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An Aspen Grove, Independence Pass, Near Aspen, Colorado. Photograph by Robert L. Clinton

IN THIS ISSUE:

Reconciling Patient Choice with Physician Conscience

by Casey Frank

The gentle mind by gentle deeds is known.
Edmund Spenser[1]

The medical profession deals with ultimate issues of life and death. Of necessity, courts intervene in these matters to preserve life, protect the innocent and vulnerable, prevent suicide, and uphold the integrity of the medical profession.[2] While courts emphasize physicians' duty to treat their patients, in some situations physicians have a right to object to a request for treatment[3] when patients make therapeutic choices that their physicians do not support for moral or religious reasons.

These conscientious objections qualify physicians' duty of care toward their patients. This duty extends to the limits of physicians' abilities and corresponds to patients' informed consent,[4] but begins only after the physician-patient relationship is established.[5] Once established, deviation from good medical practice can expose a physician to professional discipline,[6] financial liability,[7] or even criminal prosecution in extreme cases.[8] A conscience-based objection that is not legally protected and results in harm to a patient also may constitute a breach of the physician's duty to the patient and result in liability to the provider. Thus, conscientious objections, like situations where patients act against medical advice, are limited exceptions to the therapeutic alliance between physicians and patients.[9] They are protected only when authorized by a specific law, and only if they do not harm patients.

This article highlights the provider-patient relationship, where the provider is either an individual or an institution.[10] Analogous conflicts also arise between physicians and their employers, where the relative rights of the parties must be accommodated. Some relevant laws protect physicians both as physicians and as employees.[11] However, distinctive employment-law principles also affect those cases, such as the reasonable accommodation of employees and the undue hardship of employers. Those issues cannot be adequately covered here.[12]

Background

As an example to the above, if a patient elects to have a first-trimester abortion, federal law broadly protects a physician's refusal to perform it.[13] In contrast, however, consider the pregnant patient who requests an ultrasound with the intent to abort a female fetus, or the deaf couple that intends to abort a hearing child.[14] Although the physician may decline to perform the abortion itself, the physician cannot simply assert a conscience-based objection to performance of these tests because no law privileges the objection. If harm to the patient were to result from the failure to test, such as due to an undiagnosed pathology, liability for the physician may follow, unless referral and transfer protocols are meticulously observed to fulfill the patient's needs.

The question whether a provider has a right to object to treatment on moral or ethical grounds is similar, in some respects, to the situation where a patient requests treatment that a physician cannot endorse for medical reasons, and the patient acts against medical advice.[15] For example, a patient may request, directly or through a surrogate, that resuscitation efforts be made in the event of cardiac arrest. A physician may validly refuse if treatment would be so futile that no survivors have been reported in similar situations.[16] However, in contrast to a conflict between provider and patient over appropriate medical treatment, in the case of a conscience-based objection, physicians are requesting deference to their own needs, rather than the patient's, based on moral, ethical, or religious grounds. In both situations, to avoid liability, physicians must avoid patient abandonment, a well-known concept discussed at the end of this article.

The likelihood of controversy in this area has been increased by modern advances in medicine that present novel treatment choices about which there is no social consensus.[17] Although adult-human cloning is a popular topic of discussion, it currently offers few treatment choices.[18] Further, a ban on human cloning is in progress,[19] so its part in this issue has yet to emerge.

Development of the issue of tissue transplants between species, or xenotransplantation, is more advanced. Baby Fae survived briefly with a baboon heart in 1984. More recently, patients have received baboon livers and marrow,[20] and implants of pig cells to treat Parkinson's and Huntington's diseases have been reported.[21] Even if medical concerns about rejection and viral contamination were satisfied,

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physicians who support animal rights might morally object to the use of such involuntary, nonhuman donors.[22] Xenotransplantation from pigs also might breach Jewish or Islamic laws about using pork. If promising treatments like these become the norm, their usefulness could limit moral objections, because a refusal to use them would deprive patients of good medical practice. Federal regulations covering this field have already been drafted, without any reference to moral concerns.[23]

