Too Much Information:
The Burden of Informed Consent Laws on Religious Hospitals

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A bodily disease, which we look upon as whole and entire within itself, may, after all, be but a symptom of some ailment in the spiritual part.[1]

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1. NATHANIEL HAWTHORNE, THE SCARLET LETTER (1850), *reprinted in* 2 HAWTHORNE, NATHANIEL 1804–1864, 235 (1983).

INTRODUCTION

Interaction between the body, mind, and "spirit" of a religious or spiritual person is vulnerable to encroachment in the context of certain medical procedures. Many religions have strict rules governing an adherent's treatment of his or her body,[2] so it is no surprise that various religions have established medical facilities specifically targeted to their own devotees' needs. In fact, "[n]early one in every five hospital beds in the United States is now under the control of a religious entity, and ten of the twenty largest health systems in the country are religiously-owned."[3] In the United States, this sometimes leads to tension between the religious organizations that establish and manage their own hospitals and the state that works to govern them from the healthcare perspective.

One area of state regulation with the potential for significant friction is centered on "informed consent," which may be defined as, "consent to medical treatment by a patient . . . after achieving an understanding of what is involved and esp. of the risks."[4] States regulate informed consent in a variety of ways, but often they require that all medically indicated options be discussed with patients.[5] A law of this sort may seem reasonable in most contexts, but it gets more complicated in the religious arena.

> For instance, religious hospitals may require employees to adhere to certain religious directives aimed at avoiding doctrinally offensive medical procedures and counseling. Conceivably, adherence to such directives may require the omission of certain procedures on the "menu" of options.[6] For example, the Catholic Health Care Services's Ethical and Religious Directives (ERDs), a body of moral and medical principles that guide many aspects of Catholic hospital policies, state that [i]n a time of new medical discoveries, rapid technological developments, and social change . . . Catholic health care services will encounter requests for medical procedures contrary to the moral

2. For example, the Jewish Hospital HealthCare Services (JHHS) Distinctives demand that kosher food service and Jewish Chaplains always be available for patients. *See Ethical & Religious Directives*, JEWISH HOSPITAL & ST. MARY'S HEALTHCARE, http://www.jhsmh.org/About-Us/Ethical-and-Religious-Directives.aspx (last visited May 15, 2011). Catholic hospitals, as another example, may have policies against offering "birth control, abortion, sterilization, artificial insemination or in vitro fertilization." Anne M. Dellinger & Ann Morgan Vickery, *When Staff Object to Participating in Care*, 28 J. HEALTH L. 269 (1995).

3. *Religious Hospitals, Mergers, & Refusal Clauses*, LAW STUDENTS FOR REPRODUCTIVE JUSTICE, http://lsrj.org/documents/factsheets/08-09_Religious_Hospitals.pdf (last visited Mar. 27, 2011).

4. MERRIAM WEBSTER'S DICTIONARY OF LAW 244 (1996).

5. *See* discussion *infra* Part I.A for examples.

6. *See*, *e.g.*, *Ethical and Religious Directives for Catholic Health Care Services*, U.S. CONFERENCE OF CATHOLIC BISHOPS (5th ed. 2009) (General Introduction and Introduction to Part One: The Social Responsibility of Catholic Health Care Services), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. One example of a prohibited exercise is "participation in contracts or arrangements for surrogate motherhood." *Id.* at 26. Ethical and religious doctrines are extremely valuable in illustrating how the gap between medical and religious conduct is bridged, and will be discussed further in Part III.A.1.

> teachings of the Church. Catholic health care does not offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church.[7]

Thus, enforcement of this aspect of informed consent laws would directly conflict with the policies of those religious hospitals that follow these directives. Accordingly, the offended hospitals may have a claim under the Free Exercise Clause of the First Amendment to the Constitution, which reads: "Congress shall make no law respecting an establishment of religion, or prohibiting the *free exercise* thereof."[8] Though institutional claims in this context could not be phrased as potential violations of the Establishment Clause, much of the relevant case law focuses on the burden on free exercise, and this analysis is tailored accordingly.[9]

The Free Exercise Clause applies to state regulations through the Fourteenth Amendment,[10] so we will be developing potential claims through both state and federal court rulings. First, we look at the development and application of informed consent laws in general. Then we move on to how religious hospitals would fare under one of the leading cases on the subject, *Employment Division v. Smith*,[11] and whether or not any of the exceptions to the *Smith* rule apply. Finally, we go through the strict scrutiny analysis courts would use if the informed consent laws, as applied to religious hospitals, were found to fall under one or more of the *Smith* exceptions.

I. THE DEVELOPMENT AND APPLICATION OF INFORMED CONSENT LAWS

A. Background

The doctrine of informed consent between a physician and a patient goes back centuries. In English common law, physicians were charged with the tort of battery if they did not first obtain the consent of their patients before performing procedures. The idea behind the law was that without consent, performance of a medical procedure was like any other unauthorized physical contact with another person.[12]

Later, in the United States, the doctrine truly began to take form in the New York Court of Appeals decision in *Schloendorff v. Society of New York Hospi-*

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7. *Id*. at 8.

8. U.S. CONST. amend. I (emphasis added).

9. *See* ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 1265 (3rd ed. 2006) ("Although [church autonomy] is discussed under the free exercise clause, it could be phrased as an establishment clause question: When does government or court involvement in church disputes violate the establishment clause? Analytically, it does not seem to matter whether this issue is characterized as a free exercise clause issue or one involving the establishment clause.").

10. *See* Cantwell v. Connecticut, 310 U.S. 296, 303 (1940).

11. 494 U.S. 872 (1990).

12. *See Informed Consent: Encyclopedia of Everyday Law*, ENOTES, http://www.enotes.com/everyday-law-encyclopedia/informed-consent (last visited Apr. 15, 2011).

tal.[13] Judge Cardozo famously stated, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages."[14] Even though this formulation has since "pursued an inconstant course, riddled with numerous exceptions and subjected to various qualifications and refinements,"[15] it is still considered one of the "most important of the early decisions to be handed down by [the New York Court of Appeals]" on the subject of consent.[16]

Today, requiring a physician to first obtain consent from his patient is only half the professional obligation. The physician must also see to it that the consent is *informed*, such that the patient has a sufficient amount of information upon which to make a sound decision regarding treatment.[17] Ultimately, informed consent comes down to the patient's right to determine what happens to his or her body and a physician's "duty to provide a person with enough information so as to ensure that the patient's ultimate decision is based on an appreciable knowledge of his/her condition, *the available options for treatment*, known risks, prognoses, etc."[18] As mentioned in the Introduction, this Note focuses on the requirement that all available options for treatment, despite doctrinal conflicts, be discussed with patients. States may refer to this requirement as the need to present "reasonable alternatives,"[19] "alternatives permitting the patient to make a knowledgeable evaluation,"[20] or "practical alternatives."[21]

