Special Section: Conscientious Objection in Healthcare: Problems and Perspectives

How to Allow Conscientious Objection in Medicine While Protecting Patient Rights

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Abstract: Paradigmatic cases of conscientious objection in medicine are those in which a physician refuses to provide a medical service or good because doing so would conflict with that physician's personal moral or religious beliefs. Should such refusals be allowed in medicine? We argue that (1) many conscientious objections to providing certain services must be allowed because they fall within the range of freedom that physicians have to determine which services to offer in their practices; (2) at least some conscientious objections to serving particular groups of patients should be allowed because they are not invidiously discriminatory; and (3) even in cases of invidiously discriminatory conscientious objections, legally prohibiting individual physicians from refusing to serve patients on the basis of such objections is not always the best solution.

Keywords: conscientious objection; medicine; discrimination; rights; law

Guadalupe Benitez and her partner wanted to have a child, but they could not do so without the aid of artificial insemination. Seeking help, they went to the only fertility clinic in the area that accepted their insurance. Under the care of Dr. Christine Brody, Benitez took ovulation-inducing medication and made several attempts to self-inseminate, all of which failed. Eventually it was determined that trying intrauterine insemination (IUI) should be the next step. However, Dr. Brody refused to provide IUI to Benitez because Benitez's partner, Joanne Clark, was a woman, and Benitez and Clark were not married. Dr. Brody said that her religious convictions precluded her from performing IUI on Benitez. After one of Dr. Brody's colleagues, Dr. Douglas Fenton, also refused on religious grounds, Benitez was referred to a different fertility clinic. Benitez did eventually become pregnant via in vitro fertilization provided by the other clinic. However, because the other clinic was not covered by her insurance, Benitez had to pay for the expensive procedure out of pocket. Nearly a decade later, Benitez was finally compensated after successfully suing the clinic on grounds of discrimination in a case that rose to the Supreme Court of California.[1]

Should conscientious objections of the sort made by Drs. Brody and Fenton be legally prohibited? We argue here that they need not be, at least if certain other conditions are met. This is not to say that we agree with the objections of Drs. Brody and Fenton—quite the opposite. Nor is it to say that we do not think that what Drs. Brody and Fenton did was morally wrong—we think what they did was egregiously unjust. Nonetheless, we are not convinced that the best solution to this injustice is to legally forbid individual physicians from engaging

We thank the organizers and participants of the Conscience and Conscientious Objection in Healthcare conference at Oxford Martin School for their many helpful questions and comments on an earlier version of this article. This article also benefited greatly from detailed written comments provided by Katrien Devolder and Angela Ballantyne. Walter Sinnott-Armstrong is grateful to the Oxford Martin School for support.

Cambridge Quarterly of Healthcare Ethics (2017), **26**, 120–131.

doi:10.1017/S0963180116000694

in invidious discrimination. We propose a compromise solution that allows for conscientious objections while at the same time protecting patients from suffering undue burdens because of them.

The framework we propose is not supposed to be a universal solution to conscientious objection. Our aim is far more limited. First, our framework is primarily intended to operate within a context such as the United States, where healthcare is largely privatized rather than provided under a national system such as the United Kingdom's National Health Service (NHS). Second, our framework is not intended to handle all cases of conscientious objection. One task of the first part of the article is to distinguish several different kinds of conscientious objection, each of which we think requires independent consideration. Furthermore, part of our message here is that blanket policies on conscientious objection are not the best choice. Policies regulating conscientious objection must be sensitive to the social and political context in which they are to be enacted and the consequences that they are likely to produce.

Should There Be a Blanket Prohibition on Conscientious Objection in Medicine?

Paradigmatic cases of conscientious objection in medicine are those in which a physician (or other medical service provider) refuses to provide a medical service or good because doing so would conflict with the physician's personal moral or religious beliefs. Such cases are distinct from those in which a physician refuses to provide a service because the service is illegal, unsafe, medically inappropriate, or a violation of clinical norms.[2]

The refusal of Drs. Brody and Fenton to provide IUI to Benitez is one example of conscientious objection in medicine. The physicians cited their religious beliefs as their reason for refusing to provide a safe and legal service that was likely to benefit an informed patient who requested it. Should such refusals be permitted in medicine?