Physician Authority and Patient Autonomy

Historically, physician beneficence toward patients was the controlling principle of medical practice. Not until 1980 did the American Medical Association's *Principles of Medical Ethics* mention patients' rights.[24] Since that time, patient autonomy has become the ascendant ethic.[25] Physician beneficence does not inherently conflict with patient autonomy. After all, physicians alone possess the information and judgment that inform and empower patients to make wise treatment choices. Physicians must adequately inform patients to facilitate meaningful informed consent.[26] Accordingly, physician beneficence actually serves patient autonomy.[27]

Autonomy is most commonly expressed as the right to refuse treatment.[28] As a New York court stated in 1914, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."[29] Autonomy has expanded to encompass the right of patient surrogates to refuse treatment,[30] but patient autonomy is not without limitations. Indeed, while principles of patient autonomy afford a qualified right to die,[31] the U.S. Supreme Court has recently ruled that states can limit that right to the avoidance of treatment; the U.S. Constitution does not provide a right to affirmative assistance in dying.[32]

Further, patient autonomy does not extend to a right to demand treatment that conflicts with a physician's sound professional judgment. For example, in a closely watched case, a patient's daughter sued Massachusetts General Hospital and its staff for issuing a do-not-resuscitate order for her comatose, terminally ill mother. Although the plaintiff alleged no explicit permission for the order was obtained, the defendants contended that further treatment would have been medically futile. The jury agreed and refused to find the defendants negligent with respect to the patient's death.[33]

As the right to patient autonomy increases, a conscience-based right of physicians to decline to treat serves to balance authority between physicians and patients. While physicians cannot heedlessly impose their values on patients, neither can physicians be required to sacrifice their own moral integrity.[34]

"Physicians' conscientious objections are protected only when authorized by a specific law, and only if they do not harm patients."

Laws Supporting Conscience

Accordingly, the right to receive medical treatment based on good medical practice may be limited in certain circumstances by a physician's right to exercise a conscientious objection to treatment. However, the physician's objection must be justified by reference to a specific law. For example, after the right to abortion was expanded in 1973 under *Roe v. Wade*,[35] a counterpoised law was passed to protect federally funded institutions and their staffs who refuse to conduct or facilitate abortions or sterilizations.[36] These objections are now protected in both public and private institutions.[37]

Similarly, to the extent physician-assisted suicide is legal, as under the Oregon Death with Dignity Act,[38] conscientious objections to providing such assistance would not be privileged unless specifically protected by statute.[39] Federal law does not provide such protection. The Supreme Court's recent decisions entrust these issues to be resolved in the so-called "laboratory of the states."[40]

All but four states have laws that provide some protection to objections based on conscience. However, most of these laws apply exclusively to abortion.[41] In Colorado, legislation protects "policies based on moral convictions or religious beliefs" that conflict with the rights of a patient who has appointed a health care agent. Although the physician need not comply with the agent's demands, notice of any objection must be given, and the patient must be transferred. The patient cannot be held hostage to the physician's beliefs.[42]

The statute authorizing living wills also supplies protection for conscience-based objections. No reason is required for refusal to honor a living will, but the objecting physician must find another physician supportive of the patient's wishes. The physician's refusal to so refer would constitute unprofessional conduct.[43]

A third statute authorizes patients to execute cardiopulmonary resuscitation directives that prohibit resuscitation of a dying patient. Whereas, among other things, a living will allows futile treatment to be halted, a CPR directive prevents treatment from being started, and provides no conscience-based exception.[44] All of these Colorado statutes prohibit—without qualification—assisted suicide or any affirmative steps to end life.[45]

At the federal level, physicians participating in federally funded health service or research programs are protected when objecting to any treatments based on religious or moral grounds.[46]

Physicians must understand that there are no wholesale conscience rights. Federal and state laws provide only finite protection. Conscientious objection to medical treatment decisions not covered by specific laws will jeopardize the objector. Even in the exercise of valid conscience-based rights, protocols must be followed to fulfill the needs of patients.

Ascendant Patient Rights

The right of individuals to make their own medical decisions has been found in federal law for over a century.[47] The drift of these rulings has been an increasing recognition of patients' ability to refuse medical treatment, often as a constitutional liberty interest.[48] Laws protecting moral objections qualify the right of patient autonomy that has gradually emerged from the U.S. Supreme Court.

