Research Protocol: Procedural Protections in Reproductive Health Care Conscience Laws

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Procedural Protections in Reproductive Health Care Conscience Laws

I. Date of Protocol: December 2018

II. Scope: Collect laws and regulations that establish conscience rights of health care providers (including both negative rights of refusal to participate in controversial health care services, and positive rights for providers willing to participate in such services) in the context of reproductive health care services. Code these laws to understand i) what explicit procedural protections from adverse consequences are established; ii) if the laws establish protections from civil liability, which categories of providers receive those protections; iii) whether rights of refusal or rights to civil immunity are limited in situations where patients are likely to suffer injury; and iv) whether any these laws have been held unenforceable in whole or in part as a result of subsequent litigation. This dataset captures the relevant features of laws in effect as of December 17, 2018. The jurisdictions selected are the 50 states and the District of Columbia.

III. Project Team: Prof. Nadia N. Sawicki, J.D., M.Bi. (“Supervisor”); and Loyola University Chicago School of Law students Rachel Kemel, Crystal Lowery, Isabella Masini, Drew Towne Morton, and Christina Perez-Tineo (“Researchers”). For final quality control, Tom Keefe, J.D., M.A. (“Naïve Coder”) was added to the Team.

IV. Primary Data Collection

a. Project dates: April 2018 – December 17, 2018

b. Dates covered in the dataset: March 16, 1973 – December 17, 2018. This is a cross-sectional dataset analyzing reproductive health care conscience laws as they are in effect at one point in time, December 17, 2018. The effective date listed for each state is the date of the most recent version of the law or regulation within that state. If more than one law or regulation is included in the legal text for a state, the effective date reflects the date of the most recently amended or enacted law or regulation within the legal text.

c. Data Collection Methods: The team building this dataset consisted of five legal researchers (Researchers) and one supervisor (Supervisor). Research was conducted using the Westlaw database (for initial identification of relevant laws) and publicly available state legislative websites (for extracting the text of relevant laws).
i. **Step 1: Secondary Source Compilations:** The original collection of data was conducted by the Supervisor and one Researcher. The Supervisor identified two recent secondary source compilations of state health care conscience laws, and the Researcher entered the citations for these laws into an Excel spreadsheet. Laws outside the inclusion criteria were then removed.

ii. **Step 2: Targeted Westlaw Searches:** To identify relevant laws beyond those already identified by secondary sources (and to confirm those identified in such secondary sources), the Researcher and Supervisor each independently ran targeted searches in the Westlaw database. These searches were supplemented by reviewing the table of contents chapters of any relevant laws identified.

1. **Search Terms - Researcher:** (conscien*w/s object*) OR "religious objection"
2. **Search Terms – Supervisor:** (medic! OR physician! OR “health care” OR hospital) AND ((abortion OR (terminat! /3 preg!)) OR embryo! OR fetus OR service OR suicide OR euthanasia OR “end of life” OR “family planning” OR counsel! OR “stem cell!” OR dying OR contracept! OR inseminat! OR reproduct! OR “in vitro” OR decision! OR directiv! OR steriliz! OR “life sustaining” OR “life-sustaining” OR treatment) /p (refus! OR declin! OR relig! OR conscien! OR object!))

iii. **Step 3: Redundant Text Collection, Table of Contents Review, and Data Entry:** After completion of the steps above and collection of all relevant citations in the original Excel spreadsheet, the Team then extracted the text of the identified laws from publicly available state legislative websites, and entered the legal citation, statutory text, and effective date for each law into MonQcle, a web-based software-coding platform. This was done in five batches, with ten jurisdictions being worked on at a time (of those ten jurisdictions, five were completed by Researchers A and B, and five were completed by Researchers C and D). During this process, the Researchers reviewed the Tables of Contents of the relevant Act, Chapter, or other statutory or regulatory sub-division within which each identified statute or regulation was located, and identified any additional sections that were relevant to include in the dataset. At this stage, all 51 jurisdictions were 100% independently and redundantly reviewed to confirm that all relevant laws were collected by the Researchers. Divergences, or differences between the original research and redundant research, were reviewed by the Supervisor and resolved by the Team.