One possible answer is "No, because conscientious objections of any kind should (almost) never be permitted in medicine." Julian Savulescu has defended a version of this answer. He argues that "a doctor's conscience has little place in the delivery of modern medical care,"[3] and that doctors have a moral obligation "to be willing and able to offer appropriate medical interventions that are legal, beneficial, desired by the patient, and a part of a just healthcare system."[4] People who are unwilling to offer such services because of conflicts with their values, Savulescu says, "should not be doctors."[5]

For reasons we will discuss shortly, we deny that doctors have such a general moral obligation. However, our ultimate concern here is with whether there should be a legal prohibition against conscientious objection in medicine. Savulescu does not take a clear stand on this point, but some of his remarks point toward support for a legal ban. He writes, "Conscience… can be an excuse for vice or invoked to avoid doing one's duty. When the duty is a true duty, conscientious objection is wrong and immoral. When there is a grave duty, it should be illegal."[6] We are unsure what Savulescu means by "grave duty"; however, it is clear that he believes that physicians have a weighty duty to provide any medical service that is legal, beneficial, desired by the patient, and part of a just healthcare system. If this duty constitutes a grave duty, then it follows from Savulescu's position that conscientious objection in medicine ought to be illegal in (almost) all cases.

Whether it entails such a legal prohibition or not, we believe that Savulescu's position is untenable. Consider a particular medical service, such as Mohs surgery—a procedure used to remove cancerous skin cells. This service satisfies Savulescu's criteria of legality, benefit, and justice. On Savulescu's view, this means that physicians are morally obligated to provide it. But which physicians? Certainly not all physicians. Heart surgeons and ophthalmologists are not required to treat skin cancer. Nor even are all dermatologists; they are free to subspecialize in acne or psoriasis if they please, and even dermatologists who have chosen to provide Mohs surgery as part of their practice are generally not morally obligated to continue providing it. They are free to shift the focus of their practice to provide other services within their competence instead. Therefore, although Mohs surgery meets Savulescu's criteria of legality, benefit, and justice, a physician who chooses not to provide it as part of his or her practice is not generally violating any moral obligation. This physician is simply exercising the freedom to define the scope of his or her own practice.

Of course Mohs surgery is not a service that many people morally object to. However, the same point applies to more controversial services such as abortion. Medical students preparing to enter the profession are not morally obligated to specialize in obstetrics and gynecology, and those who do are not morally obligated to become abortion providers—they are free to subspecialize in ovarian cancer or infertility if they please. Even an obstetrician-gynecologist who does provide abortions is not usually under a moral obligation to continue providing them. Such a physician may choose to stop providing them for self-interested reasons, such as to avoid the costs and risks of doing so. This is especially true in the United States where abortion providers are often subject to harassment, threats, and violence.[7] In these circumstances, providing abortions involves taking on considerable costs and risks that no physician should be required to take on simply as a requirement of specializing in general obstetrics and gynecology. Therefore, although abortion meets Savulescu's criteria of legality, benefit, and justice, physicians who choose not to provide it as part of their practice are not necessarily violating any moral obligation.

What does this have to do with conscientious objections? Consider two physicians:

> Physician A: An obstetrician-gynecologist who believes that women ought to have access to an abortion, but refrains from offering abortion services as part of her own practice because of the significant costs and risks involved.
>
> Physician B: An obstetrician-gynecologist who believes that abortion is murder and should never be permitted, and, therefore, refrains from offering abortion services as part of her own practice.

Physician A's refusal to offer abortions does not constitute a conscientious objection, whereas Physician B's does. However, if Physician A is free to refrain from offering abortions, then Physician B must be as well. One cannot prohibit Physician B's conscientious objection while at the same time allowing Physician A to choose whether or not to take on the additional costs and risks involved in providing abortions.