Rochin v. California affirmed the right to bodily integrity;[49] *Skinner v. State of Oklahoma* prohibited involuntary sterilization;[50] *Griswold v. Connecticut* protected contraception;[51] and *Roe v. Wade* expanded abortion rights, qualified by distinctions among trimesters.[52] The decision in *Cruzan v. Director, Missouri Department of Health* held that persons have a limited right to refuse treatment through a surrogate.[53]

Courts have often held that patients' rights are superior to conscientious objections. For example, in *Brownfield v. Daniel Freeman Marina Hospital*,[54] a patient wanted estrogen pregnancy prophylaxis (a "morning-after pill") from a Catholic

hospital. The hospital refused to provide any information concerning this treatment. The court ruled that the patient's "right to control her treatment must prevail over respondent's moral and religious convictions." Although state law protected the right to refuse to perform an abortion, the court ruled that this did not apply because the treatment requested constituted pregnancy prevention rather than abortion. Failure to advise the patient as to her options exposed the hospital to medical malpractice damages. However, none were awarded because the plaintiff had sued only to enjoin the hospital's future behavior.

Similarly, in *Matter of Patricia Dubreuil*,[55] a patient refused blood transfusions following a Caesarean section, based on her religious convictions as a Jehovah's Witness. The hospital argued that abandonment of the patient's children would occur if the patient died. The court ruled there was insufficient proof of abandonment to overcome the strong right to free exercise of one's religion.

Even where courts have been reticent to compel a health care provider to take action contrary to a conscientious objection, the courts have upheld the patient's right to obtain such action elsewhere. Thus, in *Gray by Gray v. Romeo*,[56] there was consensus that a patient would never recover from a persistent vegetative state. The hospital objected to the termination of artificial feeding as requested by the patient's family. The hospital was ordered to terminate feeding or promptly transfer the patient to a compliant hospital.

Similarly, in *Brophy v. New England Sinai Hospital, Inc.*,[57] a wife requested the termination of artificial feeding for her husband, who was in a persistent vegetative state. The court would not order physicians to terminate treatment "contrary to their view of their ethical duty towards their patients," but ordered the transfer of the patient.[58]

In at least one case, a conscience-based objection was overridden because of a statutory mandate. In *The Matter of Baby K*,[59] a Virginia hospital was required, under various laws, to provide treatment to an anencephalic infant. The court appreciated "the dilemma facing physicians who are requested to provide treatment they consider morally and ethically inappropriate," but found no exception in the controlling statutes.[60]

The *Brownfield*, *Dubreuil*, and *Gray* courts viewed moral objections with great deference to the needs of patients. The *Matter of Baby K*, although primarily a futility case, shows that a statutory mandate takes precedence over general moral objections. The *Brophy* court took a conciliatory approach that met the needs of both patient and physician. In these cases and others,[61] advance notice to patients and assistance in meeting their goals strengthen the health care provider's ability successfully to assert his or her own conscience-based rights.

Privileged Religious Objections

The Colorado Constitution protects "liberty of conscience" in the context of religious freedom.[62] Although Colorado courts have broadly interpreted "religion,"[63] the courts have not defined this constitutional liberty in the medical treatment context. However, other states with similar constitutional language have restricted conscientious objections to those based on religious beliefs—as opposed to ethical or moral ones.

In *Preterm Cleveland v. Voinovich*, an Ohio court ruled that a law requiring physicians to provide information to women seeking abortions did not violate the state constitutional guarantee of the right "to worship Almighty God." The court ruled that the constitutional provision did not confer a general right of conscience, but only one based on religious freedom. Because the law at issue did not infringe on any explicit religious practice, it was constitutionally valid.[64]

In Illinois, a nurse relied on a state statute in asserting that she was wrongfully terminated after refusing to evict a bedridden patient because she considered the order personally immoral. The court in *Free v. Holy Cross Hospital*[65] upheld the termination because the state law protected objections for reasons of conscience only when based on religious beliefs. The court in *Doe v. Bridgeton Hospital Association, Inc.*[66] reached a similar conclusion in holding that New Jersey law limited the right to refuse to perform abortions to sectarian institutions. Nonsectarian, private, not-for-profit hospitals lacked the same right.