B. How Informed Consent Is Applied Depends on the State

Like most areas of medical malpractice, the application of informed consent depends on state law standards. Luckily, we are not faced with fifty different standards. Although the states differ as to their terminology, most state standards can be grouped into one of two categories: (1) medical/professional community; or (2) materiality.[22] Most states adhere to the professional community standard, which focuses more on physicians than patients. New York's legislature, for instance, defined a breach of this standard as "the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto . . . as a reasonable [physician] under similar circumstances would have disclosed . . . ."[23] Florida adopted the professional community standard even more explicitly, demanding that "the action of the

13. 211 N.Y. 125 (N.Y. 1914).
14. *Id*. at 129–130.
15. Bing v. Thunig, 2 N.Y.2d 656, 663 (1957).
16. *Id*. at 662.
17. *See* eNOTES, *supra* note 12.
18. *Id*. (emphasis added).
19. *See* ALASKA STAT. § 09.55.556 (2010).
20. *See* VT. STAT. ANN. tit. 12, § 1909 (2010).
21. *See* GA. CODE ANN. § 31-9-6.1 (2010).
22. *See* eNOTES, *supra* note 12.
23. N.Y. PUB. HEALTH LAW § 2805-d (2011).

[physician] in obtaining the consent of the patient . . . [be] in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community."[24] While many other states have similar statutes, they will not be explored *ad nauseum*.

Most of the remaining states use some variant of the "materiality" standard, which focuses on the patient's expectations, as opposed to the physician's community standards.[25] Washington, for example, describes a failure to obtain informed consent as a "patient consent[ing] to the treatment without being aware of or fully informed of such *material fact* or facts."[26] A fact is considered "material" if "a reasonably prudent person in the position of the patient or his representative would attach significance to it deciding whether or not to submit to the proposed treatment."[27] Several other states have similar statutes and/or rules developed through case law.

The effects these categories of state standards have on legal acknowledgement of institutional autonomy and the religious values of patients become especially relevant when exploring the possibility of exceptions to the medically-available-options aspect of informed consent laws.

II. *SMITH* PROVIDES A NEARLY IMPENETRABLE SHIELD FOR THE STATE

The Court's rule in *Smith* would likely validate the provisions in informed consent laws requiring that all available options for treatment be discussed with patients. For those familiar with *Smith*, this should come as no surprise. The rule has been criticized for both its ambiguity and for making it extremely difficult for plaintiffs to win free exercise cases.[28] The rule's shortcomings led to congressional assault in the form of The Religious Freedom Restoration Act of 1993 (RFRA).[29] RFRA does not apply directly to this Note's analysis because RFRA was judged to be unconstitutional as applied to the states,[30] but it stands as a testament to the notion that *Smith* represents a nearly impenetrable shield against plaintiffs challenging state governments.[31] This is not to suggest that the level of state protection offered by *Smith* is universally regarded as

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24. FLA. STAT. § 766.103 (2011).

25. This presumably affects what a "religious" patient expects or may demand from his or her physician. This is addressed below in Part III.A (the discussion on burdening patients) and Part III.C (presenting the practical challenges in incorporating such altered expectations into the materiality standard).

26. WASH. REV. CODE § 7.70.050 (2011) (emphasis added).

27. *Id*.

28. Justice Brown stated that "[d]espite its surface simplicity, *Smith* is not an easy case to understand or apply." Catholic Charities of Sacramento, Inc. v. Super. Ct., 32 Cal. 4th 527, 574 (2004) (Brown, J., dissenting).

29. 42 U.S.C. § 2000bb (1993)[hereinafter RFRA].

30. *See* City of Boerne v. Flores, 521 U.S. 507 (1997).

31. *See* RFRA, *supra* note 29 ("[T]he Supreme Court virtually eliminated the requirement that the government justify burdens on religious exercise imposed by laws neutral toward religion . . . .").

unjustified,[32] but that plaintiffs, for better or for worse, face an uphill battle when bringing free exercise claims.

As articulated by Justice Scalia, the *Smith* rule states: "the right of free exercise does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes).'"[33] The Court further explained that "if prohibiting the exercise of religion . . . is not the object of the [law] but merely the incidental effect of a generally applicable and otherwise valid provision, the First Amendment has not been offended."[34] Such a "neutral, generally applicable law is subject only to rational basis review, which 'requires merely that the action be rationally related to a legitimate government objective.'" This Note breaks down the analysis of informed consent laws by the *Smith* rule's two primary requirements: (1) neutrality and (2) general applicability.

The first element is "neutrality," "the minimum requirement of [which] is that a law not discriminate on its face. A law lacks facial neutrality if it refers to a religious practice without a secular meaning discernable from the language or context."[35] Research into state-informed consent laws does not yield any law that classifies on the basis of religion or religious conduct.

In addition to the facial neutrality requirement, states are forbidden from passing laws that actually "target" religious conduct or beliefs.[36] In other words, if the "object" of the law is to encroach upon religious practices *because* they are motivated by religious beliefs, that law fails the neutrality prong of the *Smith* test.[37] Once again, informed consent laws pass muster. Presenting patients with available options and counseling them about the risks associated with those options does not target religious beliefs, nor does it seem like the object is to encroach on anyone's exercise of religion.

However, if a state were to selectively or discriminatorily enforce an otherwise neutral informed consent law only against religious hospitals, such action could extinguish neutrality. This is almost certainly true in situations that fall under the Religious Land Use and Institutionalized Persons Act (RLUIPA),[38] but is less certain under a "pure" *Smith* analysis, like the one at issue, in which

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32. *See generally* William P. Marshall, *In Defense of Smith and Free Exercise Revisionism*, 58 U. CHI. L. REV. 308 (1991). Professor Marshall argued that *Smith* helps avoid violations of the Establishment Clause.

33. *Smith*, 494 U.S. at 879 (quoting United States v Lee, 455 U.S. 252, 263 (1982) (Stevens, J., concurring)).

34. *Id*. at 878.

35. Church of Lukumi Babalu Aye, Inc. v. City of Hialeah, 508 U.S. 520, 533 (1993).

36. *See* Blackhawk v. Pennsylvania, 381 F.3d 202, 209 (3d Cir. 2004).

37. *See Lukumi*, 508 U.S. at 533.

38. *See* 42 U.S.C.A. § 2000cc(b)(1) (2000); *see also* Primera Iglesia Bautista Hispana of Boca Raton, Inc. v. Broward County, 450 F.3d 1295, 1308 (11th Cir. 2006) ("[A] truly neutral statute that is selectively enforced against religious, as opposed to nonreligious assemblies," is a violation of the Equal Terms provisions of RLUIPA.).

the claimants are not entitled to RLUIPA's greater leniency. This type of "as applied" violation is alluded to in *Lukumi*[39] and *Fowler v. Rhode Island*,[40] both of which apply outside of the RLUIPA context. However, Congress's view that the relevant RLUIPA provision was needed suggests that selective enforcement was not being used to strike down as many laws as Congress desired. Still, even if the discriminatory enforcement of an informed consent law would not be as outcome determinative in a "pure" *Smith* analysis as it would be in an RLUIPA case, a court still may find that the state's actions negated the law's neutrality.

