to spur further development of protections in this field.

The first Part of these reflections considers why it is critical, and not premature, to address this issue today. The second outlines the extent to which assisted suicide is expanding its reach in state law. The third will explain how current conscience protections in existing state statutes are disappointingly inadequate and anticipate upcoming threats. Finally, these reflections explore what must be done to solidify

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COMP. L. 122, 127 (2013) ("Freedom of conscience consists of the liberty to believe in principles—especially ethical ones—according to which men shape their lives. Therefore, the right to believe necessarily needs to include a right to behave according to these beliefs."); Theriot & Connelly, *supra* note 1, at 549 ("[I]t is difficult to conceive of a scenario in which the right to conscience for medical practitioners should not prevail in a conflict with some other claimed imperative, especially given its historical and philosophical pedigree.").

7 In David Busscher, Note, *Linking Assisted Suicide and Abortion: Life, Death and Choice*, 23 ELDER L.J. 123 (2015), the author discusses the parallels in the interests at stake in abortion and assisted suicide. *See also* Susan Frelich Appleton, *Assisted Suicide and Reproductive Freedom: Exploring Some Connections*, 76 WASH. U. L.Q. 15 (1998) (discussing similarities in debates over abortion and assisted suicide); Dorothy E. Roberts, *The Only Good Poor Woman: Unconstitutional Conditions and Welfare*, 72 DENV. U. L. REV. 931 (1995) (exploring unconstitutional conditions doctrine with respect to mandated contraception as a requirement for obtaining welfare benefits); Diana Hassel, *Sex and Death:* Lawrence*'s Liberty and Physician-Assisted Suicide*, 9 U. PA. J. CONST. L. 1003 (2007) (discussing parallels between laws on physician-assisted suicide and sexual conduct); Heather Skrabak, Note, *Refusing to "Play God": Hospital Ethics Committees Can Help Navigate Religious and Moral Accommodations in Assisted Reproductive Technologies*, HEALTH LAW., June 2022, at 82 (discussing conscience and religious accommodation issues in the context of reproductive technology); Kristin M. Roshelli, Note, *Religiously Based Discrimination: Striking a Balance Between a Health Care Provider's Right to Religious Freedom and a Woman's Ability to Access Fertility Treatment Without Facing Discrimination*, 83 ST. JOHN'S L. REV. 977 (2009) (discussing religious conscience claims in the context of reproductive technology and fertility treatments for women).

protection against coercion when it comes to this most serious threat to the lives of vulnerable people.[8]

I. PROTECTION OF CONSCIENCE RIGHTS IN THE CONTEXT OF ASSISTED SUICIDE IS AN URGENT MATTER

At first blush, it may seem premature to be concerned about the coercion of those individuals and institutions who refrain from any participation—direct or indirect—in assisted suicide. It may seem unlikely that healthcare-providing institutions or individuals will be required to participate in assisted suicide as a condition for funding, licensing or other benefits. However, legal and medical change comes quickly in this area.[9]

A. There Is No Federal Constitutional Right to Assisted Suicide.

In two companion cases, *Washington v. Glucksberg*[10] and *Vacco v. Quill,*[11] the United States Supreme Court declared, unequivocally, that there is no constitutional right to assisted suicide. Given this, the likelihood that an individual or facility would be denied benefits for failing to participate in an activity to which there is no constitutional right may seem remote.

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8 A well-curated bibliography on the question of assisted suicide may be found at Alyssa Thurston, *Physician-Assisted Death: A Selected Annotated Bibliography*, 111 LAW LIBR. J. 31 (2019).

9 For a comprehensive history of assisted suicide in the United States, see generally Thaddeus Mason Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. REV. 267 (2018). The author notes that, with respect to assisted suicide, "its legal status has been in a state of rapid change across the country over the past ten years" and "the rate and pace of legalization has been accelerating." *Id.* at 268. *But see* Annie M. Bonazzi, Note, *Applicability of International Schemes of Legal Safeguards in Physician Assisted Suicide to Future United States Policy*, 4 CARDOZO INT'L. & COMP. L. REV. 795, 825 (2021) ("The United States has been slow to update its nationwide policies on assisted suicide despite an uptick of legislation in recent years."). Much of this has been driven by public opinion suggesting that "physician-assisted suicide also seems to be largely approved by the American public." Hassel, *supra* note 7, at 1020.

10 521 U.S. 702 (1997). For further commentary on *Glucksberg*, see generally Carstens, *supra* note 4, at 185–87; Pope, *supra* note 9 at 286; Bonazzi, *supra* note 9, at 799–801; Appleton, *supra* note 7 *passim*; Hassel, *supra* note 7 *passim*; Mark L. Rienzi, *The Constitutional Right Not to Kill*, 62 EMORY L.J. 121 *passim* (2012).

11 521 U.S. 793 (1997). For further commentary on *Vacco*, see generally Carstens, *supra* note 4, at 185–87; Pope, *supra* note 9, at 285–86; and Bonazzi, *supra* note 9, at 801–02. Twenty years after *Vacco*, a similar conclusion on New York's prohibition was pronounced in *Myers v. Schneiderman*, 85 N.E. 3d 57, 65 (N.Y. 2017) (holding that New York's "legislature has a rational basis for criminalizing assisted suicide, and plaintiffs have no constitutional right to the relief they seek herein").