Thus, religious-based rights have received greater deference than purely moral or ethical ones. A physician is likely to be more successful in exercising the right to conscientiously object if the objection is religiously grounded rather than based on moral or ethical values. Only in the case of abortion is the right to refuse participation so well-accepted that any objection is likely to be protected.[67]

Potential Financial Liability

Just as financial liability can result when a physician deviates from good medical practice and harm to the patient results,[68] so can liability ensue as a result of a conscientious objection. Consider a chronic alcoholic patient with cirrhosis of the liver and in need of a transplant. The patient's physician refuses to refer the patient for a transplant on moral grounds, and the patient suffers as a result. Alternatively, consider the patient discussed earlier who wants an ultrasound to determine gender, and intends to abort any female fetus. The patient's physician refuses to perform the test because of moral objections and does not discover that the patient suffers from some undiagnosed pathology that the ultrasound would have detected.

In both cases, the physician could be financially liable for the harm to the patient. Accordingly, when conscientiously objecting, protocols must be meticulously observed regarding referral and transfer to assure the patient's needs also will be met.

The intentional nature of a conscience-based decision also could threaten coverage under physicians' liability insurance. Many policies exclude coverage for injuries caused by an intentional act of the insured.[69] As the U.S. District Court for the District of Colorado has stated, "[c]overage is excluded when the insured's act is intentional and causes harm that reasonably could have been expected to flow from the intentional act."[70]

In the case of a conscientious objection, the physician intends to object to a course of treatment although the physician has no intention to harm the patient.[71] Accordingly, after a conscientious objection to treatment that foreseeably harms a patient, an aggressive insurance carrier might assert that the intentional objection to an accepted treatment constitutes a waiver of coverage. Although the carrier might be considered to be acting in bad faith, bad faith denial of insurance coverage does occur in Colorado.[72]

Avoiding Patient Abandonment

The burden of justifying deviation from the duty to provide good medical care for moral reasons rests squarely on the physician. As in the analogous and better-established area where a patient acts against

medical advice, the physician must carefully minimize any negative impact on the patient and avoid patient abandonment.

The physician can be held responsible for abandonment if he or she ends treatment of a patient, unless protocols are observed to protect the patient.[73] When a physician decides to terminate treatment, that decision must be preceded by advance notice to the patient.[74] Notice is not an end in itself, but must be sufficient to allow a patient to procure substitute medical care.[75] The patient's condition and availability of other resources must be considered in determining whether the patient has viable therapeutic alternatives.

For example, in *Brandt v. Grubin*, a psychiatrist had ceased treating a patient who later committed suicide. The court ruled that the psychiatrist was not liable because there were "specific clinics where specialized help would be available, and the patient actually underwent care at one of these clinics."[76] In *Sibert v. Boger*, a physician was ruled not liable for negligence and abandonment of a patient he had ceased treating, because in his urban location "medical service could have been obtained any day."[77] Physicians practicing in some settings, such as the military or in a rural area, may be foreclosed from exercising conscience-based rights because their patients have limited alternatives.

With both conscience-based conflicts and situations where patients act against medical advice, ethics and law require similar safeguards to protect the welfare of patients: informing a patient of all options, assistance in exercising therapeutic alternatives, and referral to a willing provider.[78] The ability of the patient to find the desired medical treatment elsewhere, without being disadvantaged, is the crucial prerequisite, allowing the safe termination of the physician-patient relationship. If referral and transfer are not feasible, the only prudent course would be to subordinate any moral objections to the patient's therapeutic choices.

Conclusion

No physician should imagine that there is a general right to conscientiously object to treating a patient after the physician-patient relationship has been established. There is not. Even where there is an explicit right of conscience, a physician may still be liable unless he or she carefully protects the patient from harm. The consequences of a conclusion to the physician-patient relationship are momentous for everyone involved.

NOTES

1. Bartlett, *Familiar Quotations* (Boston: Little, Brown, 1901).

2. *See, e.g., Cruzan by Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 271 (1990); *Washington v. Glucksberg*, 117 S.Ct. 2258, 2272 (1997).