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1. The majority of the additional sections added at this stage were “Definitions” sections that defined terms used within the conscience law.
d. **Inclusion and exclusion criteria:** Most jurisdictions have several statutes and regulations pertaining to rights of conscience relating to reproductive health care services. Only laws (statutes and regulations) that met the following criteria were included in the dataset:

- Statutes relating to conscience, religion, or moral/ethical objection in the provision of medical services (i) in a health care setting by (ii) physicians, nurses, pharmacists, hospitals, or other individual and institutional health care providers; where (iii) those statutes explicitly referenced protections in the context of reproductive health care services (such as abortion, sterilization, contraception, emergency contraception, assisted reproductive technology, genetic testing, and treatments or research involving human embryos).
- Regulations meeting the above criteria, if they independently established protections without explicit statutory authority, or established protections exceeding those established by the originating statutes.

The following were excluded from the dataset:

- Laws relating to conscience in health insurance or the financing of health care services;
- Laws relating to conscience in the provision of health care services in a prison setting (typically, laws relating to physician participation in capital punishment);
- Laws that did not explicitly apply in the context of reproductive health services;
- Regulations that were duplicative or complementary of originating statutes that had already been included in the dataset.

V. **Coding**

a. **Development of coding scheme:** The Supervisor conceptualized coding questions, and finalized them based on feedback from LawAtlas staff. When the questions were finalized, the Supervisor entered them into MonQcle, a web-based software-coding platform. The text of sub question X.4 was later modified slightly to better reflect the data being captured.

b. **Coding methods:** Below are specific rules used when coding the questions and responses in the dataset. After each batch of coding was completed, the Team met to assess whether additional variables beyond those originally identified needed to be added; if that was the case, the coding protocol and all coding was updated accordingly.

**Parent Questions:** “Is there a conscience law relating to [medical service]?” With respect to each medical service below, “yes” was coded where the law referred to conscientious, moral, ethical, or religious beliefs regarding that service; or where it referred to a provider’s decision to participate in or refuse to participate in that service.
Q1: “Abortion” was coded “yes” if the law referenced “abortion;” “termination of pregnancy;” or “death,” “destruction,” “termination,” or “removal” of a “fetus” or “embryo.”

Q2: “Sterilization” was coded “yes” if the law referenced “sterilization”

Q3: “Contraception” was coded “yes” if the law referenced “yes” if the law references “contraception,” “birth control,” or “family planning.” Laws that only referred to “emergency contraception” were coded only as “emergency contraception,” not “contraception.”

Q4: “Emergency contraception” was coded “yes” if the law referenced “emergency contraception” or the “morning-after pill”

Q5: “Assisted reproductive technology” was coded if the law referenced “assisted reproduction,” “artificial insemination,” “in vitro fertilization,” or “surrogacy”

Q5: “Genetic counseling” was coded if the law referenced “genetic counseling”

Q5: “Cloning” was coded if the law referenced “cloning,” “human cloning,” or “embryo cloning”

Q5: “Stem cells” was coded if the law referenced treatment or research involving “stem cells” or “embryonic stem cells”

Q5: “Research on gametes or embryos” was coded if the law referenced “research,” “experiments,” “procedures,” or “destruction of” “gametes,” “in vitro embryos,” or a “fetus” or “child” in an “artificial womb.”

Q5: “Medical use of fetal tissue” was coded if the law referenced medical procedures involving “fetal tissue” or “fetal organs”

Q5: “Umbilical cord banking” was coded if the law referenced “umbilical cord banking”

Sub-Questions 1.1, 2.1, 3.1, 4.1: “Which explicit procedural protections does the law provide?”

“Civil liability” was coded where the law referenced “liability,” “civil liability,” “damages,” or “claim for damages.”

“Criminal prosecution” was coded where the law referenced “criminal liability,” or “prosecution.”

“Disciplinary action” was coded where the law referenced “discipline,” “professional discipline,” “disciplinary action,” “disciplinary or recriminatory action,” “recrimination,” “recriminatory action,” “sanction,” “penalty,” or “punishment.”

If a law referenced “discipline” in the context of employment, it was coded as both “Disciplinary action” and “Employment action.” If a law referenced “discipline” by the state or a state actor, it was coded as both “Disciplinary action” and “Government action”
“Discrimination” was coded where the law referenced “discrimination”
  o If a law referenced “discrimination” in the context of employment, it was coded as both “Discrimination” and “Employment action”

“Employment action” was coded where the law referenced adverse action by an “employer,” “health care institution,” or “medical staff”; where it references adverse action relating to the terms of employment (hiring, dismissal, demotion, promotion, transfer, wages, benefits); where it references “staff privileges”; or refers to the objecting provider as an “employee” or “contractor.”