In *Glucksberg*, a Washington State statute prohibited assisted suicide. Three terminally ill patients,[12] four physicians treating terminally ill patients, and the nonprofit organization "Compassion in Dying,"[13] argued that Fourteenth Amendment liberty interests were harmed by this state ban. Writing for the majority, Chief Justice Rehnquist observed that "opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal, and cultural heritages."[14] He reasoned:

> The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Constitution also requires, however, that Washington's assisted-suicide ban be rationally related to legitimate government interests. . . . This requirement is unquestionably met here.[15]

Of particular note is the comprehensive listing of the government interests cited by the Court. They include:

- "[U]nqualified interest in the preservation of human life;"[16]
- "[S]uicide is a serious public-health problem, especially among persons in otherwise vulnerable groups;"[17]
- "Those who attempt suicide—terminally ill or not—often suffer from depression or other mental disorders;"[18]
- "The State . . . has an interest in protecting the integrity and ethics of the medical profession . . . . [P]hysician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming;"[19]
- "We have recognized, however, the real risk of subtle coercion and undue influence in end-of-life situations;"[20]

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12 All three of the patients died before this case was decided. *Glucksberg*, 521 U.S. at 707.

13 "Compassion in Dying" is described by Chief Justice Rehnquist in his opinion as "a nonprofit organization that counsels people considering physician-assisted suicide." *Id.* at 708.

14 *Id.* at 711.

15 *Id.* at 728.

16 *Id.* (quoting Cruzan v. Mo. Dept. of Health, 497 U.S. 261, 282 (1990)).

17 *Id.* at 730.

18 *Id.*

19 *Id.* at 731.

20 *Id.* at 732.

- "The State's interest . . . extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and 'societal indifference;'"[21] and
- "[T]he State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia."[22]

In *Vacco v. Quill*, decided at the same time as *Glucksberg*, the Supreme Court faced a due process argument in favor of assisted suicide. The Court rejected that line of argument as well and cited similar interests in upholding an assisted suicide ban in New York State.[23]

A quarter of a century has now passed. While a growing number of states have legalized assisted suicide, *Glucksberg* and *Vacco* remain the definitive federal constitutional analysis of assisted suicide. Of particular interest, the Court recognized the coercion that could arise from recognizing a right to assisted suicide. Specifically, the court's enumeration of its concerns about the "integrity and ethics of the medical profession," a "real risk of subtle coercion and undue influence," and the possibility of "even involuntary euthanasia," forebode a day when these harms might materialize in the form of conscience threats.

B. Federal Legislation Expresses Skepticism About Assisted Suicide

In addition to the Supreme Court's rejection of a constitutional right to assisted suicide, the federal government has taken other opportunities to express skepticism toward assisted suicide. For example, the Assisted Suicide Funding Restriction Act of 1997,[24] signed into law by President William Clinton, expressed significant reservations about assisted suicide, noting, "[a]ssisted suicide, euthanasia, and mercy killing have been criminal offenses throughout the United States."[25] In the wake of Oregon's legalization of assisted suicide in 1994,[26] this Act made a clear stand against offering federal financial support "by

21 *Id.* (quoting Compassion in Dying v. Washington, 49 F. 3d 586, 592 (9th Cir. 1995), *rev'd on reh'g en banc*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom. Glucksberg*, 521 U.S. 702).

22 *Id.*

23 Vacco v. Quill, 521 U.S. 793, 808–09 (1997) (citing such state interests as "prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia").

24 Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12, 111 Stat. 23 (1997) (codified at 42 U.S.C. §§ 14401–14408 (2018)).

25 42 U.S.C. § 14401(a)(2) (2018).

26 *See id.* § 14401(a)(3) (referring to "recent legal developments" through which "it may become lawful in areas of the United States").

providing explicitly that Federal funds may not be used to pay for items and services (including assistance) the purpose of which is to cause (or assist in causing) the suicide, euthanasia, or mercy killing of any individual."[27]

In addition to federal financial support, the Act also prohibits the use of "a health care facility owned or operated by the Federal government"[28] or "any physician or other individual employed by the Federal government to provide health care services"[29] from furnishing items or services "for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing."[30]

Even more closely related to conscience questions, the Act also stated that the Social Security Act:

> [S]hall not be construed . . . to require any provider or organization . . . to inform or counsel any individual regarding any right to obtain an item or service furnished for the purpose of causing, or the purpose of assisting in causing, the death of the individual, such as by assisted suicide, euthanasia, or mercy killing.[31]

The Affordable Care Act also included a provision explicitly focused on assisted suicide. It provided:

> The Federal Government, and any State or local government . . . may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing or for the purpose of assisting in causing the death of any individual, such as by assisted suicide . . . .[32]

Yet, this should not create a false sense of comfort. For example, it does not clearly define which "individuals" or "entities" may be covered. It also does not clearly define "assisted suicide" for purposes of this provision. That may be necessary because, in a disingenuous semantic maneuver, multiple state statutes authorizing assisted suicide explicitly state that it is *not* assisted suicide. For example, Washington's statute proclaims, "[a]ctions taken in accordance with this chapter do

27 *Id.* § 14401(b).
28 *Id.* § 14402(c)(1).
29 *Id.* § 14402(c)(2).
30 *Id.*
31 *Id.* § 14406(1).
32 42 U.S.C. § 18113(a) (2018). For further commentary on this provision, see generally Carstens, *supra* note 4, at 183–84.

not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law."[33]

The question of conscience rights for health-care workers is also a politically charged issue—subject to ongoing debates and significant proposed changes.[34] For example, proposed regulations issued by the Department of Health and Human Services (HHS), particularly under Section 1557 of the Affordable Care Act, were the subject of intense debate in 2022.[35] Events such as this suggest that there is still opposition to protecting the conscience rights of health-care workers. A threat to those rights in one context can pose a risk to those rights in others.