The second requirement is "general applicability," which refers to a law that is not aimed at the promotion or restriction of religious beliefs, such that it "extends to all conduct that undermines the purposes of the law and does not selectively burden religiously motivated conduct."[41] Of the fairly extensive list of informed consent laws I have studied, both religiously and non-religiously motivated physician-patient exchanges fall within the scope of the laws' application. Furthermore, requiring hospitals to ensure that their employees are discussing all options with their patients does not "evince hostility to religion."[42] These laws apply "irrespective of whether the beliefs underpinning the regulated expression are religious or secular."[43]

When otherwise generally applicable laws have exceptions for non-religious reasons, this undermines the above arguments, sometimes even to the point of causing the laws to fail the requirement.[44] States tend not to codify explicit "exceptions," yet some statutes refer to "defenses" to informed consent malpractice claims, which arguably play the same role. Common examples include a waiver of the right to disclosure, nondisclosure of risks that are remote or commonly known, and circumstances where consent is impossible.[45] Another common exception, or defense, is sometimes referred to as the "therapeutic privilege," which exempts disclosure that "would have so seriously upset the patient that the patient would not have been able to dispassionately weigh the

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39. *See Lukumi*, 508 U.S. at 532 ("At a minimum, the protections of the Free Exercise Clause pertain if the law at issue . . . regulates or prohibits conduct because it is undertaken for religious reasons.").

40. 345 U.S. 67, 70 (1953) ("To call the words which one minister speaks to his congregation a sermon, immune from regulation, and the words of another minister an address, subject to regulation, is merely an indirect way of preferring one religion over another.").

41. Combs v. Homer-Center Sch. Dist., 540 F.3d 231, 242 (3d Cir. 2008) (citing *Blackhawk*, 381 F.3d at 209).

42. Brown v. City of Pittsburgh, 586 F.3d 263, 284 (3d Cir. 2009) (rejecting the plaintiff's claim that restrictions on protests outside abortion clinics "impermissibly interfere[d] with her religiously motivated efforts to dissuade women from undergoing abortions.").

43. *Id.*

44. *See* Michael P. Moreland, *The Things that are not Caesar's: Religious Organizations as a Check on the Authoritarian Pretensions of the State: Institutional Conscience and Moral Dilemmas: Why "Freedom of Conscience" Is Bad for "Church Autonomy,"* 7 GEO. J.L. & PUB. POL'Y 217, 220 (2009) (citing *Blackhawk*, 381 F.3d at 209).

45. *See*, *e.g.*, ALASKA STAT. § 09.55.556 (2010); N.C. GEN. STAT. § 90-21.13 (2010); VT. STAT. ANN. tit. 12, § 1909 (2010).

risks of refusing to undergo the recommended treatment."[46]

The mere existence of non-religious exemptions is not determinative, however, and must represent a "substantial category of conduct . . . that undermines the purposes of the law to at least the same degree as the covered conduct that is religiously motivated."[47] The aforementioned exceptions primarily exhibit a concern for physicians being held liable for not providing information that the patient could not have "processed." Failure to discuss the risks, in other words, could not have caused an injury if the disclosure would have fallen on deaf ears. This argument could be made for religiously motivated nondisclosure of medically available options as well, in the sense that religious patients may not be willing to even *consider* options that would violate their faith. Therefore, such an omission would not have caused any injury. This seems like a weaker argument, however, because patients' religious beliefs presumably do not make them *incapable* of processing the information. Therefore, the non-religious exceptions do not seem to "undermine[] the purposes of the law to at least the same degree as the covered conduct that is religiously motivated."[48]

The *Smith* rule does not require much of state laws, so unless a law has a direct religious connection, the analysis moves fairly quickly. It is hard to imagine an informed consent law that is anything but generally applicable, and educating patients about available medical procedures is not a religious belief or practice being targeted. There is still a glimmer of hope for religious hospitals, however, because the analysis does not necessarily end here. Some courts have read exceptions into the *Smith* opinion, and we explore some of them in the next section.

III. *SMITH*'S EXCEPTIONS

In *Smith*, Justice Scalia mentioned, in dicta, certain instances where the application of the Court's rule may not be appropriate. Some courts have seized on that language to create exceptions to the general rule. We will take each of the potentially applicable exceptions in turn, starting with church autonomy.

A. Church/Institutional Autonomy

Justice Scalia noted that "church autonomy" was outside the scope of his articulated rule,[49] but the doctrine could just as easily be perceived as a kind of "non-exception exception" because of its level of importance beyond *Smith*'s boundaries.[50] The basic idea behind the doctrine of church autonomy is that the

46. Cobbs v. Grant, 502 P.2d 1, 12 (Cal. 1972).

47. Moreland, *supra* note 44.

48. *Id.*

49. *See* Employment Div. v. Smith, 494 U.S. 872, 877 (1990) ("The government may not . . . lend its power to one or the other side in controversies over religious authority or dogma.").

50. *Cf.* Mark E. Chopko, *Shaping the Church: Overcoming the Twin Challenges of Secularization and Scandal*, 53 CATH. U. L. REV. 125, 130–31. ("The guarantee of this institutional autonomy is not some mere technicality or exception to the rule; it is the rule, wrought from difficult conflict and offered

state and its courts should not get involved in the governance of religious organizations, especially with regard to "questions of discipline, or of faith, or ecclesiastical rule, custom, or law" that have been established by such an organization.[51] In *Catholic Charities of Sacramento, Inc. v. Superior Court*, the California Supreme Court summed up the *Watson* Court's reasons for "deferring to religious authorities on religious questions."[52] First of all, courts don't have the knowledge base to effectively analyze religious doctrine, and attempting to do so "would only involve [the courts] in a sea of uncertainty and doubt . . . ."[53] Second, church members "implicitly consent to the church's governance in religious matters," so second-guessing the church's rules impairs: (a) the right of the organization to develop those rules on its own and (b) "the right to form voluntary religious organizations."[54] These two impairments mentioned in *Watson* are not necessarily exhaustive but served as a jumping-off point for subsequent court decisions that further developed, and at times expanded, the doctrine.

Whether the doctrine of church autonomy protects religious hospitals in the context of informed consent laws depends on (1) whether a hospital can be considered a protected religious organization, and (2) whether the doctrine covers a situation where the state is compelling a religious hospital to provide patients with all medically available options. We tackle these issues in turn.