“Government action” was coded where the law referenced action by the “state,” “commonwealth,” “administrative agency,” “regulatory agency,” any “public” entity (“public actor,” “public official,” “public institution”), “political subdivision;” references granting or denial of a “certificate of need”; or references “administrative liability”

“State licensure” was coded where the law referenced adverse action by state “licensing boards,” “licensing agencies,” or “medical boards,” or references “loss of licensure” or “adverse licensing action”
  o If the law’s protections fall within the category of “State licensure,” they were also coded as “Government action”

“Education” was coded where the law referenced adverse action relating to “education,” “training,” “residency,” or “degrees.”

“Funding” was coded where the law referenced adverse action relating to awards of public or private funds, including “funds,” “grants,” “contracts,” “public benefits,” “public assistance,” or “government assistance”
  o If the funding protections specifically referenced “government” or “public” funding, they were also coded as “Government action”

Sub-Questions 1.2, 2.2, 3.2, 4.2: “Which providers, if any, are entitled to protection from civil liability?”

For this question, Researchers coded based on both the substantive conscience laws, and any statutory definitions applicable to those laws.

“Any person” was coded where the law referenced “persons” or “a person” without providing additional detail.

“Any health care provider” was coded where the law referenced a “health care provider,” “medical provider,” “person who furnishes or assists in the furnishing of health care services,” or a similar broad catch-all term. Where the law defined “health care provider” by identifying a defined set of individuals (for example, “physicians, nurses, and social workers”), then only those named individual providers were coded. However, if the definition of the term “health care provider” included a catch-all (for example, “physicians, nurses, social workers, and any other providers of medical services”), the law was coded for both the named individual providers as well as the catch-all “Any health care provider.”
“Any licensed professional” was coded where the law referenced “licensed professionals” or “licensed health care professionals”

“Physician” was coded where the law referenced a “physician” or “doctor”

“Pharmacist” was coded where the law referenced “pharmacist”

“Registered Nurse” was coded where the law referenced “nurse,” “registered nurse,” advanced practice nurse,” or “nurse practitioner”

“Mental health professional” was coded where the law referenced “social worker,” “counselor,” “psychologist,” or “psychiatrist”

“Student” was coded where the law referenced “student”

“Public employee” was coded where the law referenced “employee” or “agent” of the “state,” the “government,” an “agency,” or the “public”

“Health care facility staff” was coded where the law referenced “employee,” “agent,” or “staff” at any of the health care facilities described below; or an “employee” or “agent” of any health care provider

“Health care facility” was coded where the law referenced “hospital,” “health care institution,” “health care entity,” “medical facility,” “ambulatory surgical center,” “clinic,” “long-term care facility,” “skilled nursing facility,” or an “employer” of a health care provider, without reference to whether that facility is public, private, or religious. Health care facility” was coded where the law referenced a “facility,” “institution,” or “corporation” without specific reference to health care services. References to a health care facility’s “governing board” or “directors” were not separately coded.

“Private health care facility” was coded where the law referenced a health care facility (see above), but modified with the terms “private” or “non-public”

“Religious health care facility” was coded where the law referenced a health care facility (see above), but modified with the terms “religious” or “denominational”

**Sub-Questions 1.3, 2.3, 3.3, 4.3:** “Does the conscience law establish any explicit patient protections?”

Where any of the variables were satisfied, Caution Notes were used to record the relevant statutory text.

“Provider rights limited in emergencies” was coded where the law withdraws protections in the context of “emergency,” “endangering the life of a patient,” “life-threatening situations,” or contexts “likely to result in patient death”

“Provider rights limited in cases of malpractice” was coded where the law withdraws protections in the context of “malpractice,” “negligence,” “violation of” or “contrary to” “generally accepted health care standards” or “reasonable medical standards;” or where the law requires that the provider’s behavior be consistent with “generally accepted health care standards” or “reasonable medical standards”
• “Provider rights limited in cases of miscarriage” was coded where the law withdraws protections in the context of “miscarriage,” “inevitable abortion,” or “spontaneous abortion” (unless those terms are defined to apply only to miscarriages where the fetus no longer has a heartbeat), or where the statutory definition of abortion explicitly excludes miscarriage.

• “Provider rights limited in cases of ectopic pregnancy” was coded where the law withdraws protections in the context of “ectopic pregnancy,” or where the statutory definition of abortion explicitly excludes ectopic pregnancy.

• “Patient must be referred to another provider” was coded where the law requires that the refusing provider “refer” the patient to another provider or “provide a referral;” or that the refusing provider or someone else (for example, the provider’s employer) “assign,” “delegate,” or “arrange” for another provider to perform the requested service.

• “Provider must make informed consent disclosures” was coded where the law requires that a provider inform the patient of the risks and benefits of all medically appropriate treatments and their alternatives.