Furthermore, in the context of abortion, explicit statutory frameworks were deemed necessary to protect healthcare providers from coerced participation. This was true even though "the Supreme Court itself indicated in *Roe v. Wade*, and its companion case *Doe v. Bolton*, that the right to be free from governmental interference in procuring an elective abortion did not entail the power to compel another to provide that procedure against his or her will."[36]

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33 WASH. REV. CODE § 70.245.180 (2023).

34 *See* Alice Miranda Ollstein & Adam Cancryn, *Biden Administration to Rescind Trump 'Conscience' Rule for Health Workers*, POLITICO (Apr. 19, 2022), https://www.politico.com/news/2022/04/19/biden-trump-conscience-rule-00026082 [https://perma.cc/PK53-J5VH].

35 *See* Louis Brown, *Press Release: HHS Regulation Section 1557 Attacks Human Dignity, Medical Conscience and Religious Freedom Rights, and Threatens Health Access*, CHRIST MEDICUS FOUND. (July 28, 2022), https://christmedicus.org/press-release-hhs-regulation-section-1557-attacks-human-dignity-medical-conscience-and-religious-freedom-rights-and-threatens-health-access/ [https://perma.cc/EZB3-QQAN] (arguing that the proposed rule 1557 "erodes the foundations of civil rights in health care—the right to life, the right of conscience, and the right of religious freedom, which are necessary to protect human dignity in medicine").

36 Theriot & Connelly, *supra* note 1, at 550. For a fuller discussion of abortion, which for many years was treated as a constitutional right, see *id.* at 557–59; *see also* Wardle, *supra* note 1, at 13–27. Yet, despite this Supreme Court declaration, statutes were deemed necessary to protect providers. Thus, initiatives such as the Church Amendments, Coats-Snowe Amendments, and Hyde-Weldon Amendment were enacted. For fuller discussion of the Church amendments, see generally Theriot & Connelly, *supra* note 1, at 576–77; Carstens, *supra* note 4, at 181–82; Rienzi, *supra* note 10, at 150; Douglas Nejaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2535–37 (2015); Wardle, *supra* note 1, at 28–30; Irene Prior Loftus, Note, *I Have a Conscience, Too: The Plight of Medical Personnel Confronting the Right to Die*, 65 NOTRE DAME L. REV. 699, 705, 721–26 (1990). For fuller discussion of the Coats-Snowe Amendments, see generally Theriot & Connelly, *supra* note 1, at 577; Carstens, *supra* note 4, at 182; Wardle, *supra* note 1, at 30. For fuller discussion of the Weldon Amendment, see generally Theriot & Connelly, *supra* note 1 at 577–78; Carstens, *supra* note 4, at 182; Rienzi, *supra* note 10, at 151; Wardle, *supra* note 1, at 32–33.

II. STATE LEGISLATION AUTHORIZING ASSISTED SUICIDE IS RAPIDLY EXPANDING

Even though there is no federal constitutional right to assisted suicide, the number of states allowing it by statute has grown steadily. This has come in "an accelerating wave of well-funded ballot initiatives and heavily lobbied state statutes to overcome resistance from deeply rooted public disapproval of PAD ["physician assisted suicide"] and to overpower sustained opposition from conscientious religious groups."[37] Indeed, "[a]lthough many significant and ongoing efforts exist at the federal level to protect conscience rights in healthcare, when it comes to the specific medical practice of PAD, the most important conscience clashes are unfolding state by state."[38]

As seen below, these state protections are quite narrow and inadequate. As more states legalize assisted suicide and offer only weak conscience protections to accompany that development, the possibility of unconstitutional conditions can arise—particularly with respect to funding and licensing.

In 1994, Oregon became the first state to legalize assisted suicide.[39] It was followed by Washington State,[40] Montana,[41] Vermont,[42] California,[43] Colorado,[44] the District of Columbia,[45] Hawaii,[46] New Jersey,[47] and Maine.[48]

In addition, assisted suicide legislation has been proposed or is pending in many other states.[49] Unfortunately, while "society has a longstanding policy of supporting suicide prevention"[50] for most people, especially the young, healthy and strong, when it comes to assisted

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37 Carstens, *supra* note 4, at 187.

38 *Id.* at 184.

39 OR. REV. STAT. §§ 127.800–127.995 (2023). For additional discussion of Oregon's legislation, see generally Pope, *supra* note 9, at 277–80; Bonazzi, *supra* note 9, at 803–11 (discussing both the Oregon statute and its progeny adopted in other jurisdictions).

40 WASH. REV. CODE §§ 70.245.010–903 (2023).

41 Legalized by the Montana Supreme Court in Baxter v. State, 2009 MT 449, ¶¶25–28, 354 Mont. 234, 224 P.3d 1211. For further discussion of the *Baxter* case, see generally Rienzi, *supra* note 10, at 146; Pope, *supra* note 9, at 291–99.