1. Is a Hospital a Church?

The first issue is whether a hospital can even qualify for these protections as a religious organization or if it is simply considered a healthcare provider. Fortunately, the two are not necessarily mutually exclusive. In *Board of Education v. Allen*,[55] the Court explained that institutions may qualify as both religious and secular, such that the two are not mutually exclusive.[56] Although the Court was referring to schools at the time, the concept may be just as applicable to religious hospitals—they provide both healthcare *and* religious services.[57]

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to point the way to a preservation of authentic freedom for religion in the United States."). The "rule" addressed by Professor Chopko is not limited to *Smith*'s rule specifically, but the sentiment seems quite applicable in this context.

51. Watson v. Jones, 80 U.S. 679, 727 (1872).

52. 32 Cal. 4th 527, 542 (2004).

53. *Id*. (citing *Watson*, 80 U.S. at 732).

54. *Id*. (citing *Watson*, 80 U.S. at 728–29, 733–34).

55. 392 U.S. 236 (1968).

56. *Id*. at 245 ("[T]his Court has long recognized that religious schools pursue two goals, religious instruction and secular education.").

57. *See, e.g.*, *Spiritual Services*, KETTERING HEALTH NETWORK, http://www.khnetwork.org/spiritual/ (last visited Mar. 27, 2011) ("Spiritual care staff . . . offer a wide range of religious knowledge and nurturing experience . . . [such as] prayer, counsel, support and [other] religious services . . . ."); CHRISTIAN HEALTH CARE CENTER, http://www.christianhealthcare.org/ overview.html#mission (last visited Oct. 20, 2011) ("The mission is rooted in the belief that we minister to the whole person, recognizing that a person's faith should be utilized, strengthened, and nourished. Accordingly, we respect and care for the physical, emotional, and spiritual needs of those we serve."); ZEN HOSPICE

The argument that there is necessarily a dichotomy between medical and religious conduct is expressly rejected by the Catholic Church in its ERDs. In fact, ERDs, which are "concerned primarily with institutionally based Catholic health care services," stand for more than just the proposition that healthcare providers *may* provide *some* religious services, but rather that the two functions are *completely inseparable*.[58] "The mystery of Christ," the ERDs explain, "casts light on every facet of Catholic health care."[59] "[T]he animating principle of health care," they continue, "is Christian love."[60] The mission statements presented in footnote 56 and the JHHS Distinctives in footnote 2 suggest that other religious organizations adhere to a similar view of the unity between religion and healthcare.

What qualifies as a religious institution is often a statutory determination. Perhaps one of the most notorious examples is the constitutionally validated set of requirements laid out in *Catholic Charities of Sacramento, Inc. v. Superior Court*.[61] The California statute, the Women's Contraception Equity Act (WCEA),[62] mandated prescription contraceptive coverage in certain health insurance contracts. The WCEA included a religious employer exception but, in order to qualify, all of the following had to be true of the organization, or "entity":

> (A) The inculcation of religious values is the purpose of the entity.
> (B) The entity primarily employs persons who share the religious tenets of the entity.
> (C) The entity serves primarily persons who share the religious tenets of the entity.
> (D) The entity is a nonprofit organization as described in . . . the Internal Revenue Code of 1986 . . . .[63]

The plaintiff in that case, Catholic Charities, did not fulfill these requirements. Because we are not examining the employee hiring practices or structure of any particular religious hospitals, it is not crucial that we detail the reasons why Catholic Charities did not qualify. The important thing to realize is that

PROJECT, http://www.zenhospice.org (last visited Mar. 27, 2011) ("The 'Zen' in our name reflects our approach of bringing mindfulness and compassion to our care for the dying, their caregivers, and the bereaved. This approach is grounded in the 2,500 year-old teachings of the Buddha, especially as they relate to coping with death and dying."); Jan Ziegler, *Traditional Chinese Medicine Taps "Qi" for Health*, JOURNAL OF THE NATIONAL CANCER INSTITUTE, http://jnci.oxfordjournals.org/content/91/12/1000.full (last visited Mar. 27, 2011) ("A qi gong physician . . . is said to be able to channel qi to a patient directly and in the Chinese system, the unimpeded and balanced flow of internal 'qi' is considered crucial to health—particularly to the prevention of cancer.").

58. *See* U.S. CONFERENCE OF CATHOLIC BISHOPS, *supra* note 6.
59. *Id.*
60. *Id.*
61. 32 Cal. 4th 527 (2004).
62. CAL. HEALTH & SAFETY CODE § 1367.25 (2003).
63. 32 Cal. 4th at 539.

even a state statute as strict as the WCEA may be adjudged constitutional.

That is not to say that the statutory requirements in the WCEA passed with flying colors. Even the majority acknowledged that the third prong, requiring that "the entity serves primarily persons who share the religious tenets of the entity," was "problematic."[64] The court realized that, under this provision, religiously affiliated soup kitchens would have to turn away nonbelievers in order to avoid losing their protected status.[65] Nonetheless, the court refused to invalidate the statute because Catholic Charities did not meet any of the other requirements. Further still, Justice Kennard concurred because she thought the first prong, requiring inculcation of religious values to be the organization's purpose, was suspect as well.[66] Finally, Justice Brown dissented on the ground that the definition was "such a crabbed and constricted view of religion that it would define the ministry of Jesus Christ as a secular activity."[67]

Some courts have tackled the religiosity of healthcare entities specifically. The Eighth Circuit, for example, had to decide whether a religious hospital qualified as a "religious organization" to see if it fit within the religious discrimination exemption in Title VII of the Civil Rights Act of 1964.[68] This inquiry was part of a "*Lemon* test"[69] analysis in an Establishment Clause claim, but the court's method and conclusion are nonetheless revealing. The court focused on the composition of the hospital's board of directors (all were church representatives), the level of control the affiliated church had over the hospital's policies (its Articles of Association could be amended only with the approval of multiple levels of church officials), and the religious duties of certain employees (the claimant was hired as a chaplain to "provide[] a religious ministry of pastoral care, pastoral counseling . . . and liturgical services for persons in the hospital.").[70] The court concluded that "[i]t cannot seriously be claimed that a church-affiliated hospital providing this sort of ministry to its patients is not an institution with 'substantial religious character.'"[71] Under *Scharon*, a hospital's qualification as a religious entity is a case-by-case factual determination.

