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VIEWPOINT

Conscientious objection and LGBTQ discrimination in the United States

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Abstract

Given recent legal developments in the United States, now is a critical time to draw attention to how 'conscientious objection' is sometimes used by health care providers to discriminate against the LGBTQ community. We review legal developments from 2019 and present several cases where health care providers used conscientious objection in ways that discriminate against the LGBTQ community, resulting in damaged trust by this underserved population. We then discuss two important conceptual points in this debate. The first involves the interpretation of discrimination (provider versus patient-centered views), and we argue for a patient-centered view; the second involves the use of the people versus procedure distinction to reach a compromise between LGBTQ individuals and the clinicians who do not want to treat them. We argue the distinction is problematic when applied to treatment of the LGBTQ population.

Keywords Conscientious objection · Discrimination · LGBTQ rights · Healthcare access

Given recent legal and political developments, now is a critical time to draw attention to how 'conscientious objection' is sometimes used by health care providers in the United States (US) to discriminate against the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community. A conscientious objection occurs when a clinician refuses to provide or perform a legal and professionally accepted medical good or service on the basis that doing so would violate their deeply held moral or religious values. Laws and policies protecting the right of a clinician to invoke

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conscientious objection largely originated in 1973 following the Supreme Court ruling in *Roe v. Wade,* which legalized abortion in the United States. Conscientious objection has also been invoked around practice of physician-aid in dying, sterilization, and prescription of emergency contraception. However, some clinicians invoke conscientious objection to treating LGBTQ patients. Conscientious objection to treating LGBTQ patients is often motivated by clinician discomfort with this patient population or clinician opposition to providing treatment that they see as enabling immoral behavior (such as non-heterosexual sex and non-cisgender identity). LGBTQ individuals are already at greater risk across many health metrics, including suicidal ideation, anxiety, eating disorders, HPV infection, breast cancer, cervical cancer, and obesity [1–4]. LGBTQ individuals are also less likely to have health insurance, fill prescriptions, or pursue medical care when needed. Clinicians exacerbate these disadvantages when permitted to invoke conscientious objection to discriminate against LGBTQ individuals. In practice, conscientious objections to treating LGBTQ patients can result in referral to a willing provider, but the legal requirement to refer varies by state. Even when a provider makes a referral, this can result in substantial delays in treatment. Thus, this population suffers, or is at risk for suffering adverse health consequences.

We review legal developments in 2019 and present several cases of health care providers using conscientious objection in ways that invidiously impact the LGBTQ community (Table 1). These illustrate the nature of the discrimination and its effects. Undoubtedly many more instances occur than we present. We then review two important conceptual points in this debate. The first involves the interpretation of 'discrimination' (provider vs patient-centered views), and we argue for a patient-centered view; the second involves the use of a people versus procedure distinction to reach a compromise between LGBTQ individuals and clinicians who do not want to treat them. We argue the distinction is problematic, especially when understood as a phenomenon affecting the LGBTQ population.

Recent developments have brought public attention to the issue of conscientious objection related to LGBTQ rights. In May of 2019, the Trump administration issued a new "Final Rule," [5] by the authority of the Office of Civil Rights in the United States Department of Health and Human Services that substantially expanded the scope of who can object and what can be objected to in the medical context. The approach to conscientious objection in the Trump administration's Final Rule is consistent with a view of conscientious objection that bioethicist Mark Wicclair calls "conscience absolutism." It does not place *any* substantial constraints on the exercise of conscience, effectively permitting clinicians to conscientiously object to serving members of the LGBTQ community [6]. The Final Rule immediately prompted legal complaints from those who argued it would legally permit providers to refuse treatment for LGBTQ individuals [7] and in early November of 2019, a federal judge struck down the Final Rule. The Trump administration made other equally troubling propositions: One would allow taxpayer funded agencies to refuse adoption services to LGBTQ couples on the basis of the agencies' religious beliefs [8]; the other would overturn referral requirements for individual medical providers or institutions exercising conscientious objection [9].