42 VT. STAT. ANN. tit. 18, §§ 5281–5293 (2023).

43 CAL. HEALTH & SAFETY CODE §§ 443–443.22 (West 2023).

44 COLO. REV. STAT. §§ 25-48-101 to -123 (2023).

45 D.C. CODE §§ 7-661.01–.16 (2023).

46 HAW. REV. STAT. §§ 327L to 327L-25 (2023).

47 N.J. STAT. ANN. §§ 26:16-1 to -20 (West 2023).

48 ME. STAT. tit. 22, § 2140 (2023).

49 *See, e.g.*, H.R. 1930, 93rd Leg., Reg. Sess. (Minn. 2023); S.B. 239, 2023 Leg., 82nd Sess. (Nev. 2023); H.B. 5210, 2023 Leg., Jan. Sess. (R.I. 2023).

50 H.R. Con. Res. 68, 117th Cong. (2022).

suicide of those "who are elderly, experience depression, have a disability, or are subject to emotional or financial pressure to end their lives"[51] because they are facing a terminal illness, public support is increasing for assisted suicide statutes. As public support increases, the prevalence of assisted suicide among states may, tragically, increase.

Despite common assertions that assisted suicide will be limited to cases involving a six-month life expectancy, a fully competent, nondepressed adult patient, with no euthanasia facilitated by a third party, the trajectory consistently moves toward expanding the scope of assisted suicide rapidly once first steps are made in that direction.

For example, in *Shavelson v. California Department of Health Care Services*, a recent—unsuccessful—attempt was made in California to expand assisted suicide statutes to embrace active euthanasia.[52] The claim asserted was that it was a deprivation of equal protection to deny access to assisted suicide to someone who, due to physical disability, is unable to do so without the active assistance of another.[53]

Several years ago, a dispute in Hawaii involving the question of whether assisted suicide could take place at a nursing home and assisted living community located on land owned by the Catholic Church raised another flash point in the conscience dispute. Ultimately, the Kahala Nui retirement community allowed it in the independent living section but not the nursing home facility.[54] However, this dispute over the scope of the legislation is one that may resurface as an aging population often resides in institutional settings such as these rather than in private homes. Many such institutions have a religious affiliation.

Even the most cursory examination of the expansion of assisted suicide practices in other nations leads to the undeniable conclusion that once the first step is taken down this path, the practice gains momentum—to the extent that euthanizing minor children and

51 *Id.*

52 Shavelson v. Cal. Dep't of Health Care Servs., No. 21-cv-06654-VC, 2021 WL 4261209, at *1–2 (N.D. Cal. Sept. 20, 2021).

53 *Id.* at *1.

54 This case received a good deal of media attention, reflecting interest in the question raised. *See generally* Timothy Hurley, *Kahala Retirement Home Changes Policy to Allow Medically Assisted Death*, STAR ADVISOR (Mar. 8, 2019), https://www.staradvertiser.com/2019/03/08/hawaii-news/retirement-home-changes-policy-to-allow-death-with-dignity/ [https://perma.cc/4LVH-Y2G2]; *The Latest: Retirement Home Says It Doesn't Discriminate*, AP NEWS (Nov. 1, 2018), https://apnews.com/article/7e59dce0d8944583abcce5d3e4f42e08 [https://perma.cc/PZE9-RH8G]; Audrey McAvoy, *ACLU Objects to Hawaii Retirement Home Assisted Suicide Ban*, AP NEWS (Nov. 2, 2018), https://apnews.com/article/81d6c526a9f74fc3b5518c0fad9d692d [https://perma.cc/XB2E-3WMN]; Carstens, *supra* note 4, at 196–97.

nonterminally ill disabled persons is now available in some legal regimes.[55] Each expansion deepens and accelerates the moral dilemmas that medical professionals face. This can also expand the scope of individuals and institutions who may be coerced to become involved or complicit in them.[56]

III. STATE STATUTES CONTAIN INADEQUATE CONSCIENCE PROTECTIONS

When jurisdictions adopt assisted suicide statutes, proponents loudly proclaim that the statutes contain conscience protections that will protect those who object to them by allowing them to avoid participation. However, these are woefully inadequate.[57] Given the hostility toward conscience protection in the medical field,[58] it is unlikely that future statutes will offer more meaningful safeguards. There is also a growing sense of what one commentator described as a "'public utility' model of medicine" which claims that because medical care is essential and medical professionals have licenses, conscience protections must yield to other concerns.[59] What this model fails to appreciate is that "when the conscience of the medical practitioner has been sacrificed to the collective will of the age, human suffering ensues."[60]

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55 *See, e.g.*, *Belgium Minor First to Be Granted Euthanasia*, BBC (Sept. 17, 2016), https://www.bbc.com/news/world-europe-37395286 [https://perma.cc/S89P-TGD8] (discussing Belgian law allowing euthanasia of minors); Maria Cheng, *'Disturbing': Experts Troubled by Canada's Euthanasia Laws*, ASSOCIATED PRESS (Aug. 11, 2022), https://apnews.com/article/covid-science-health-toronto-7c631558a457188d2bd2b5cfd360a867 [https://perma.cc/HN6L-83B9] (describing Canadian law allowing euthanasia of nonterminally ill disabled persons).