In his paper, *Constitutional Protection for Church Autonomy: A Practitioner's View*,[72] Professor Mark Chopko's requirements for an organization to fall under the protection of institutional autonomy seem to be more in line with Justice Brown's conception than the validated WCEA's definition in *Catholic Charities of Sacramento*. Professor Chopko reasoned that "[t]he closer the structure [of a religiously affiliated institution] is to the performance of a core religious

64. *Id*. at 567.
65. *Id*.
66. *Id*. at 569 (Kennard, J., concurring).
67. *Id*. at 583 (Brown, J., dissenting).
68. *See generally* Scharon v. St. Luke's Episcopal Presbyterian Hosp., 929 F.2d 360 (8th Cir. 1991).
69. *See generally* Lemon v. Kurtzman, 403 U.S. 602 (1971).
70. *Scharon*, 929 F.2d at 362.
71. *Id*. (quoting *Lemon*, 403 U.S. at 616).
72. Mark E. Chopko, *Constitutional Protection for Church Autonomy: A Practitioner's View*, *in* CHURCH AUTONOMY: A COMPARATIVE STUDY, 95, 95–116 (Robbers ed., 2001).

function, . . . the more likely that the constitutional autonomy principles . . . will apply."[73] Qualifying religiously affiliated institutions, or "faith communities," specifically include "auxiliary institutions: primary and secondary schools, religious charitable entities, religious colleges and universities, and *hospitals*."[74]

In sum, if courts apply a definition from a specific state statute or from case law, the question of whether a religious hospital makes it to the next stage of the church autonomy analysis will depend on the specific hospital claiming protection. However, if courts apply a "broadly inclusive" definition like Professor Chopko's, then religious hospitals are more likely to be entitled to whatever protection the church autonomy doctrine can provide under the circumstances.

2. Even if a Hospital Qualifies, Does Church Autonomy Save It from *Smith*?

If a religious hospital is found to fall within the protection of the church autonomy doctrine, the question remains whether or not the doctrine constitutes enough protection to overcome *Smith* in this analysis. This depends on how broadly the doctrine is construed. Both courts and academics fall somewhere along a wide spectrum, ranging from those who apply the doctrine to a very narrow class of organizations and factual scenarios to those who employ a fairly general concept of institutional autonomy.

On the very broad end of the spectrum, Justice Brown, in her dissent in *Catholic Charities of Sacramento*, pointed out that "[s]ince *Smith* focused exclusively on the individual's free exercise of religion, some courts have reasoned that religious institutions are exempted entirely from the *Smith* analysis."[75] The reasoning goes that because *Smith* does not explicitly refer to anything but individual obligations, those obligations should not automatically be extended to churches.[76] Under this formulation, assuming religious hospitals qualify as religious institutions, the exception would apply and we could move past *Smith* to strict scrutiny of informed consent laws. As already mentioned, however, institutional autonomy is not always applied this extensively.

In *Catholic Charities of Diocese of Albany v. Serio*, the New York Court of Appeals similarly entertained the notion that "an exception to the holding of *Smith* can be derived from the doctrine of church autonomy, which prevents states from interfering in matters of internal church governance or determining ecclesiastical questions."[77] Under this narrower formulation, informed consent laws would be unlikely to fall under the exception. Requiring physicians to present all medically available options does not represent an attempt by the state to come down on one side or the other in an *internal* debate over "religious authority or dogma."[78] Instead, the conflict is between the hospital and the state,

73. *Id*. at 97.
74. *Id*. (emphasis added).
75. 32 Cal. 4th 527, 574 (2004) (Brown, J., dissenting).
76. *Id*. (citing EEOC v. Catholic Univ. of Am., 83 F.3d 455, 462 (D.C. Cir. 1996)).
77. 7 N.Y.3d 510, 523 (2006) (internal citations omitted).
78. *See id.* at 524 (citing Employment Div. v. Smith, 494 U.S. 872, 877 (1990)).

and because the state is not deciding a religious question, this *external* conflict is essentially no different than any other state-imposed burden that inspires a free exercise claim. Bringing this conflict within the scope of church autonomy would constitute a significant expansion of the doctrine, such that the exception would swallow the rule.

Furthermore, the state would not be imposing itself on the hospital by deciding which religious leaders were permitted to decide which medical procedures or counseling services were offensive to their religion. Rather, informed consent standards "merely regulate[] one aspect of the relationship between plaintiffs and their employees."[79] Without a doubt, the "aspect of the relationship" being regulated in this case is important. Dictating how physicians in a religious hospital are permitted to serve the public arguably limits the religious aspect of the hospital to internal administration. Still, the *Serio* court's rendition of the doctrine does not seem to extend much beyond protection of internal governance, so the mere fact that the impinged aspect of employee-employer relations is important does not necessarily bring it within the scope of church autonomy.

The plaintiffs in *Serio*, a group of faith-based social service and health care facility operators, pointed out that some federal courts have further specified a "ministerial exception" to *Smith* as part of the overarching church autonomy doctrine.[80] The plaintiffs argued that this exception amounted to the "right for a religiously-affiliated employer to structure all aspects of its relationship with its employees in conformity with church teachings."[81] That interpretation would almost certainly protect religious hospitals from having to abandon their rules governing staff members' health counseling, but the New York Court of Appeals refused to take the doctrine that far. It examined the exception's roots and decided to limit the rule as it had been applied thus far—to employment discrimination claims with actual "ministers."[82] Just how broadly "ministers" is defined is not as relevant in this analysis as some of the other facets of church autonomy because we are not focusing on protecting non-religious employees from religious employers.

Although the New York Court of Appeals did not necessarily expand the doctrine far enough to protect religious hospitals from informed consent laws, its definition of church autonomy was not as narrow as that in *Catholic Charities of Sacramento*, in which the majority referred to the doctrine as "the rule of the so-called church property cases."[83] Needless to say, the court was not fond of the idea of applying the doctrine to any new factual situations. As

79. *Id.*
80. *See id.*
81. *Id.*
82. *See id.* ("The existence of a limited exemption for ministers from antidiscrimination laws does not translate into an absolute right for a religiously-affiliated employer to structure all aspects of its relationship with its employees in conformity with church teachings.").
83. 32 Cal. 4th 527, 541.

mentioned in the introduction to this section, the court essentially applied the original formulation of the doctrine articulated in *Watson*. It is not unusual for courts to cite *Watson* as the foundational case, but the Supreme Court of California went one step further and insisted that "[t]he rule's modern formulation is similar."[84] The court cited more modern cases,[85] but did not actually extend the rule beyond its original parameters. The plaintiff's argument for a more general interpretation of "matters of internal church governance" was rejected.[86] The court asserted that the government is allowed to pass laws that conflict with religious beliefs without deciding religious questions, and thus, the "church property cases" were not applicable.[87] It does not take much analysis to reach the conclusion that religious hospitals' objections to the absence of a religious exemption in informed consent laws do not fit within this limited view of church autonomy. Even if a state could not be compelled to add an express exemption, however, it may be a different situation if the state selectively enforced the informed consent law against a religious hospital, threatening its license.[88]

Like the courts, academics disagree as to the scope of the doctrine, which implicates the perceived level of respect due religious institutions regarding their internal governance. Professor Moreland, for instance, believes there is little evidence of a strong commitment to church autonomy. In his article *The Things that are not Caesar's*, Professor Moreland states that although there is:

> a recognition of church autonomy in a narrow range of cases—church property dispute cases, ministerial employment cases, and doctrinal disputes that are brought to civil courts . . . these and other constitutional values and doctrines do not, in fact, evidence a robust, underlying commitment in our law to the *libertas ecclesiae*[89] principle.[90]

Not surprisingly, Professor Moreland leaned heavily on *Catholic Charities of Sacramento*.