Table 1 Examples of discrimination against LGBTQ individuals

Year	State	Service refused	Reason	Outcome
2001	California	In vitro fertilization	Patients were a lesbian couple	Patient: "It does do a great deal of damage to a person when you tell them they aren't worthy of having a child or having a family." [10]
2006	California	Breast augmentation	"God made her a man."	Patient: "The emotional distress of not having breasts at that time was very significant for me…It was very depressing" [11]
2006	Washington	Medication for diabetes and high blood pressure	The physician stated his religious beliefs prohibited him from providing treatment to a gay man	Patient won legal case against physician [12]
2012	New Jersey	HIV medication and visitation rights	"This is what he gets for going against God's will."	Refusal caused patient to miss five doses of medication [13]
2013	Illinois	Hormone replacement therapy	The clinic stated it "does not have to treat people like you."	Patient: "When they said, 'we don't have to treat people like you,' I felt like the smallest, most insignificant person in the world" [14]
2015	Michigan	Treatment of pediatric patient	Physician stated, "I felt that I would not be able to develop the personal patient doctor relationship that I normally do."	Parents: "We're not your patient—she's your patient […] your job is to keep babies healthy and you can't keep a baby healthy that has gay parents?" [15]
2015	New Jersey	Hysterectomy	Patient received email stating "as a Catholic Hospital we would not be able to allow your surgeon to schedule this surgery."	Patient: "St. Joseph's Healthcare who says it prides itself on a 'patients first' approach, completely disrespected who I am as a person and that is not how a hospital should treat people" [16]
2016	California	Hysterectomy	The Ethical and Religious Directives for Catholic Health Care Services prohibits sterilization except in some circumstances which did not apply in this case	The hospital promptly arranged for Minton's surgery to be performed at a non-Catholic hospital, but Minton's lawyers argued this referral does not absolve the Catholic hospital of discrimination [17]

Table 1 (continued)

Year	State	Service refused	Reason	Outcome
2016	Georgia	Testosterone injections	"What kind of a doctor would prescribe this to a girl?"	"It was already hard enough to get treated with respect by the average pharmacist/doctor/nurse but now they'll have a policy they can point to [in order to] justify their bigotry" [18]
2018	Missouri	PrEP	Physician did not want to "enable immoral sexual behavior" of a bisexual patient	The objection caused a significant delay in the patient receiving the prescription [19]

In June of 2020, the United States Supreme Court ruled that the use of the word "sex" in the Civil Rights Act should be interpreted as prohibiting discrimination based on gender identity and sexual orientation. Before this ruling, the legality of discrimination based on these characteristics had been determined by individual states. Even with this landmark ruling, it remains to be seen how the legal permissibility of clinicians using conscientious objection against members of the LGBTQ community will evolve. As our research reveals in Table 1, proposals by the Trump administration are worrisome given the ways individual physicians and institutions have invoked conscientious objection to enable discrimination against the LGBTQ community, resulting in substantial direct or indirect harm to the health and dignity of this patient population. Direct harm results when treatment to LGBTQ individuals is denied or delayed; indirect harm results when trust is eroded between LGBTQ individuals and their medical providers.

Provider vs. patient-centered views of discrimination

Although most participants in the debate over conscientious objection agree that discrimination should not be permitted, debate continues about the interpretation of 'discrimination.' Some interpret discrimination as occurring when providers are *required* to treat LGBTQ patients against their conscience (a provider-centered view), while others interpret discrimination as occurring when providers are *permitted* to turn away patients based on their LGBTQ identity (a patient-centered view). These contrasting interpretations are present in the debate over the Trump Final Rule that held the provider-centered view of discrimination. Those making legal complaints against the rule held the patient-centered view of discrimination. We hold that the patient-centered view of discrimination ought to take precedence in these cases because, in contrast to providers, LGBTQ patients are a marginalized group who, due to stigma and discrimination, commonly experience health inequities. Not only do they face mistreatment and subpar health care in clinical encounters due to their sexual orientation or gender identity or both [20], they commonly experience impediments to receiving or applying for insurance that is readily available to heterosexual or cisgender (one whose gender identity corresponds with sex assigned at birth) people, or both. For example, cisgender lesbian couples, who are not able to achieve pregnancy without donor sperm, often have to pay extra out-of-pocket for fertility treatments to confirm they need medical assistance to reproduce, whereas cisgender heterosexual couples' claims that they have not been able to conceive via heterosexual intercourse are sufficient proof [21]. Clinicians who conscientiously object to treating LGBTQ patients exacerbate substantial health inequities this population already experiences. As shown by the table above, these health inequities include direct physical (such as refusal of blood pressure medication) or mental health (such as exacerbation of depression and anxiety) harms as well as indirect (such as erosion of trust resulting in reluctance to pursue future medical care) harms.

Unlike LGBTQ individuals, clinicians have chosen to be in their professional roles. Permitting clinicians to consciously object to patients based on their sexual orientation, gender identity, or both, reinforces the problematic belief that LGBTQ

individuals have actively 'chosen' their lifestyle and consequently are ethically blameworthy and are themselves responsible for discriminatory treatment [22]. In short, the patient-centered view of discrimination ought to take precedence because the LGBTQ population is already a marginalized group that suffers from substantial health inequities. They, unlike clinicians, have not chosen to be members of an oppressed group in need of health care.

Even if 'conscience clauses' prohibit clinicians' use of objections to avoid treating LGBTQ individuals as we argue they should, important practical considerations remain: How should LGBTQ individuals respond to learning a provider objects to their identity? Would a member of this population even want to be treated by such a provider? These practical questions fall outside the scope of this paper; we focus primarily on whether law and policy ought to protect providers who conscientiously object to treating LGBTQ individuals. Our sense is that patient-oriented law and policy on LGBTQ discrimination will make discrimination against LGBTQ people socially unacceptable. Success could, over time, reduce the prevalence of objecting providers. We see the United States (US) Civil Rights Act as an informative and hopeful precedent: through its provisions, including the prohibition of discrimination on the basis of race in public accommodations and federally funded programs, it has both chipped away at incidences of structural racism and changed cultural beliefs about the acceptability of racism.