56 For a full discussion of "complicity-based conscience claims," see generally Nejaime & Siegel, *supra* note 36.

57 This inadequacy is not limited to the assisted suicide context. *See* Wardle, *supra* note 1, at 27–28 (observing, more generally, that "[m]ost state conscience protection laws are very narrow—focused on specific procedures and particular work groups (such as doctors or nurses), and most state laws have been construed very narrowly and grudgingly").

58 *See* Martha S. Swartz, *"Conscience Clauses" or "Unconscionable Clauses": Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL'Y, L. & ETHICS 269, 270 (2006) ("Prioritizing their personal moral objections to abortion over the patient's health, these professionals ignored the standard that traditionally has guided health care providers in performing their professional responsibilities."); *id.* at 277 ("[T]he monopolistic state-granted licenses that medical professionals receive should preclude these professionals from injecting their personal beliefs into their professional practices.").

59 Theriot & Connelly, *supra* note 1, at 551 (quoting R. Alta Charo, *The Celestial Fire of Conscience—Refusing to Deliver Medical Care*, 352 NEW ENG. J. MED. 2471, 2473 (2005)).

60 *Id.* at 562.

A. Individual Providers

Many providers have significant qualms about assisted suicide.[61] Currently, when it comes to direct participation by an individual physician, "it seems clear that the general consensus against assisted suicide precludes the state from forcing an unwilling person to assist a suicide."[62]

The statutes purportedly protect conscientious objection by individual health care providers.[63] The Oregon statute, upon which many are based, provides that "[n]o professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance."[64] It goes on to state that "no health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life."[65] In like vein, the Washington statute declares that "[o]nly willing health care providers shall participate."[66] What these statutes—and those modeled on them—do not make clear is who is covered by statutes such as these. Physicians and nurses may be well within their scope, but these statutes do not clarify the rights of pharmacists, nursing home employees, social workers, nursing aides, and others.

The Oregon statute requires that, in the case of such a refusal, the healthcare provider "shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider."[67] This seems to be a permissible, passive request for delivery of documents that should best be viewed as belonging to the patient.

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61 Kubick, *supra* note 6, at 2 (reporting that "a 2018 survey of physicians revealed that even though 60% of respondents think physician-assisted suicide should be legal, only 13% of those who favor its legalization . . . *'would unequivocally perform the practice if it were legal'*" (quoting Peter T. Hetzler III, James Nie, Amanda Zhou & Lydia S. Dougdale, *A Report of Physicians' Beliefs about Physician-Assisted Suicide: A National Study*, 92 YALE J. BIOLOGY & MED. 575, 584 (2019))).

62 Rienzi, *supra* note 10, at 144.

63 For a broad discussion of conscientious objection in the medical context, see generally Mark R. Wicclair, *Conscientious Objection, Moral Integrity, and Professional Obligations*, 62 PERSPS. BIOLOGY & MED. 543 (2019); Farr A. Curlin & Christopher O. Tollefson, *Conscience and the Way of Medicine*, 62 PERSPS. BIOLOGY & MED. 560 (2019); Maxine M. Harrington, *The Ever-Expanding Health Care Conscience Clause: The Quest for Immunity in the Struggle Between Professional Duties and Moral Beliefs*, 34 FLA. ST. U. L. REV. 779 (2007).

64 OR. REV. STAT. § 127.885(2) (2023); *cf.* WASH. REV. CODE § 70.245.190(b) (2023).

65 OR. REV. STAT. § 127.885(4) (2023).

66 WASH. REV. CODE § 70.245.190(d) (2023).

67 OR. REV. STAT. § 127.885(4) (2023); *cf.* WASH. REV. CODE § 70.245.190(d) (2023).

However, beyond this, many of the state statutes require individuals to provide a referral for assisted suicide—a forced involvement that for many constitutes cooperation with an intrinsic evil.[68] As Dr. Edmund Pellegrino observed:

> Respect for the patient's autonomy does not include referral to a physician who will carry out the procedure if that procedure involves an act the physician deems intrinsically and seriously wrong. For a conscientious physician, this would be an inadmissible degree of formal cooperation.[69]

For those with a conscientious objection to participating in assisted suicide, their first objection would be to any forced formal cooperation. "Formal cooperation may take various forms, such as authorizing wrongdoing, approving it, prescribing it, actively defending it, or giving specific direction about carrying it out. Formal cooperation, in whatever form, is always morally wrong."[70]

More expansively—and more difficult to discern—material cooperation is also a threat for those in the healthcare community:

> [C]ooperation is *material* if the one cooperating neither shares the wrongdoer's intention in performing the immoral act nor cooperates by directly participating in the act as a means to some other end, but rather contributes to the immoral activity in a way that is causally related but not essential to the immoral act itself. . . . Assessing material cooperation can be complex . . . . Any moral analysis of collaborative arrangement must also take into account the danger of scandal."[71]

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68 *See* Andrew S. Kubick, *End-of-Life Options Act Fails to Protect Conscience Rights*, 46 ETHICS & MEDS., June 2021, at 1, 2 ("No objecting physicians should write such a referral. Referring a patient to another physician who will assist in the suicide brings about a level of cooperation with evil that is immoral. In Catholic moral theology, that referral would constitute an act of proximate mediate material cooperation, and the objecting physician would be guilty of a grave sin."); Kubick, *supra* note 6, at 2 (condemning the requirement to make a referral because it "demands objecting physicians cooperate with the evil of physician-assisted suicide by providing that referral to a doctor who is willing to write a prescription for a lethal dose of sedatives").