Professor Mark Chopko, on the other hand, seems to offer a more expansive rendition of the doctrine. In his paper, *Constitutional Protection for Church Autonomy: A Practitioner's View*, he defines church autonomy as "the right of religious communities (hierarchical, connectional, and congregational) to decide upon and administer their own internal religious affairs without interference by

84. *Id*. at 542.

85. *See*, *e.g*., Serbian Orthodox Diocese v. Milivojevich, 426 U.S. 696 (1976).

86. 32 Cal. 4th 527, 542 (2004).

87. *See id.*

88. *See* discussion about "targeting" *supra* Part III.

89. *Libertas ecclesiae* may be defined as "the liberty of the Church to govern herself." Father Richard John Neuhaus, *The Pope John XXIII Lecture Series: The Persistence of the Catholic Moment*, 52 CATH. U.L. REV. 269, 271 (2003).

90. Moreland, *supra* note 44, at 223-24 (quoting Richard W. Garnett, *John Courtney Murray on the "Freedom of the Church,"* 4 J. CATH. SOC. THOUGHT 59, 63 (2007)).

the institutions of government."[91] Under this articulation, physician-patient counseling sessions may be protected.

Unfortunately for religious hospitals, neither *Catholic Charities of Sacramento* nor *Serio* seems to rescue them from *Smith*'s firm grip. Accordingly, we move now to another exception—hybrid rights.

B. Hybrid Rights

Justice Scalia explained a "hybrid rights" exception to the Court's rule in *Smith*:

> The only decisions in which we have held that the First Amendment bars application of a neutral, generally applicable law to religiously motivated action have involved not the Free Exercise Clause alone, but the Free Exercise Clause in conjunction with other constitutional protections, such as freedom of speech and of the press, or the right of parents . . . to direct the education of their children. Some of our cases prohibiting compelled expression, decided exclusively upon free speech grounds, have also involved freedom of religion.[92]

In other words, "a 'hybrid' case is one in which a single claim encompasses several protected interests."[93] Put another way, if the law "burdens the free exercise of religion *and* some other constitutionally-protected activity, there is a First Amendment violation unless the strict scrutiny test is satisfied."[94] Here, cases involving informed consent law disputes suggest that the implicated independent constitutional right may be freedom of expression.[95] If a physician in a religious hospital, or even someone representing the hospital itself, asserts this alternative ground[96] for invalidation of state-imposed informed consent regulations, this could qualify as one of Justice Scalia's "hybrid situation[s]," or, as the court in *Serio* called it—a "hybrid right."

Before delving into the analysis, it is important to note that both critics and supporters of the hybrid rights exception have pointed out the difficulty, or even futility, in structuring a concrete hybrid rights analysis. The absence of any

91. Chopko, *supra* note 72, at 96.

92. 494 U.S. at 881–82 (internal citations omitted).

93. First Covenant Church v. City of Seattle, 120 Wash.2d 203, 216 (1992).

94. Gregory W. McCracken & Robert I. McMurry, *Update on First Amendment Issues: Religious Activities and Signs and Adult Uses*, 4 A.L.I.-A.B.A. Course of Study Materials (Course Number SK002).

95. U.S. CONST. amend. I ("Congress shall make no law . . . abridging the freedom of speech . . . ").

96. A hospital's adherence to religious directives as reflected in its policies is no less "expressive" than a church's architectural design, which the Washington Supreme Court adjudged a "communication of religious beliefs . . . closely related to the structure's theological doctrine." *See* Stanley H. Friedelbaum, *Free Exercise in the States: Belief, Conduct, and Judicial Benchmarks*, 63 ALB. L. REV. 1059, 1069–70 (2000) (citing *First Covenant Church*).

applicable framework in *Smith* likely contributed to its nine year dormancy,[97] as well as its rejection in the Second and Sixth Circuits.[98] Professor Vincent Bonventre goes so far as to suggest that the exception "renders free exercise of religion entirely superfluous . . . [because a] violation of free speech, parental rights, or some other constitutionally protected liberty is prohibited by itself."[99] Even if free exercise is not completely overshadowed, hybridizing it with freedom of expression makes for a particularly muddy analysis because the two rights seem practically inseparable, with the former being an extension or clarification of the latter.[100] Even if these companion rights cannot be fully separated, especially since a complete freedom of expression analysis is beyond the scope of this Note, I hope to at least show that however important freedom of expression may be to religious hospitals and physicians, that *accompanying* right is usurped by the *competing* right protected by informed consent laws—patient autonomy.

Interferences with freedom of expression can be quite injurious in the context of the physician-patient relationship. Policymakers must tread carefully when drafting policies that govern the information a physician shares with his patient, especially when the content of that information may be infused with ethical viewpoints. As the court in *In re Requena* stated, "A process for making specific ethical decisions which does not even take into account the views of the treating physicians directly involved with the individual patient whose care is under consideration is . . . seriously flawed."[101] Although that case dealt with physicians disagreeing with a *hospital's* policies, as opposed to those imposed by the *state*, the statement supports the notion that informed consent laws are encroaching on particularly sensitive freedom of expression territory.

Specific to informed consent laws in the freedom of expression context, *Planned Parenthood League v. Bellotti* stands for the proposition that there is a "broad scope available to physicians" when choosing which information they wish to provide to patients.[102] In that case, the court noted that freedom of

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97. *See* Steve France, *Not Under My Roof You Don't: Courts Split on Religious Liberty vs. Discrimination in Landlord/Tenant Disputes*, 85 A.B.A. J. 26 (1999).

98. *See* McCracken & McMurry, *supra* note 94.

99. *See* Vincent Martin Bonventre, *The Fall of Free Exercise: From No Law to Compelling Interests to Any Law Otherwise Valid*, 70 ALB. L. REV. 1399, 1412 (2007).

100. *See* Bret Boyce, *Equality and the Free Exercise of Religion*, 57 CLEV. ST. L. REV. 493, 522 (2009) ("The Free Exercise Clause specif[ies] that the same broad protections accorded to core political speech and association shall also be accorded to religious speech and association."). *Cf.* L. Martin Nussbaum, *Watson v. Jones and the Doctrine of Church Autonomy*, *in* THE ROTHGERBER JOHNSON & LYONS RELIGIOUS INSTITUTIONS GROUP, *available at* http://www. churchstatelaw.com/commentaries/watsonvjones.asp (last visited Oct. 20, 2011) ("Woven throughout the body of Church Autonomy law is a repeated recognition that government has no subject matter jurisdiction over church communications, regardless whether those communications take the form of sermons, . . . pastoral counseling communications, [or] church-communicant communications . . . .").