• “Patient must be provided with information regarding access to services” was coded where the law requires that a provider inform the patient about resources relating to the service requested.

• “Patient must be notified of provider’s refusal” was coded where the law requires that the refusing provider or someone else (for example, the provider’s employer) notify the patient that the requested treatment is being denied.

• “Provider must return patient’s prescription” was coded where the law requires return of a prescription.

**Sub-Questions 1.4, 2.4, 3.4, 4.4:** “Has the conscience law been held unenforceable in whole or in part?”

To answer this sub-question, Researchers used the Westlaw database (via the History and Citing References tools) to identify judicial opinions in cases that negatively affected the validity of the conscience law. Where the conscience law was found invalid in whole or in part by case law, the question was coded “Yes.” Caution Notes were used to record the case citation and a brief description of its holding. Caution Notes were also used to record cases upholding the validity of the conscience law, and these were coded “No.”

**VI. Quality Control**

**a. Quality control – research:** As described in Part IV-c above, all 51 jurisdictions were 100% redundantly researched to confirm that all relevant laws were collected by the Researchers. On December 17, 2018, all Original Coders re-reviewed these laws on publicly available state legislative websites to ensure that they had not been amended since the original coding.
b. **Quality control – redundant coding:** All 51 jurisdictions were 100% redundantly coded – that is, each record was coded independently by two Researchers (the Original Coder and the Redundant Coder). Coding was done in five batches, ten jurisdictions at a time (of those ten jurisdictions, five were coded by Researchers A and B, and five were coded by Researchers C and D).

c. **Quality control – weekly statistical quality control:** After Researchers completed coding of each batch of jurisdictions, the Supervisor exported the data into a Microsoft Excel document to calculate divergence rates. The Supervisor then collected all divergences, codes of “Other,” and Caution Notes into a Coding Review Worksheet. Coding review meetings were conducted weekly, and all divergences were resolved through consultation and discussion with the Team. Questions and variables that were causing confusion were edited for clarity; some new variables were added; and then checked across the dataset to make sure coding was consistent. The rate of divergence for Batch 1 (AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA) was 5.18% on September 18, 2018. The rate of divergence for Batch 2 (HI, ID, IL, IN, IA, KS, KY, LA, ME, MD) was 9.91% on October 2, 2018. The rate of divergence for Batch 3 (MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ) was 3.60% on October 23, 2018. The rate of divergence for Batch 4 (NM, NY, NC, ND, OH, OK, OR, PA, RI, SC) was 2.39% on November 6, 2018. The rate of divergence for Batch 5 (SD, TN, TX, UT, VT, VA, WA, WV, WI, WY, DC) was 5.66% on November 20, 2018.

d. **Quality control – naïve coding:** After all jurisdictions were coded and discrepancies resolved, the Supervisor selected 11 jurisdictions (21.5% of records) to be redundantly coded by a Naïve Coder. The Naïve Coder had not been previously involved with the project. He was given a brief orientation by the Supervisor and instructed to code the records in accordance with the Coding Protocol all Researchers had been using. The rate of divergence between the naïve coding and original coding was 5.46% on December 11, 2018. The majority of divergences arose because the Naïve Coder did not respond to Sub-Questions X.4 (relating to enforceability), and occasionally left answers blank rather than coding “No.” There were only five discrepancies that required any substantive discussion; these were reviewed and resolved as a Team.

e. **Quality control – final check:** Once all of the coding and quality control was completed, the Supervisor did a final review of coding answers, citations, and caution notes. The final review resulted in several clarifying questions which were resolved among the Supervisor and the primary coders for each jurisdiction. All unnecessary caution notes were deleted and all necessary caution notes were edited for publication.

f. **Deletion of unanswered responses:** The Supervisor reviewed the final dataset, and deleted from MonQc1e the following null variables/responses:

i. Q 2.2: Religious health care facility

ii. Q 3.2: Any licensed professional, Pharmacist, Mental health professional, Religious health care facility
iii. Q 3.3: Provider rights in cases of malpractice, Provider must return patient’s prescription

iv. Q 4.1: Disciplinary action, State licensure, Education, Funding

v. Q 4.2: Any person, Any health care provider, Physician, Pharmacist, Registered Nurse, Mental health professional, Student, Public employee, Health care facility staff, Private health care facility, Religious health care facility

vi. Q 4.3: Provider rights limited in cases of malpractice, Provider must make informed consent disclosures, Patient must be provided with information regarded access to services, Patient must be notified of provider’s refusal