69 Edmund D. Pellegrino, *Commentary: Value Neutrality, Moral Integrity, and the Physician*, 28 J.L. MED. & ETHICS 78, 79 (2000)). Dr. Pellegrino elaborated more fully on these questions in Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 FORDHAM URB. L.J. 221 (2002).

70 U.S. CONF. CATH. BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 24 (6th ed. 2018) [hereinafter ETHICAL AND RELIGIOUS DIRECTIVES].

71 *Id.*

Thus, while state protections may offer some safeguards protecting conscience in matters of formal cooperation, the referral requirement neglects to do so in matters of material cooperation.[72]

B. Institutions

Protections are woefully inadequate for institutions who wish to offer or support only that care that is consistent with their mission.[73] State statutes allow some protection, but it is not as robust as it should be.[74]

Again, using the archetypal Oregon statute, an institution "may prohibit another health care provider from [engaging in assisted suicide related activities] on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's policy."[75] The Oregon law also allows for a range of sanctions if these prohibitions are not respected on the premises of the healthcare provider or while acting in the course of employment or an independent contracting relationship with the healthcare provider opposed to the assisted suicide.[76]

However, a

> "premises clause" creates an immense limitation on the ability of healthcare institutions to control whether or not their employees will offer PAD to their patients, regardless of any conscience objections from the employing hospital. . . . [T]he hospital is . . . rendered legally powerless to stop the doctor from prescribing the medication—so long as the patient leaves the hospital premises before ingesting it.[77]

In addition, statutes such as Oregon's also allow two other courses of action that may undermine the moral commitments of institutions.

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72 Indeed, respecting the right to refuse material cooperation is an idea sharply criticized. *See* Charo, *supra* note 59, at 2473 ("In this culture war, both sides claim the mantle of victimhood—which is why healthcare professionals can claim the right of conscience as necessary to the nondiscriminatory practice of their religion, even as frustrated patients view conscience clauses as legalizing discrimination against them when they practice their own religion.").

73 Others have observed this more broadly. *See, e.g.*, Theriot & Connelly, *supra* note 1, at 574 ("Many states fail to protect medical institutions altogether, while others would seemingly permit violations of conscience so long as a practitioner works in a public facility.").

74 For an overview of state conscience protections, see Theriot & Connelly, *supra* note 1, at 587–600.

75 OR. REV. STAT. § 127.885(5)(a) (2023); *cf.* WASH. REV. CODE § 70.245.190(2)(a) (2023).

76 OR. REV. STAT. §§ 127.885(5)(b)(A)–(C) (2023).

77 Carstens, *supra* note 4, at 201.

They protect the ability of healthcare providers to participate in assisted suicide activities as long as they are acting "outside the course and scope of the provider's capacity as an employee or independent contractor."[78] This casts doubt on the ability of a healthcare provider to prohibit its employees from engaging in this activity in the "off hours." More troubling, the Oregon statutes, and those like it, would not prevent a "patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider."[79]

These limitations can curtail the ability of institutions to insist that their employees conform to the institution's views on the sanctity of vulnerable life in its end stages. Yet, such institutional witness is vitally important. Indeed, "ministering to the sick has been a traditional religious vocation; the government should not create conditions that force individuals and organizations long committed to that task to give it up."[80]

For example, the Ethical and Religious Directives for Catholic Health Care Services[81] states that "Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel."[82] In addition, "[e]mployees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives,"[83] and "Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way."[84] The assisted suicide statutes, however, do not seem to protect the right of such a religiously affiliated institution to insist that employees refrain from participation in assisted suicide-related activities outside the

78 OR. REV. STAT. § 127.885(5)(b)(C)(i) (2023).

79 OR. REV. STAT. § 127.885(5)(b)(C)(ii) (2023).

80 Kent Greenawalt, *Objections in Conscience to Medical Procedures: Does Religion Make a Difference?*, 2006 U. ILL. L. REV. 799, 820.

81 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 70. These Directives are discussed more fully in Carstens, *supra* note 4, at 194–97.

82 ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 70, at 9.

83 *Id.*

84 *Id.* at 21. For additional perspectives on the conscience issues at play explicitly in Catholic healthcare institutions, see generally Brietta R. Clark, *When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict*, 82 OR. L. REV. 625 (2003). For a broader discussion of Catholic institutional claims in a variety of settings, see generally Angela C. Carmella, *Catholic Institutions in Court: The Religion Clauses and Political-Legal Compromise*, 120 W. VA. L. REV. 1 (2017).

institution as a condition of employment. This may create an inconsistent witness to the sanctity of life when an employee of a religiously affiliated institution engages in such activity in his or her "off hours."