101. 213 N.J. Super. 475, 484–87 (Ch. Div. 1986).

102. *See* 641 F.2d 1006, 1018 n.14 (1st Cir. 1981) (referencing with approval the challenged statute's acknowledgement of this principle).

expression demanded that "the physician remain[] completely free to give any additional information desired . . . whether complementary to or contradictory of the information contained in the [state-regulated] form."[103] The difference, however, is that the challenged consent form in *Bellotti* required physicians to discuss with patients abortion details deemed by the court *not* to be "directly material to any medically relevant fact."[104] The examples of informed consent laws researched for this Note require only that all medically *relevant* options be presented to patients. Therefore, we cannot claim that the regulation demands inclusion of otherwise irrelevant information that could amount to "coercive state indoctrination of particular values or ethical judgments."[105]

Another consideration that may[106] weigh against physicians in religious hospitals is the other end of the doctor-patient relationship. *Patient* autonomy must factor into a freedom of expression claim that otherwise focuses on *physician* autonomy, especially since patient autonomy is presumably the focus of informed consent laws. As the court in *Brownfield v. Daniel Freeman Marina Hospital* explained, "[t]he duty to disclose such information arises from the fact that an adult of sound mind has 'the right, in the exercise of control over [her] own body, to determine whether or not to submit to lawful medical treatment.'"[107] Informed consent laws address precisely this concept—providing adequate information so the patient can make an intelligent decision regarding his or her treatment options. Without this information, the patient's decision does not represent a "[m]eaningful exercise of this right."[108]

Although freedom of expression gives physicians a wide berth when it comes to the information they choose to share with their patients, the state is not entirely restricted from regulating that interaction. The right of the patient to make an informed decision pushes back on the physician's freedom of expression, so complete omission of medically relevant facts weighs against the physicians in this case. Therefore, it may not make much of a difference if freedom of expression is tagged onto the overall free exercise claim to form a hybrid right.

103. *Id.* at 1017–18.

104. *Id*. at 1020.

105. *Id*. at 1022.

106. I purposefully use the word "may" because the argument could be made the other way as well—that patients going to a religious hospital wish to avoid being given the option of undergoing treatment adverse to their religious views (assuming the patient's beliefs are consistent with the hospital's directives). Thus, the patient's autonomy is encroached upon when the state demands they are presented with those options. Because there would be Fourteenth Amendment implications, that argument could also form the basis of a hybrid right. That argument deserves attention, but is outside the scope of this Note.

107. 208 Cal. App. 3d 405, 414 (Cal. Ct. App. 1989) (citing Cobbs v. Grant, 8 Cal. 3d 229, 242 (1972)).

108. *Id*.

IV. IF AND WHEN *SMITH* IS OFF THE TABLE, *SHERBERT V. VERNER* RETURNS

There are only two ways to conquer *Smith*: (1) prove that a law burdening religious practice is not neutral or not of general application; or (2) prove that one of the exceptions applies. When one of these conditions is met, strict scrutiny is triggered.[109] In other words, if and when *Smith* is off the table, the court is essentially back to a "pre-*Smith*" analysis under *Sherbert v. Verner*,[110] where "[t]he door of the Free Exercise Clause stands tightly closed against any governmental regulation of religious *beliefs*. . . ."[111] Although informed consent laws may not be invalidated under the *Smith* test without selective enforcement, they are relatively close to fitting into one of the exceptions, and thus strict scrutiny should be applied.

The strict scrutiny test for free exercise claims, laid out in *Sherbert*, is divided into three prongs. The court inquires as to whether: (1) "the [law] imposes any burden on the free exercise of the [plaintiff's] religion," (2) a compelling state interest justifies the burden, and (3) the "secular objective" can be achieved only through the challenged restriction. A "yes" to the first inquiry launches the court into the analysis, while a "no" to either of the remaining inquiries invalidates the law. Here, just like under the *Smith* test, the provisions of interest in informed consent laws likely pass the test.

A. *Hospitals, Physicians, and Patients Are All Burdened*

Cases define "burden" differently, but even under the very narrow definition employed in *Lyng v. Northwest Indian Cemetery Protective Association*,[112] informed consent laws burden religious hospitals and physicians. For religious individuals or organizations to be burdened under *Lyng*, they must be (a) "coerced by the Government's action into violating their religious beliefs" or (b) penalized for the exercise of their religious rights.[113] Informed consent laws coerce religious hospitals and physicians into violating their beliefs by presenting them with a Hobson's choice: they can either (a) violate their religious beliefs by presenting options they find offensive or (b) break the law by adhering to those beliefs, and thus, expose themselves to medical malpractice lawsuits.[114]

The free exercise of religion is burdened for the patients as well. This burden may be more difficult to see at first glance, because it is not a situation in which the physician is actually *performing* an unwanted procedure on the patient. However, the burden flows from the personal, even intimate, nature of the

109. *See* Church of Lukumi Babalu Aye, Inc. v. City of Hialeah, 508 U.S. 520, 546 (1993).
110. 374 U.S. 398 (1963).
111. *Id*. at 402 (citing Cantwell v. Connecticut, 310 U.S. 296, 303 (1940)).
112. 485 U.S. 439 (1988).
113. *Id*. at 449.
114. *See* Chopko, *supra* note 72, at 111 ("If religious organizations create unsafe conditions that cause accidents, the general tort rules would hold religious organizations accountable to the same extent as their secular cousins.").

physician-patient relationship. This relationship is largely based on the exchange of information, the flow of which begins, absent state intervention, with the hospital's adoption of policies that fall in line with the tenets of its controlling church. It then trickles down to the physician and his duty to follow those rules, ending with the patient's trust that he or she is not receiving recommendations and counseling inconsistent with his or her shared faith. In *Cobbs v. Grant*, the Supreme Court of California explained that these counseling sessions "transcend[] arms-length transactions," because "the patient . . . has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process . . . ."[115] When you add the element of spiritual guidance to that interaction, it becomes that much more precious.[116] If hospitals are not permitted to fully engage in such practices, market density is stunted and thus, patients' free exercise of religion is burdened.

In *Sherbert*, the Court mentioned that the burden was on a cardinal principle of the plaintiff's religion,[117] but courts are generally reluctant to inquire into the "centrality" of beliefs.[118] The Court in *Thomas v. Review Board of the Indiana Employment Security Division*, for instance, stated that "the guarantee of free exercise is not limited to beliefs which are shared by all of the members of a religious sect."[119] Thus, the analysis focuses on the burden of some religious belief, rather than the belief's centrality to the religion in question. Here, even with the evidentiary burden being on the religious hospitals, moving on to the next step should not present a problem.