These examples show that Savulescu's view is incompatible with the moral and legal freedom that physicians are, and should be, afforded to define the scope of

their own practices. In most healthcare systems, physicians are generally free to specialize and subspecialize as they please, and even within a specialty, they are free to choose which services they will offer within a reasonable range. Often these choices are based on personal preferences and interests. For example, psychiatrists may limit their practice to a particular mental health issue that they are most interested in, for example, eating disorders, thereby refusing to offer a wide range of other psychiatric services. Physicians may also choose not to offer certain services that involve taking on greater liability or costs. As Mark Wicclair notes, "health care professionals can refuse to provide a good or service for a variety of self-interested reasons—broadly understood to include concern for one's own health and well-being as well as of persons one cares about."[8]

If physicians are free to refrain from offering a service on the basis of their personal preferences or interests, then physicians must also be free to refrain from offering that service on the basis of moral or religious objections to it. The fact that a physician declines to offer a particular service for moral or religious reasons rather than for self-interested reasons cannot make a difference to whether that physician is permitted to refrain from offering it. Therefore, many instances of conscientious objection must be allowed simply because they fall within the range of freedom that physicians have to define the scope of their practices. No blanket prohibition against conscientious objection in medicine is tenable.

Of course physicians do not have unlimited freedom to choose which services they offer. They are subject to several constraints that preclude certain choices, including certain choices based on conscientious objections. We will briefly discuss just three such constraints here.

First, the extent to which physicians are free to determine the scope of their own practice varies across different health systems. A physician working in a private practice in the United States has much greater leeway to decide which services to offer than a physician employed by a public health system such as the United Kingdom's NHS. This is because physicians within the NHS have certain contractual obligations incurred upon accepting their employment. These obligations may preclude some conscientious objections. If a physician voluntarily signs a contract that requires the physician to provide abortions, then the physician cannot refuse to provide abortions without breaching his or her contract. However, this does not mean that any physician without such a contractual obligation is morally obligated to provide abortions. Nor does it show that any physician is required to enter into such a contract, or that the NHS must or should include such requirements in its contracts.

Second, even in private practices, physicians do not, and should not, have unlimited rein to decide which services they will offer. Certain services are so essential to the practice of medicine, or to the practice of a particular specialty, that offering them is never within a physician's discretion. For example, a primary care provider may not refuse to offer physical examinations. This rules out some conscientious objections. For example, a male gynecologist cannot refuse to treat women on the basis of a religious objection to intimately examining members of the opposite sex. Someone with such an objection should not become a gynecologist. However, this religious objection should not preclude him from becoming a physician. He could choose a specialty, such as psychiatry, where intimate physical inspections are generally unnecessary.

Third, in emergency situations, physicians may be required to provide services that they are competent to provide but have chosen not to offer as part of their regular practice. This constraint has limited import here because the cases that are usually at issue in debates about conscientious objection are not emergencies. Granted, there are exceptions to this generalization, such as cases where an abortion is necessary to save a mother's life. In such cases, the obligation to provide life-saving treatment may include the obligation to provide an abortion.

These constraints show that physicians' freedom to choose which services they offer is not unlimited. However, these constraints do not amount to an obligation to provide any service that meets Savulescu's criteria. Nor can they be grounds for a general prohibition against conscientious objection in medicine. As long as physicians are allowed some range of freedom to determine the the scope of their own practices based on their preferences and interests, they must also be allowed to make choices within that range on the basis of their moral and religious values.

What About Discrimination?

So far, our argument has emphasized the freedom that physicians have to determine which services they offer. Now we ask, to what extent are they also free to choose which patients they will offer those services to?

At this point we must distinguish two different kinds of refusals:

1) Cases in which a physician refuses to provide a service because of the nature of the service itself (e.g., abortion or euthanasia).
2) Cases in which a physician refuses to provide a service to a particular patient because of some characteristic of the patient (e.g., being gay or unmarried).

In cases of type 1, the identity and characteristics of the patient are irrelevant. The physician deems the service itself to be immoral regardless of whom it is performed on. In contrast, the identity and characteristics of the patient are what matter to the physician in cases of type 2. The physician would willingly provide the service to some patients but not to other patients. Of course, these reasons are not exclusive; therefore, we could construct a case in which a physician has both kinds of reasons. Nonetheless, the reasons are still distinct.