C. Prospective Patients

Many argue that protecting the conscience rights of providers can harm the autonomy of patients and their "rights to direct their own medical care."[85] This argument is particularly vehement where substantially all of a region's healthcare institutions are run by a religious community such as Catholic, Adventist, or Baptist communities with significant healthcare presences. There are also those who claim that protections against forced complicity in the act of another "present special concerns about third-party harm."[86]

However, patients—particularly vulnerable patients near the end of their lives—also have an interest in being treated at institutions that share their philosophy of care and life. Indeed, "[a]bandoning the right to conscience of the medical practitioner not only harms the individual practitioner but also threatens harm to his patients as well—the harms . . . are actually inseparable from one another."[87]

This right of patients to receive care in institutions that reflect their values is under-appreciated. This would be particularly true in the context of a patient who was an adherent of a particular faith who sought assurances that treatment in a health care facility managed by his or her denomination would faithfully follow the moral teachings of that tradition. More broadly, in the context of earlier "right to die" cases, one commentator noted that requiring abandoning an institutional commitment to sustaining life "would perpetuate the fear of [the facility's] predominantly geriatric population and their families that the facility would begin carrying out these requests routinely."[88]

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85 Swartz, *supra* note 58, at 314.

86 Nejaime & Siegel, *supra* note 36, at 2519. Nejaime and Siegel argue that "respect for conscience does not require us to ignore the special features of complicity-based conscience claims that endow them with capacity to harm other citizens. . . . [F]ew would affirm a result in which some citizens are singled out to bear significant costs of another's religious exercise." *Id.* at 2521.

87 Theriot & Connelly, *supra* note 1, at 565; *see also id.* at 566 ("[I]f the right to conscience were robustly defended, all patients . . . would presumably be able to access and receive care from medical practitioners who share their values.").

88 Loftus, *supra* note 36, at 705.

D. Anticipate Upcoming Threats

Currently, most discussion of conscience protections are in the abortion, reproduction, or gender contexts.[89] Critics have been growing more vocally hostile to these protections, arguing, "[h]ealth care providers already enjoy broad rights—perhaps too broad—to follow their guiding moral or religious tenets when it comes to sterilization and abortion. An expansion of those rights is unwarranted."[90]

One commentator, writing in 2006 said, terrifyingly:

> Where there is ongoing disagreement within the medical ethics community about a particular form of treatment, physicians would not be obligated to provide it. For example, [they] would not be obligated to participate in physician-assisted suicide . . . since the requested action is not generally accepted from a medical ethics standpoint and, moreover, is currently illegal in all states except Oregon. *If the status of this activity changes from both the viewpoint of prevailing medical ethics and the law, the obligations of health care professionals would similarly change.*[91]

Thus, even if protections currently offered are adequate today, that could change very quickly. If assisted suicide becomes more widespread, or if popular political support for it increases, such protections may be diminished. This illustrates the importance of enshrining protections in the law clearly and expansively before this scenario happens.

IV. PROSPECTIVE CONSIDERATIONS

Those who oppose assisted suicide believe that assisting another in intentionally ending life is a gravely immoral act. While it is vitally important to protect individual and institutional conscience by avoiding coercion into participating in such an act[92] or being complicit in it, the advocacy should not begin and end here. Strong opposition to the wrong itself must continue. In the effort to defend conscience in

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89 *See, e.g.*, Theriot & Connelly, *supra* note 1, at 574.

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

91 Swartz, *supra* note 58, at 349 (emphasis added) (citations omitted). A similar observation was made, with grave concern, in Theriot & Connelly, *supra* note 1, at 570–71 ("It would appear that many believe that the right to conscience should be permitted only insofar as the reason for its exercise in any particular instance accords with the collective conscience of the professional community.").

92 Kubick, *supra* note 6, at 3 ("To violate man's conscience, either by prohibiting him from committing good acts or coercing him to commit evil acts, is a direct assault on the very dignity of man and the God in whom that dignity reflects.").

the strongest terms possible, the importance of continued evangelization and persuasion on the moral question itself cannot be overlooked. While protecting the right not to be coerced into doing evil is critical, it is equally important to persuade others of the *reason* for that opposition and, hopefully, change minds, hearts and law itself.

Until then, it is critically important to ensure that there are substantial protections in place for those who want no part in assisted suicide. To do so, lawmakers, theologians, and ethicists must do more to develop a comprehensive understanding of "material cooperation" and consider how far protections should extend—and who gets to decide.[93]

Critics argue that often it is "difficult for patients to know in advance which hospitals have policies restricting access to certain procedures,"[94] and there is stress connected with transferring patients.[95] Statutes could require advanced notice of conscience objections of individuals and institutions. Advanced notice of a meaningful kind could allow prospective patients to select providers with full knowledge of limits on the services that can reasonably expect.[96] Assisted suicide cases would be unlikely to arise in emergency situations where such advanced notice would not be a reasonable way to provide critical information to potential patients and their families.

The protections against forced participation should be explicitly broad. In the context of institutions, this would cover clinics, hospitals, and medical practices. However, it should also include religiously affiliated nursing homes and assisted living facilities. With respect to individuals, a broad array of professionals should be covered, including physicians, pharmacists, nurses, nursing aids, and social workers. Currently, protections are more narrowly drawn as they "tend to cover a relatively discrete set of medical practitioners directly related to the covered medical procedures or medications."[97] However, the

93 *See* Theriot & Connelly, *supra* note 1, at 579 (indicating that the protection should extend "to all stages of a particular procedure, to include not only participation but also assistance, facilitation, or referral").

94 Swartz, *supra* note 58, at 333.

95 Addressed more fully in *id.* at 289–91.

96 *See* Swartz, *supra* note 58, at 287–92 (discussing dangers of not requiring advance notice); Nejaime & Siegel, *supra* note 36, at 2576 ("Patients can be gravely injured when they are denied service in emergency situations or deprived information regarding treatment options. But even aside from these injuries, refusal of service can inflict dignitary harms.").