B. The State's Interest Is Compelling

For the second prong, the evidentiary burden is on the state to prove it has a compelling interest that justifies the law's burden on the religious practitioner. As with the first prong, courts differ in their definition of "compelling interest." Some define it very generally, focusing on the law's furtherance of the state's police power. Other courts define it more specifically, such that the state must show it has a compelling interest *not* to make an exception for religious exercise. Further still, some courts apply both definitions.[120] In *Gonzales*, the Court "looked beyond broadly formulated interests justifying the general applicability of government mandates and scrutinized the asserted harm of granting

115. 8 Cal. 3d 229, 242 (1972).

116. *See* KETTERING HEALTH NETWORK et al., *supra* note 57.

117. *Sherbert*, 374 U.S. at 406.

118. *See*, *e.g.*, *Lyng*, 485 U.S. at 457–58 ("[A] legal test under which [the Court] would decide which [practices] are 'central' or 'indispensable' to which religions, and by implication which are 'dispensable' or 'peripheral,' . . . [is not] squared with the Constitution or with our precedents . . . . [The Court cannot be] required to weigh the value of every religious belief and practice that is said to be threatened by any government program.").

119. 450 U.S. 707, 716 (1981).

120. *See* Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal, 546 U.S. 418, 430–32 (2006).

specific exemptions to particular religious claimants."[121] Although this level of specificity was dictated by RFRA,[122] which does not apply to state laws, the Court pointed out that RFRA largely adopted the method of analysis used in *Sherbert* and *Wisconsin v. Yoder*.[123] Because *Lukumi* stands for the proposition that pre-*Smith* precedent like *Sherbert* and *Yoder* applies once plaintiffs move beyond the *Smith* test, *Gonzales*'s level of specificity applies to our analysis as well.

Even if the state is required to specify how its compelling interest "would be adversely affected by granting an exemption"[124] to the informed consent law, it will likely prevail. As discussed in Part III.B, the compelling state interest is protecting the right of patients to make fully informed decisions about their own body and medical treatment. More than just a public health issue, the interest is in preserving personal autonomy. There does not appear to be any way to accomplish that goal without requiring physicians to present all medically available options, because patients need adequate information in order to fully exercise their right to decide.

C. The Secular Objective Cannot Be Achieved Through Other Means

When defined with the level of specificity dictated in *Gonzales* and pre-*Smith* precedent, the compelling interest prong practically merges with the third inquiry—whether the "secular objective" can be achieved only through the challenged restriction. However, the third prong does offer an opportunity to break down potentially viable exceptions, or lack thereof, in more detail.

On one hand, it seems clear that even if we assume exceptions could be made, they would have to be extremely narrow to avoid inadequately informing patients about important medical options. This would require balancing the medical importance of specific options—to make sure it would not be too dangerous to exclude them—against the level of aversion to each religion—to see if it is even worth making the potentially harmful exception in the first place. These considerations inevitably lead to a "centrality" analysis specifically rejected in *Lyng*.[125] Of course, in some circumstances, a religious hospital's and its physicians' stance on a particular procedure will not be an issue, because "[t]he sincerity of their beliefs, and the centrality of those beliefs to their faiths, [will] not [be] in dispute."[126] However, this will not always be the case with smaller religions or objections to less common medical procedures. Therefore, non-religious exemptions would undermine the state's compelling interest, while even minor religious exemptions could lead courts into an improper area

121. *Id*. at 431.
122. *See* 42 U.S.C. § 2000bb (1993).
123. *See Gonzales*, 546 U.S. at 431 (*citing Yoder*, 406 U.S. 205 (1972); *Sherbert*, 374 U.S. 398 (1963).
124. *Yoder*, 406 U.S. at 236.
125. *See Lyng, supra* note 118.
126. Catholic Charities of Diocese of Albany v. Serio, 859 N.E.2d 459, 463 (N.Y. 2006).

of analysis.

On the other hand, both major categories of state standards for informed consent, outlined in Part I.B, somewhat lend themselves to factoring in religious hospitals. First of all, the "professional community" standard is governed by accepted standards in the same or similar medical community. The whole analysis hinges on how the state legislature and courts define "community," and they could conceivably expand the concept to include "faith communities." In other words, religious hospitals could represent their own class with a different set of standards. The problem, however, is that the professional community standard is supposed to provide some consistency in application, and, given the abundance of religions that own and operate hospitals, the state interest in consistent application would be undermined.

In the remaining states that apply a "materiality" standard, the inquiry could theoretically take into account the religious beliefs of the patient and whether or not they chose a particular religious hospital based on those beliefs. This would give a fuller, and arguably fairer, picture of the patient's expectations from the institutional perspective as well. Hospitals that manage expectations by making their religious policies clear to the public should not be penalized for merely following through with the implementation of those policies. The problem with this approach is not altogether different from the problem with the proposed professional community alteration. Here, consistency in the application of the materiality standard is supposed to come from the objective "reasonable patient" perspective. If the religious beliefs of each patient had to be considered, juries would be tasked with assessing the reasonable Catholic or Buddhist patient. Again, the state's interest in consistent application of a manageable tort standard would be undermined.

CONCLUSION

The bad news for religious hospitals and their physicians is that they would have a very difficult free exercise case against informed consent laws requiring that all medically indicated options be discussed with patients. They fare the worst under the *Smith* test because informed consent laws are generally applicable, and educating patients about available medical procedures does not constitute a religious belief or practice being targeted. There are some exceptions to *Smith* that seem somewhat applicable, but neither the doctrine of church autonomy nor freedom of expression as a "hybrid right" definitively saves the hospitals from *Smith*'s clutches.

Even if the hospitals somehow navigate their way through the significant obstacles imposed by *Smith*, the strict scrutiny test outlined in *Sherbert* may not provide much of a sanctuary. Although state-imposed counseling for patients is a burden on religions offended by certain medical options, there seems to be no other way to accomplish the compelling state interest of protecting patient autonomy. Therefore, religious hospitals and physicians may have to present options adverse to their religious beliefs.

The good news is that, in some ways, the encroachment may not be as harmful as this Note implies. Some religious organizations see state requirements as simply the price of managing certain types of institutions, like hospitals or schools. Catholic institutions, for example, adhere to "principles of cooperation derived from moral theology [that] sometimes permit compliance—even if reluctantly—with state requirements."[127] Of course, this is not always the case with Catholic hospitals, nor is it necessarily the case with hospitals associated with other religions, but it is still uplifting to know that this division is not necessarily contentious.

Perhaps even more encouraging for religious hospitals is the fact that *Smith* is not always applied mechanically in state courts. New York courts, for instance, apply a balancing test when plaintiffs show a burden on the exercise of their religion, even if the burdening law is generally applicable and neutral.[128] Thus, sometimes even an incidental burden may lead to the invalidation of a state law under the formidable *Smith* test.

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127. Moreland, *supra* note 44, at 224.
128. *See Serio*, 859 N.E.2d at 466.