3. *The American College of Physicians Ethics Manual*, Annals of Internal Medicine (1992), 117: 948.

4. *Miller v. Van Newkirk*, 628 P.2d 143, 146 (Colo.App. 1980).

5. *Greenberg v. Perkins*, 845 P.2d 530, 534 (Colo. 1993).

6. Disclipinary actions may include admonition, censure, suspension, or license revocation. CRS §§ 12-36-117 and 118. *See also State Board of Medical Examiners v. McCroskey*, 880 P.2d 1188, 1194-1195 (Colo. 1994).

7. *United Blood Services v. Quintana*, 827 P.2d 509, 526 (Colo. 1992); *Greenberg, supra*, note 5 at 533-534.

8. *See generally* Annas, "Medicine, Death and the Criminal Law," 333 *NEJM* 8 (Aug. 24, 1996); *Matter of Joseph Verbrugge, MD,* No. ME 93-06 (Colo. May 17, 1994); *People v. Einaugler*, 208 A.D.2d 946 (N.Y. App.Div. 1994).

9. Patient-physician conflict in decision making appears significant. *See* Gilbert, "Doctors Often Fail to Heed Wishes of the Dying Patient," *The New York Times* (Nov. 22, 1995), A1.

10. The article relates to most providers of health care services.

11. 42 U.S.C. § 300a-7(a-c) (1974).

12. *See, e.g., Swanson v. St. John's Lutheran Hospital*, 597 P.2d 702, 710 (Mont. 1979); *compare Brener v. Diagnostic Center Hospital*, 671 F.2d 141, 143-146 (5th Cir. 1982).

13. 42 U.S.C. § 300a-7(a-c) (1974).

14. The second case comes from bioethicist Thomas Murray at Case Western Reserve University. *See* Lavine, "Who Deserves to Be Born," *The New York Times* (Dec. 29, 1995), A11.

15. What is valid medical treatment in one context clearly may be inappropriate in another. For example, a physician could refuse a request for castration by a member of the Heaven's Gate cult on purely medical grounds, whereas a patient with advanced prostate cancer might insist on castration as medical treatment.

16. American Heart Association, "Guidelines for cardiopulmonary resuscitation and emergency cardiac care, VIII: ethical considerations in resuscitation," 268 *JAMA* 2282 (1992).

17. *See generally* Rosenthal, "Hardest Medical Choices Shift to Patients," *The New York Times* (Jan. 27, 1994), A1.

18. *See, e.g.*, Boffey, "Cloning as an Anticlimax," *The New York Times* (April 1, 1997), A16.

19. H.R. 922, H.R. 923, and S. 368, introduced in early 1997, would ban all human cloning.

20. Altman, "Cross-Species Transplants Raise Concerns About Human Safety," *The New York Times* (Jan. 9, 1996), B7.

21. Goodman, "The Promises and Risks of Animal Transplants," *The New York Times* (June 5, 1997), 18.

22. *See* Francione, "Xenografts and Animal Rights," 22 *Transplantation Proceedings* 1044 (1990).

23. Draft Public Health Service Guidelines on Infectious Disease Issues in Xenotransplantation, 61 F.R. 185: 49,920-49,932 (Sept. 23, 1996).

24. Veatch, *A Theory of Medical Ethics* (N.Y.: Basic Books, 1981).

25. Beauchamp and Childress, *Principles of Biomedical Ethics* (N.Y.: Oxford Univ. Press, 1989), 67-119.

26. *The American College of Physicians Ethics Manual*, Annals of Internal Medicine (1992), 117: 950.

27. Pellegrino, "Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship," 10 *J. Con. H. L. & Policy* 47 (Spring 1994).

28. *Stamford Hospital v. Vega*, 674 A.2d 821 (Conn. 1996) (right to refuse transfusion superior to hospital's interest in protecting patients); *accord Bee v. Greaves*, 744 F.2d 1387, 1392 (10th Cir. 1984), *rev'd on other grounds*, 910 F.2d 686 (10th Cir. 1990); *but contrast Laurie v. Senecal*, 666 A.2d 806 (R.I. 1995).

29. *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 129-130 (N.Y. 1914).