97 Theriot & Connelly, *supra* note 1, at 574; *see also id.* at 581 ("Conscience protections should cover not only those medical professionals who directly provide the medical procedure or prescribe the medication, but should be extended as well to those healthcare

consciences of all those whose involvement in the assisted suicide could constitute material or even formal cooperation deserve protection. Indeed, it may be even more important to be explicit about these protections for those other than physicians. In the hierarchy of the medical community, they may be the ones most reluctant to raise objections.

In addition, while religion shapes the views of many about assisted suicide, conscience protections should not be limited to those with religious objections.[98] Protections should extend to those whose objections are based on nonsectarian moral, ethical, or professional judgments.[99] While, traditionally, opposition to assisted suicide has its roots in religious belief, those who come to oppose it from a moral conviction without overt religious origins should still be protected.

Some critics argue that because medicine is an essential good and licenses create a monopoly, conscience protections should not be afforded as much protection as would be acceptable in other scenarios. One version of this critique is that "[m]edicine needs to embrace a brand of professionalism that demands less self-interest, not more."[100] Another version of this critique holds:

> [L]icensing systems complicate the equation: such a claim would be easier to make if the states did not give these professionals the exclusive right to offer such services. By granting a monopoly, they 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—all the worse if it is not in

practitioners or assistants who facilitate or assist in the provision of such services or medications.").

98 This debate is discussed at length in Greenawalt, *supra* note 80.

99 This may not just be religious but a right of conscience more broadly. *See* Bertelsen, *supra* note 6, at 130 ("From the history of the drafting of the Bill of Rights it seems clear that behind the religion clauses stood the idea of liberty of conscience, even if the word 'conscience' did not appear in the final version of the amendment."); Theriot & Connelly, *supra* note 1, at 583 ("The right to conscience need not, and should not, be limited solely to the religious predicate. A more inclusive conscience protection regime—one that includes moral, ethical, or philosophical bases along with the religious—is consistent with the idea of conscience as an unalienable right."); Carstens, *supra* note 4, at 179 ("Conscience is difficult, but not impossible, to define apart from religion."). *See generally* Nathan S. Chapman, *Disentangling Conscience and Religion*, 2013 U. ILL. L. REV. 1457.

100 Cantor, *supra* note 90, at 1485; *see also id.* ("As the gate-keepers to medicine, physicians and other health care providers have an obligation to choose specialties that are not moral minefields for them."); *id.* ("Conscience is a burden that belongs to the individual professional; patients should not have to shoulder it.").

> fact a personal act of conscience but, rather, an attempt at cultural conquest.[101]

However, this neglects the harm that can come by adopting a view that the medical profession should become one that is amoral—and ignores the long tradition that holds medical professionals to high moral standards. Indeed, the ancient, religious Hippocratic Oath stated:

> I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion. In purity and according to divine law will I carry out my life and my art.[102]

On the constitutional level, Mark Rienzi has proposed that the Due Process Clauses under the Fifth and Fourteenth Amendments protect against forced participation in killings.[103] He argues that "across a variety of different contexts, our laws have frequently recognized the right of individuals to choose not to participate in a wide variety of government-conducted or government-permitted killings."[104] Currently, this may offer protection in the context of assisted suicide. However, additional recognition of this should be made explicit. One commentator has proposed the use of a "ministerial exception"[105] to allow religious medical institutions to require their employees to comply with their medical ethics perspectives as a condition of employment. This reflects the reality that the moral ethos of a religious medical institution depends upon the supportive witness of its medical professionals.

CONCLUSION

Often, it can be tempting to avoid addressing a potential legal challenge when it may not be as ripe for a solution as other disputes.

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101 Charo, *supra* note 59, at 2473.

102 The Hippocratic Oath, NAT'L LIBR. OF MED. (Feb. 7, 2012), https://www.nlm.nih.gov/hmd/greek/greek_oath.html [https://perma.cc/3NQ8-S384].

103 *See* Rienzi, *supra* note 10. For Professor Rienzi's further discussion of this theme in the specific context of abortion, see generally Mark L. Rienzi, *The Constitutional Right Not to Participate in Abortions:* Roe, Casey, *and the Fourteenth Amendment Rights of Healthcare Providers*, 87 NOTRE DAME L. REV. 1 (2011).

104 Rienzi, *supra* note 10, at 129.

105 *See* Carstens, *supra* note 4, at 203–19 (arguing that under *Hosanna-Tabor Evangelical Lutheran Church and School v. Equal Employment Opportunity Commission*, 565 U.S. 171 (2012), and *Our Lady of Guadalupe School v. Morrissey-Berru*, 140 S. Ct. 2049 (2020), a religious medical institution should be able to use the ministerial exception to ensure that its employees personify its values).

Currently, the heated debates about conscience in the medical arena seem to be focused more directly on other questions involving reproduction, abortion, and gender. However, as the legal landscape changes it is important to ensure that strong conscience protections are in place to guard against future storms. One such storm is the increasing legal authorization of assisted suicide in the United States as well as abroad. The consciences of those individuals and institutions who serve those most vulnerable need and deserve protection of the broadest scope possible—and with a greater sense of urgency.