One might wonder whether this distinction can be drawn for sex-specific procedures? The answer is yes, because the distinction has to do with the *reasons* the physician has for objecting. If a physician objects to abortion solely because of the nature of the procedure (such as that, in that physician's view, it involves killing an innocent person), then the fact that all abortion patients are women is irrelevant to this physician's reasons for refusing to perform the procedure. This physician would refuse to perform an abortion on a male who somehow became pregnant (do not ask how). Because the gender of the patients is not the basis of the physician's objection, this case would be considered type 1 rather than type 2. This is not to suggest that all objections to abortion are of type 1. We grant that explicit or implicit sexist attitudes and beliefs may explain much of the opposition to abortion that presently exists in the United States and elsewhere. However, this does not show that no refusals to perform abortions are purely of type 1, even if most are of type 2 or a mix of both types.

Returning to our main argument, so far we have shown that many conscientious objections of type 1 must be allowed because they fall within the range of freedom that physicians have to define the scope of their practices. But does this freedom also cover conscientious objections of type 2? Are physicians free to choose which patients they will provide services to just as they are free to choose which services they will offer?

To some extent, they must be. Many of the choices that physicians make about how to specialize are in essence choices to work exclusively with a particular patient population. For example, those who enjoy working with children are free to become pediatricians and treat only children, and those who want to treat only women can become gynecologists or seek employment in a women's hospital. Of course such choices are rarely, if ever, made on the basis of moral or religious objections to treating adults or men. But if physicians are free to choose to work with a particular patient population on the basis of their personal preferences and interests, must not they be free to make such choices on the basis of their moral and religious beliefs as well?

Consider the case of Benitez that we described at the outset. This is clearly a case of type 2. Drs. Fenton and Brody had no objection to IUI as a procedure. What these physicians objected to was performing that procedure on an unmarried lesbian. Why was it wrong for them to restrict their practice on the basis of these religious beliefs? Why could they not simply define their practice as providing fertility treatments to married heterosexual women?

We suggest that the answer has nothing to do with conscientious objection per se. The problem is not that the physicians brought their religious values into medicine. Rather, the problem is that in doing so they engaged in invidious discrimination. And physicians, like everyone else, have a moral duty not to invidiously discriminate. The American Medical Association Code of Medical Ethics is explicit on this point:

> The creation of the patient-physician relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, *physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination.*[9]

To what extent does this obligation rule out conscientious objections in medicine?

First, the obligation not to engage in invidious discrimination does not seem to preclude conscientious objections of type 1. If a physician's reasons for refusing to provide active euthanasia are based solely on the procedure, then those reasons seem not to discriminate against anyone or any group. Admittedly, cases of type 1 still might have discriminatory effect on one person or group. If all or a large number of physicians refuse to perform abortions, resulting in inadequate or unfair health services for women, then one can say that there is discrimination against women at the level of the system—that the system fails to adequately provide a service that many women need. Still, as long as the individual physicians refuse

because of the nature of the procedure rather than because of the gender of the patients, the grounds for the individual physicians' refusals are not invidiously discriminatory.

What about cases of type 2? Not all cases of type 2 are invidious discrimination. Physicians at women's hospitals do not provide services to men, but such hospitals are not guilty of invidious discrimination against men. Why not? Because invidious discrimination necessarily involves a negative attitude or judgment about the person or persons being discriminated against, and physicians at women's hospitals do not base their refusal to serve men on such negative attitudes or judgments. There are also men's health clinics that specialize in treating men's health issues. The refusal of such clinics to provide services to women is not invidiously discriminatory because that refusal is not based on negative attitudes or judgments about women.

Of course physicians who choose to work in women's hospitals or men's health clinics do not typically do this on the basis of conscientious objections to treating members of the opposite sex. But what about physicians who do conscientiously object to providing certain services to members of the opposite sex? For example, a survey conducted in the United Kingdom found that 36 percent of Muslim medical students objected in principle to performing intimate inspections of patients of the opposite sex.[10] Do such objections constitute invidious discrimination? Not necessarily. Some might insist that the Muslim doctrines that forbid inspection of members of the opposite sex are themselves invidiously discriminatory, but we will not get into that debate here. We assume that at least some Muslim physicians object to intimately inspecting members of the opposite sex while still respecting and valuing them and their rights. On that assumption, and given that it is permissible for women's and men's health clinics to provide services only to one gender of patients, it is difficult to see why it would be impermissible for Muslim physicians to provide services only to patients of their own sex. For example, a female Muslim physician could choose to practice in a women's health clinic where intimately inspecting members of the opposite sex is unnecessary. The fact that she cites religious reasons for her choice does not magically transform a practice that is not invidiously discriminatory—providing services only to women—into an invidiously discriminatory one.

