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When conscientious objection runs amok: A physician refusing HIV preventative to a bisexual patient

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Abstract

This paper reports of a case where a physician conscientiously objected to prescribing PrEP to a bisexual patient so as not to "enable immoral sexual behavior." The case represents an instance of conscience creep, a phenomenon whereby clinicians invoke conscientious objection in sometimes objectionable ways that extend beyond the traditional contexts of abortion, sterilization, or physician aid in dying. This essay uses a reasonability view of conscientious objection to argue that the above case represents a discriminatory instance of conscience creep that should not be permitted.

Keywords

Conscientious objection, LGBTQ, discrimination, reasonability

The case

A male patient was seen by his primary care physician at a student health clinic—a compensatory service provided to this patient for being a teaching assistant at his university—and requested a prescription for the HIV preventative known as PrEP (Pre-Exposure Prophylaxis).[a] PrEP is a safe, effective, FDA-approved daily medication that works to block important pathways used by HIV to set up the infection. In his medical history, the patient disclosed that he engages in intercourse with both males and females, prompting the physician to tell the patient that, given the Catholic commitments of the university, such a prescription could not be written before the administration was consulted. The patient left without the prescription but with a promise that he would be informed of a decision soon. Upon discovering that no *Catholic* objection to prescribing PrEP exists, the physician decided to conscientiously object to prescribing PrEP to the patient. Citing his religious beliefs, the physician, sincerely believing the patient's sexual lifestyle to be sinful, refused to write a prescription that would "enable immoral sexual behavior," and thus render him complicit in harming the well-being of his patient. Only after several weeks had passed did another physician, who was informed of the situation, step in and prescribe the medication to the patient.[b]

Referral, conscience creep, and reasonability

Mark Wicclair has described three general approaches to conscientious objection. At one extreme, Conscience Absolutism asserts that conscientious objections should always be permitted, while at the other extreme, the Incompatibility Thesis asserts that conscientious objections should never be permitted. In the middle, compromise approaches offer criteria that conscientious objections must meet to be honored.[1] Most compromise views include a referral criterion, which holds that physicians may conscientiously object so long as they refer; they may "step away, but not between, patients and their access to legal, professionally accepted medical treatment".[2] The referral approach has been generally accepted as an ethical compromise when physicians invoke conscientious objections in traditional contexts, such as abortion, sterilization, or physician

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aid in dying (PAD).[3] However, the phenomenon of conscience creep has put pressure on the referral approach. Conscience creep refers to the number of ways conscientious objection is invoked outside of traditional contexts, affirming a worry that permitting conscientious objection will, in the words of Julian Savulescu, lead to a "Pandora's box of idiosyncratic, bigoted, discriminatory medicine".[4] The opening case describes an instance of conscience creep that challenges the referral view in just the sort of way Savulescu imagined.

Wicclair's compromise approach to conscientious objection prohibits discrimination against members of the LGBTQ community. To support this criterion, Wicclair cites professional codes that prohibit discrimination based on sexual orientation and gender identity, concluding that until "good reasons" can be presented to defend the differential treatment of this population, then it should be considered discrimination.[1] The trouble with Wicclair's view is that he has not articulated a way to assess what constitutes a good reason. Reasonability approaches to conscientious objection have attempted to develop standards for evaluating whether the reasons given for an objection are "good".[5] Using the reasonability view of conscientious objection advanced by Jason Eberl,[6] this article argues that a physician's conscientious objection against members of the LGBTQ community should not be permitted because no "publicly defensible reasons" can be given to justify the differential treatment of this group.

Eberl argues that to be honored, a conscientious objection must be reasonable, meaning it must be possible to offer an argument for the objection that is defensible within the public sphere. To be defensible in the public sphere, an argument must not rely upon faith-based premises, although it may lead to a conclusion that is consistent with the conclusions of other arguments that rely on faith-based premises.[6] For example, physician aid in dying, which is opposed by Catholicism using arguments relying on faith-based premises (e.g., one has a duty to God to refrain from suicide), can also be opposed using secular arguments such as Daniel Callahan's view that PAD does not fall within the proper scope of medical practice, which is the healing of broken bodies.[7] Furthermore, Eberl draws a common distinction between objections to performing a specific type of action (e.g., abortion, PAD), and objections based on discrimination—the differential treatment of an individual based on a morally irrelevant trait. Determining whether differential treatment of LGBT individuals constitutes discrimination depends on whether reasonable arguments can be publicly defended that conclude the LGBTQ lifestyle constitutes a morally relevant trait—a question intensely debated in the U.S. context.