30. *Woodland v. Angus*, 820 F.Supp. 1497, 1516 (C.D.Utah 1993); *Matter of Quinlan*, 355 A.2d 647 (N.J.1976).

31. *Bouvia v. Superior Court (Glenchur)*, 225 Cal. Rptr. 297 (Cal.App. 1986); *Cruzan, supra*, note 2, *but compare Ross v. Hilltop Rehabilitation Hospital*, 676 F.Supp. 1528, 1537 (D.Colo.

1987) (depressed, mentally ill quadriplegic not allowed to discontinue gastrostomy tube feeding).

32. *Vacco v. Quill*, 117 S.Ct. 2293, 2302 (1997); *Washington, supra,* note 2 at 2275. In Colorado, assisted suicide constitutes manslaughter. CRS § 18-3-104(1)(b).

33. *Gilgunn v. Mass. General Hospital*, Superior Ct. No. 92-4820-H (1995); Kolata, "Withholding Care From Patients: Boston Case Asks, Who Decides," *The New York Times* (April 3, 1995), A1. *But see Matter of Baby K*, 832 F.Supp. 1022, 1027 (E.D.Va. 1993) (hospital required under various statutes to treat an anencephalic infant); *see also Suenram v. Society Valley Hospital,* 383 A.2d 143 (N.J. 1977) (cancer patient's right to treatment with Laetrile was superior to disapproval by the state or hospital); *In re Wanglie,* No. Px-91-283 (D.Minn. July 1991). In these cases, where treatment was ordered over professional opposition, a particular law or unusual circumstances has been at issue and no absolute right to treatment has been established.

34. *The American College of Physicians Ethics Manual*, Annals of Internal Medicine (1992), 117: 948.

35. 410 U.S. 113 (1973); *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989).

36. 42 U.S.C. § 300a-7(a-c) (1974). Further impetus for this law arose from the case of *Taylor v. St. Vincent's Hospital*, 369 F.Supp. 948, 950 and n.1 (D.Mont. 1973), where a federal court ordered a private Catholic hospital to allow a doctor to perform a sterilization during a Caesarean.

37. *Maher v. Roe*, 432 U.S. 464 (1977); *Harris v. McRae*, 448 U.S. 297 (1980); *Webster, supra*, note 35; *Rust v. Sullivan*, 500 U.S. 173 (1991).

38. Or. Rev. Stat. § 127.800 (1994); *upheld Lee v. State of Oregon*, 107 F.3d 1382, 1392 (9th Cir. 1997). A bill to repeal the statute has been introduced, Or. S.B. 1216 (1997).

39. A statute similar to the Oregon law, the Colorado Death With Dignity Act, H.B. 96-1185, was introduced January 12, 1996, but withdrawn indefinitely on February 6, 1996.

40. *Washington, supra*, note 2 at 2275, Justice O'Connor, concurring.

41. Wardle, "Protecting the Rights of Conscience of Health Care Providers," 14 *J. Leg. Med.* 177 (June, 1993).

42. CRS §§ 15-14-506, 15-14-507. *See also* CRS § 15-18.5-101 *et seq.*

43. CRS § 15-18-113.

44. CRS § 15-18.6-104.

45. CRS §§ 15-14-504(4), 15-18-112(1), 15-18.5-101(3), 15-18.6-108, 18-3-104(1)(b).

46. 42 U.S.C. § 300a-7(d). *See also Gray by Gray v. Romeo*, 697 F.Supp. 580, 590 n.6 (D.R.I. 1988).

47. *Union Pac. R. Co. v. Botsford*, 141 U.S. 250 (1891); *but contrast Bowers v. Hardwick*, 478 U.S. 186 (1986) (bodily-based rights limited since homosexual practice has no basis in the U.S. Constitution).

48. *Cruzan, supra*, note 2 at 262.

49. 342 U.S. 165 (1952).

50. 316 U.S. 535 (1942).

51. 381 U.S. 479 (1965).

52. *Supra*, note 35.

53. *Supra*, note 2 at 261.

54. 256 Cal.Rptr. 240, 242 (Cal.App. 1989).

55. 629 So.2d 819, 828 (Fla. 1993); *accord Fosmire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1990); *but contrast State v. Perricone*, 181 A.2d 751 (N.J. 1962) (parents guilty of neglect of their infant for refusing, on religious grounds, to grant permission for blood transfusions for the infant).