Now consider a more restricted set of cases:

3) Cases in which a physician refuses to provide a service to a particular patient because of some *negative attitude or judgment* about some characteristic of the patient.

Are cases of type 3 necessarily cases of invidious discrimination? No. Although a negative attitude or judgment is necessary for invidious discrimination, it is not sufficient. Suppose that a physician refuses to treat an admitted, active pedophile for erectile dysfunction because that physician correctly judges that the pedophile is highly likely to reoffend. This is a negative judgment about the patient, but refusing to treat in this case is not invidious discrimination, in our opinion. Of course there are difficult questions about exactly what sort of care may be withheld from patients whom a physician justifiably fears may commit a crime,[11] but we set those aside for now.

To isolate cases of invidious discrimination we need to add one more word:

4) Cases in which a physician refuses to provide a service to a particular patient because of some *unjustified* negative attitude or judgment about some characteristic of the patient.

The case of Benitez is an example of type 4. Drs. Brody and Fenton held unjustified negative attitudes towards Benitez's sexual orientation and marital status. Those negative attitudes were the primary reason that they refused to provide IUI to Benitez. This was invidiously discriminatory, and physicians, like everyone else, have a moral duty not to engage in invidious discrimination. Drs. Brody and Fenton violated this moral duty. Therefore, although we have argued that many kinds of conscientious objection do not violate physicians' moral duties, this does not include the religious objections of Drs. Brody and Fenton. What Drs. Brody and Fenton did was wrong. But should it be illegal?

Should Discriminatory Conscientious Objection Be Against the Law?

Just because an action is morally wrong does not entail that it ought to be illegal. To determine whether it should be illegal, it is important to ask whether it is a legitimate domain for the law to become involved in and whether making it illegal is the best solution to the underlying moral problem. We grant that the law may legitimately intervene to prevent invidious discrimination in medicine. We therefore focus our attention on the second question: Whether legally prohibiting invidiously discriminatory conscientious objections is the best solution to the problem. To answer this question, we must consider the costs and probable effects of various legal interventions.

One way for the law to become involved is to legally prohibit individual physicians from engaging in conscientious objections of type 4. Individual physicians who refuse to treat patients on the basis of unjustified negative attitudes would then be subject to lawsuits and possible legal sanctions. This would, in effect, legally require some physicians to provide services to patients they believe it is immoral to provide those services to. What would such a law achieve?

One answer is simply that it would force physicians to serve patients like Benitez whom they would otherwise refuse to serve because of unjustified negative attitudes or judgments. This might seem to be a good outcome, but is it really? We doubt that legally compelling physicians to serve patients whom they are prejudiced against is really in patients' best interests. Physicians who are forced to treat patients that they object to treating are less likely to devote themselves wholeheartedly to helping those patients get what they want and deserve. And patients who know that their physicians harbor negative attitudes about them are less likely to trust their doctors. Imagine how you would feel knowing that the physician performing an intimate procedure on you holds an unjustified negative attitude toward your sexual orientation or your marital status. Forcing physicians to treat patients they object to treating is not conducive to good physician–patient relationships.

A different answer would focus on changing the underlying unjustified negative attitudes. Perhaps prohibiting physicians from acting on the basis of their prejudices will reduce the incidence of such prejudices? Maybe, but it might also

lead to such prejudices becoming even more entrenched. Although we agree that society must work to change unjustified negative attitudes, marginalizing physicians who hold such attitudes and forcing them to act against their consciences is unlikely to be the most effective means of doing so.

The strongest reason for legally prohibiting physicians from engaging in invidious discrimination looks at the systemic injustices that such discrimination contributes to. The refusal of some fertility doctors to provide IUI and other treatments to lesbian patients often places undue burdens on those patients, simply because of their sexual orientation. Benitez, for example, was forced to seek treatment from a clinic that was not covered by her insurance, costing her thousands of dollars. One can easily imagine circumstances in which such discrimination makes fertility treatments inaccessible to lesbian couples either because they cannot afford them, or because there are simply no clinics in the area willing to provide them. Although couples are always free to seek help outside of their area, not everyone has the resources or leeway to move or travel somewhere for treatment. In some cases, these barriers may even prevent same-sex couples from having the children that they would otherwise have. In short, discrimination against same-sex couples creates significant—and sometimes insurmountable—barriers to having children that are not faced by heterosexual couples. That is unjust. However, we are still not convinced that legally requiring individual physicians to serve patients whom they object to serving is the best solution to this injustice.