Discrimination

In the opening case, the physician believed the LGBTQ lifestyle to be morally relevant because it causes harm to self and others. Judgments of harm can be complex: They require determining who ought to be considered (e.g., only the patient, the family, society as a whole), whether only imminent harm or also future-oriented harm may be considered, and, finally, what kinds of harms count. Considering significant physical harm (e.g., disability, severe suffering, death) are uncontroversial, but debate surrounds whether other types of harm (e.g., psychological, social, or financial) ought to be included. For example, Maura Priest has argued that the harm principle should be extended to include psychological harm and used as a basis to override parental refusals of puberty-blocking hormones for transgender children.[8]

In refusing PrEP to a bisexual patient, the physician in the above case is not considering physical, psychological, social, or financial harm, but rather, what Gregory Bock calls "spiritual harm" in his moral calculus.[9] Bock's conception of spiritual harm includes both (1) consideration of how a patient might be "ostracized or excommunicated" by their spiritual community, and (2) acknowledgment that "there might be eternal consequences that cannot be undone".[9] The physician invokes the second, metaphysical sense here with his concern that providing the medication will enable his patient to engage in activity that may have eternal consequences.

However, by grounding his objection in religious belief, the physician makes a judgment of spiritual harm that relies upon a purely faith-based premise—that of the existence of a divine being who has decreed the LGBTQ lifestyle to be sinful—which is the very thing Eberl's reasonability view will not permit. To validate his claim, the physician would have to provide an argument that differential treatment of LGBTQ individuals results in *harm that can be demonstrated in the public sphere* yet attempts to establish such claims have been thoroughly discredited. For example, in 2009 the Catholic League of San Francisco argued it should not be required to adopt children to gay or lesbian parents because such adoptions "would actually mean doing violence to these children" (Catholic League v. San Francisco). Columbia Law School successfully refuted this claim by compiling a list of seventy-five research studies showing that children of LGBTQ parents "fare no worse" than children of heterosexual parents.[c]

The psychological harm to the physician's moral integrity that would result from performing an action

they find ethically objectionable deserves consideration. For example, there are ways to still show respect to the genuine objections of otherwise misguided clinicians by giving them a chance to voice their view to a supervisor, acknowledging the authenticity of their belief, and explaining the ethical position of the institution to ensure LGBTQ patients receive the same treatment as every other patient. Critically, what should be avoided in these cases are easy fixes, like what was done in the opening case, where the physician was permitted to step away and refer to a willing colleague. This accommodation of the conscientious objection sends the message that objections to treating LGBTQ individuals are permissible, reasonable, defensible, or understandable in some sense. Instead, objections to providing the standard of care to LGBTQ individuals should be treated with the same unwillingness to accommodate as a race-based objection. Permitting referral in these cases does more to mask rather than address morally unacceptable behavior in a medical setting.

Claims of discrimination become more complex when physicians object to a procedure that only affects a certain group, such as performing gender-affirming surgery. For example, although he prohibits discrimination, Eberl's reasonability view explicitly permits conscientious objections to performing gender-confirming surgery on the grounds that such objections can be based on defensible arguments, such as contested data as to the efficacy of these surgeries for alleviating gender dysphoria.[6] Eberl is drawing a distinction between impermissible conscientious objections based on discrimination and permissible conscientious objections where a physician refuses to perform a morally contested procedure for any patient. However, the opening case did not involve an objection to a good or service, but an objection to providing a good or service to a particular type of patient (a bisexual patient who engages in "immoral sexual behavior"). There was no reason to think the physician would have objected to prescribing PrEP to a married heterosexual couple desiring HIV prevention. Prescribing PrEP is standard of care for any patient concerned about exposure to HIV and, just like blood pressure medication, should be prescribed to heterosexual or LGBTQ individuals alike.

Conclusion

Conscientious objection runs amok when doctors are permitted to refuse to prescribe the standard of care to certain groups because of discriminatory beliefs. This article argued Eberl's reasonability view articulates a principled standard (public reason) that can be applied to the opening case to conclude that the physician's objection constituted an instance of invidious discrimination. Permitting conscientious objections based on discrimination leaves LGBTQ patients in a position where their ability to access care, such as a prescription for an HIV-preventative medication, may be restricted by the prejudice of their physician. Furthermore, referral in these cases is not ethically permissible, even when a willing colleague is available to ensure timely patient access to care, because it sends a message that these discriminatory objections are ethically permissible. Therefore, refusals to treat LGBTQ individuals fail the reasonability test, constitute discrimination, and should not be permitted.

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Notes

a. PEP, or post-exposure prophylaxis, is prescribed after exposure of an HIV-negative individual to an HIV-positive individual. For more on PrEP and PEP, see: https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/HIVprevention.html.
b. This case occurred at the Student Health Center on the campus of Saint Louis University in the summer of 2018. It should be emphasized that the university has no moral objection to prescribing PrEP to bisexual students.
c. See: http://whatweknow.law.columbia.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-wellbeing-of-children-with-gay-or-lesbian-parents/. The site also lists four studies that concluded children of LGBTQ parents *are* significantly disadvantaged compared to their counterparts of heterosexual parents. One of the studies published in 2012 by Mark Regnerus, has received considerable attention.[10] The Family Research Council cites it as the study to "top all previous research".[11] The validity of the controversial study was lambasted in a letter signed by two hundred sociologists. Controversy over the study lead the publishing journal to perform an internal audit on the peer-review process.[12]

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