56. *Supra*, note 46 at 582-583, 586. *See also Matter of Jobes*, 529 A.2d 434, 437, 450 (N.J. 1987) (nursing home forced to remove jejunostomy feeding tube in spite of moral objections).

57. 497 N.E.2d 626, 628, 632, 638-39 (Mass. 1986).

58. *Id.* at 639 n.40.

59. *Supra*, note 33 at 1027.

60. 42 U.S.C.A. § 1395dd; 29 U.S.C.A. § 794; The ADA, 42 U.S.C.A. § 12101, *et seq.*; *see also* The Health Care Decisions Act, Va. Code Ann. § 54.1-2990.

61. *See, e.g., Elbaum by Elbaum v. Grace Plaza of Great Neck Inc.*, 544 N.Y.S.2d 840, 847 (N.Y. App.Div. 1989) (law did not support objections to termination of feeding).

62. Colo. Const. Art. H, Section 4, Religious Freedom. Other statutes protect secular conscience: CRS §§ 15-14-507, 15-18-113, 15-18.5-101, 15-18.6-104, 17-42-101(1), 25-6-201.

63. *See DeBose By and Through DeBose v. Bear Valley Church of Christ*, 890 P.2d 214, 220 (Colo.App. 1995), *rev'd on other grounds*, 928 P.2d 1315 (Colo. 1997).

64. 627 N.E.2d 570, 579 (OhioApp. 1993).

65. 505 N.E.2d 1188, 1190 (Ill.App. 1985); *see also Cohen v. Smith*, 648 N.E.2d 329, 336 (Ill.App. 1995) (Right of Conscience Act in medical treatment limited to religious beliefs).

66. 366 A.2d 641, 647 (N.J. 1976).

67. 42 U.S.C. § 300a-7(a-c) (1974); *Maher, supra*, note 37; *Harris, supra*, note 37; *Webster, supra*, note 35; *Rust, supra*, note 37.

68. *United Blood Services, supra*, note 7 at 526; *Greenberg, supra*, note 5 at 533-534.

69. *American Family Mut. Ins. Co. v. Johnson*, 816 P.2d 952, 954-959 (Colo. 1991).

70. *Allstate Ins. Co. v. Lewis*, 732 F.Supp. 1112, 1115 (D.Colo. 1990).

71. *Butler v. Behaeghe*, 548 P.2d 934, 938 (Colo.App. 1976).

72. *See, e.g., Herod v. Colorado Farm Bureau Mut. Ins. Co.*, 928 P.2d 834 (Colo.App. 1996).

73. *Pearson v. Norman*, 106 P.2d 361, 363 (Colo. 1940).

74. *Goebel v. Colorado Dept. of Institutions*, 764 P.2d 785, 807 (Colo. 1988).

75. *Collins v. Meeker*, 424 P.2d 488, 498 (Kan. 1967); *Lee v. Dewbre*, 362 S.W.2d 900, 902-903 (Tex.Civ.App. 1962).

76. 329 A.2d 82, 89 (N.J.Super. 1974).

77. 260 S.W.2d 569, 571-572 (Mo. 1953).

78. *The American College of Physicians Ethics Manual*, Annals of Internal Medicine (1992), 117: 950.

Community Housing Service Offers Guide on Landlord/Tenant Rights

Community Housing Services, a nonprofit agency in Denver, recently published the second edition of *Know Your Rights: The Colorado Law Guide for Landlords and Tenants*. This book answers questions specific to Colorado landlord/ tenant laws, which can save money, aggravation, and time in court.

No legal training is needed to understand the rights of landlords and tenants as described in this valuable guide. *Know Your Rights* provides information on leases, the eviction process, security deposits, maintenance, and many other issues for people who either own or lease rental property. The income from the sales of this book supports the important work of Community Housing Services in assisting low- and moderate-income people find and retain affordable housing.

Know Your Rights may be purchased for $12.15, including sales tax, postage, and handling. To order, send a check or money order to: Community Housing Services, Inc., 1905 Sherman St., #920, Denver, CO 80203.