A Framework for Allowing Invidiously Discriminatory Conscientious Objection

The strongest reason to ban invidiously discriminatory conscientious objections of type 4 is to prevent undue burdens from being imposed on some disadvantaged subset of patients. However, that admirable goal is not sufficient to justify a legal ban when the same goal could be achieved by another means at less cost, including fewer restrictions on the freedom of physicians. Even Savulescu admits this: "When a doctor's values can be accommodated without compromising the quality and efficiency of public medicine, they should, of course, be accommodated. If many doctors are prepared to perform a procedure and known to be so, there is an argument for allowing a few to object out."[12]

Is there a way to accommodate physicians' conscientious objections to serving certain patients without unduly burdening those patients or compromising their medical care? In what remains, we outline one way that this could be accomplished. The key moves in our proposal are to focus on the clinic or hospital instead of the individual physician, and then to shift the costs of invidiously discriminatory conscientious objections from innocent patients to those who assert the objections. Our proposal consists of three key elements.

First, *publicity*. Any physician, hospital, or clinic that refuses to treat a particular patient population must publically announce that fact. For example, a fertility clinic that refuses to treat lesbian couples must include a statement to that effect on its website and in its promotional materials. Why? Because this publicity is needed in order to save time, costs, and embarrassment when a lesbian couple goes to a clinic only to be told that they will not be treated there. In addition, it also exposes the clinic to public scrutiny for their refusal. Those who want to protest against such views will know where to protest, and we personally will be happy to join such protests.

Second, *provide information*. A physician or clinic that refuses to serve a patient because of a conscientious objection to some characteristic of the patient must provide the patient with the name of another physician who will serve them. Of course, some physicians and clinics will object, because they think that it would be immoral for them to refer patients to physicians who will do what they see as immoral. However, when they tell patients about other physicians, they do not have to encourage or even approve of what those patients or physicians do. This would not be a formal referral.[13] This need not even be done directly by the physician—the clinic could provide information sheets or have links to other physicians on their website. All they are required to do is provide information in a clear and accessible way. And it is important to note that there is a crucial difference between expressing approval of something and simply providing the information that others are willing to do it. The former can be immoral in cases in which the latter is not.

Moreover, a physician is supposed to provide a patient with information about all options that are reasonable, even if the physician thinks that one of the reasonable options would be a mistake. That is required for informed consent to a medical procedure. If one physician refuses even to tell a patient about another physician, the refusing physician must deny that the other physician provides a reasonable option. That physician must assume that the other physician is unreasonable. In that way, physicians who refuse to inform their patients about other physicians disrespect their fellow physicians. A physician who engages in conscientious objection asks us to respect his or her religious views; therefore, it is unfair for that physician not to respect others' in return. We do not have to respect their views if they do not respect ours.

Third, *paying costs*. Suppose that a physician publicly refuses to provide a service to a certain patient and tells that patient about another physician who will provide that service to that patient, so that the first two principles are met, but suppose that the other physician costs more or is far away. That is what happened when Benitez had to go to a clinic that did not take her insurance. Who should have to pay the extra costs?

It might seem that the physician should pay the costs because the physician who engages in conscientious objection is the one who causes the problem. For example, Dr. Brody engaged in invidious discrimination; therefore, it is natural to see her as creating the extra expenses for Benitez. However, this is too simple. If the physician works for a clinic or hospital, then there will be much less of a problem if that clinic or hospital has other physicians on staff who are willing to treat that patient. Benitez, for example, would not have been forced to go elsewhere if some other physician in the same clinic had agreed to perform IUI for her, despite the refusal of Dr. Brody. Then her insurance would have covered the procedure, and Benitez would have had no extra expenses as a result of Dr. Brody's refusal. Therefore, the ultimate problem was not just Dr. Brody, it was the clinic's failure to have any physician on staff who was willing to provide IUI to Benitez. We conclude that it is the clinic that should pay any extra costs that Benitez incurred.