When addressing conscientious objection toward particular groups of people, we advocate for a macrolevel perspective that incorporates justice as a primary consideration. Supporting clinicians who refuse to treat members of a marginalized group based solely on their group membership conflicts with national initiatives to reduce healthcare inequalities for historically disadvantaged groups and violates core virtues of the medical profession, namely the ethical tenet to do no harm. While there is a proper role for respecting clinicians' beliefs, permitting conscientious objection to LGBTQ individuals goes too far by insidiously upholding systemic disadvantages common for this population, and leading to discriminatory practices based on personal characteristics that have no place in medicine.

A compromise: using the people vs. procedure distinction

Some bioethicists have suggested that a compromise approach to LGBTQ discrimination and conscientious objection can be reached using a distinction between objecting to *procedures* versus categories of *people*. For this distinction, the law would not permit a clinician to object to providing a good or service to a type of person, such as a LGBTQ individual, if that clinician is willing to provide the good or service to other types of people. For example, take the 2006 case from Washington in Table 1 involving a physician who did not want to provide medication for diabetes or high blood pressure to an LGBTQ individual. This would not be a valid exercise of conscientious objection under the people versus procedure distinction because that clinician would provide those goods to other types of patients. The physician objected to treating a type of person and not a procedure. According to this distinction, a surgeon who refuses a genitourinary operation as a means of a

gender-affirming procedure would be permitted to conscientiously object because the refusal is to perform a type of procedure, not to treat a type of person [23].

Although this distinction is meant as a compromise position, we anticipate it would prohibit most of the conscientious objections made against LGBTQ individuals—a result we are glad to accept. For example, an endocrinologist would not be permitted to refuse prescribing testosterone to a transgender (one whose sense of personal gender identity does not correspond with sex assigned at birth) male if also prescribing testosterone to cisgender males. These physicians must either conscientiously object to prescribing testosterone to all patients, or none, a choice we anticipate physicians will be reluctant to make. Because treatments are unique to a particular group of people (as for the example of testosterone), this distinction seems weak. Some may claim that gender-affirming surgery (one of many 'top' or 'bottom' surgical procedures that change one's sexual characteristics to better align with their gender identity) for transgender individuals is treatment unique to a particular population. When we look at the component parts of this surgery, however, we recognize that the same procedures are also provided for cisgender individuals. The main difference is the medical reason for the surgery. Transgender men may undergo phalloplasty (a surgical procedure involving the construction, reconstruction, or modification of a penis) as part of gender-affirming care, but cisgender men may also have this treatment in certain situations, such as reconstructive surgery following penile cancer. Thus, it is difficult to see how the people versus procedure distinction applies as most procedures—even ones that may, upon first consideration, seem unique to LGBTQ individuals (as for phalloplasty)—are performed on patients who are not members of the LGBTQ community.

Even if there are treatments that only LGBTQ individuals undergo, we still consider the distinction problematic because it may obscure underlying motivation for refusals: prejudicial beliefs about disadvantaged groups. In other contexts, the invocation of a people versus procedure distinction to mask discrimination would be obviously suspect. Imagine a business owner who denied acting in a discriminatory way against disabled persons in wheelchairs by refusing to build wheelchair ramps, "I don't discriminate against people with disabilities, I just hate these pesky ramps!" As others have argued, it may be difficult, if not impossible, to untangle people's reasons to show that bias against a certain group is not a factor in refusals that target a particular disadvantaged group [24]. We are concerned the distinction could be used to obfuscate discriminatory objections by concealing them as merely objections to types of procedures.

Conclusion

We have provided several examples of cases where clinicians refused care to LGBTQ patients solely due to their sexual orientation, gender identity, or both. We acknowledge that without a national database to track conscientious objections, the stories we have presented only suggest what may be a far more widespread problem of discrimination and adverse health events for a particularly vulnerable population. The debate around conscientious objection and LGBTQ rights is likely to

intensify as technological advances expand the medical possibilities for this patient population, including the use of fertility technologies such as uterine transplants for transwomen, shared motherhood, the use of mitochondrial DNA transfer to produce three-parent babies (human offspring produced using genetic material from one man and two women) for lesbian couples, and the use of synthetic gametes (mature sperm or eggs generated by manipulating stem cells) for same-sex couples to have biologically related children [25]. In order to ensure fair treatment and quality healthcare for LGBTQ individuals, we need to emphasize patient over provider interpretations of discrimination and critically assess the people/procedure distinction in this debate.

Declaration

Conflict of interest The authors have no conflict of interest to report.

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