This gives clinics a choice. One option would be for the clinic to hire sufficient staff who do not object to serving that population. Another option would be for the clinic to pay the extra costs for patients to go elsewhere. These extra costs would include not just the clinic bill but also any additional costs, including time and transportation to the other clinic. These costs can be high if patients have to go far away to get treatment.

Either choice will increase the clinic's expenses. Hiring extra staff and paying for patients to go elsewhere both affect the clinic's bottom line. However, although those expenses might be bad for the clinic, they are good for society. First, they are necessary to protect innocent and often disadvantaged patient groups. These expenses are costs of doing business fairly. Second, these financial pressures will motivate progress in the long run. Clinics can avoid these expenses simply by hiring physicians who treat all patients equally. As a result, those physicians will have a market advantage. They will have an easier time finding employment, and they will garner higher salaries. Over time, financial incentives will decrease the number of physicians who engage in invidious discrimination.

Remember also that this third principle applies only to cases of invidious discrimination, that is, cases in which a physician refuses to perform a procedure because of some unjustified negative attitude toward the patient. When women-only clinics refuse to treat men, this discrimination is not invidious as long as it is not based on any negative attitude toward men. Moreover, the existence of women-only clinics does not typically cause men to incur extra costs or place them under other undue burdens. Physicians in women-only clinics should publicize that they do not treat men, and they should tell men where they can find another physician who will treat them, but there will be no extra costs for them to pay, because women-only clinics do not place undue burdens on men.

In addition to incentivizing social progress, our proposal also has the benefit of preserving the freedom of individual physicians. Admittedly, it still restricts the freedom of clinics, but clinics are contractual and commercial institutions—they do not have consciences in the same way that individual physicians do; therefore, their claims to conscientious objection have less weight. It also provides clinics with a choice—they can either hire staff without conscientious objections, or they can pay the costs incurred by those they unjustifiably refuse to serve. Providing them this choice affords them greater freedom than simply banning invidiously discriminatory conscientious objections altogether.

Of course, one might wonder why preserving this freedom is good when it amounts to preserving the freedom to engage in invidious discrimination. One possible answer is that allowing physicians the freedom to abide by their consciences is valuable, even when their consciences are gravely mistaken. Another answer goes back to our discussion of the doctor–patient relationship. Allowing physicians to refuse to serve patients whom they are prejudiced against protects patients from being treated by physicians who hold unjustified negative attitudes toward them. As we said earlier, this is important both in terms of physicians' ability to wholeheartedly work for their patients' benefit, and in terms of a patients' ability to trust her physicians.

Further Questions

What we have provided here is only an outline of a proposal—many details would need to be filled in before it could actually become a policy. One might also ask how far we are willing to go with this framework. What if a disadvantaged patient group cannot find adequate healthcare anywhere because so many physicians refuse to treat them? What if a patient with body integrity identity disorder (BIID) requests amputation of a healthy limb? What if a physician in a fertility clinic refuses to treat a woman on the basis of moral and religious beliefs that the mixing

of races is contrary to God's will? What if a county clerk refuses to issue marriage licenses to gay couples? What if a baker refuses to make a wedding cake for a gay couple? In each of these cases, our reply is that we need to look carefully at the particular circumstances, and consider the merits of various possible solutions. We do not claim that the law should never outlaw any form of conscientious objection in medicine, much less that the law should never forbid conscientious objection by county clerks or bakers. We take no position here on whether society should prohibit conscientious objection in the additional cases listed in this paragraph. For now, our aim has only been to show why allowing some conscientious objections, even invidiously discriminatory ones, might be a better solution than banning them.

Overall, then, we have argued that: (1) many conscientious objections to providing certain services must be allowed because they fall within the range of freedom that physicians have to determine which services to offer in their practices; (2) at least some conscientious objections to serving particular groups of patients should be allowed because they are not invidiously discriminatory; and (3) even in cases of invidiously discriminatory conscientious objections, legally prohibiting individual physicians from refusing to serve patients on the basis of such objections is not always the best solution. Allowing such objections within a framework that mitigates the burdens imposed on patients affords physicians greater freedom and avoids forcing both doctors and patients into potentially noxious doctor–patient relationships.

Notes

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