

William & Mary Journal of Race, Gender, and Social Justice

Volume 16 (2009-2010)

Issue 2 *William & Mary Journal of Women and the Law: 2009 Symposium: From the Courtroom to the Mother's Womb: Protecting Women's Privacy in the Most Important Places*

Article 5

February 2010

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Richard F. Storrow, *Medical Conscience and the Policing of Parenthood*, 16 Wm. & Mary J. Women & L. 369 (2010), <https://scholarship.law.wm.edu/wmjowl/vol16/iss2/5>

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MEDICAL CONSCIENCE AND THE POLICING OF PARENTHOOD

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ABSTRACT

As state and local anti-discrimination provisions become more and more comprehensive, physicians who refuse to treat patients for reasons of sexual orientation or marital status are beginning to face legal liability. Increasingly, physicians are invoking codes of medical ethics alongside more familiar constitutional law claims in support of their claim to insulation from legal liability. This Article explores what medical ethics has to say about physicians who, for sincerely held religious reasons, refuse to treat patients for reasons of sexual orientation or marital status. The issue is explored through the lens of a case recently decided by the California Supreme Court in which infertility physicians refused to help a lesbian couple have a child with the aid of artificial insemination. Through a close examination of the provisions of medical ethics codes and the arguments based on those codes raised in the California case, this Article concludes that medical societies should not support carving out an exception from anti-discrimination laws for physicians who, for reasons of religious conscience, want to express their class-based biases in the clinic.

INTRODUCTION

- I. THE CONTROVERSY
 - II. CODES OF MEDICAL ETHICS
- CONCLUSION

INTRODUCTION

The difficulty a liberal society confronts in seeking to protect autonomy through rights is no more salient than in recent disputes involving the exercise of medical conscience to refuse patients' treatment requests. The traditional understanding of the right balance in this context is that although a "patient retains [a] negative liberty-right to refuse medical treatment, this does not translate to a positive

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liberty-right to demand treatments or procedures that the health care provider finds objectionable.”¹ The traditional understanding rests in part upon considerations of the dignity and autonomy of patients, considerations that were only beginning to take shape at the dawn of the bioethics movement and, in time, became its centerpiece.²

In the course of the maturation of bioethics as a distinct discipline, concerns that the field is insufficiently attentive to issues of social justice have emerged. Scholars of bioethics have begun to attack the traditional understanding as inadequately protective of patients’ interests and rights, particularly patients in underrepresented groups. The attack is especially pronounced in response to reproductive rights and end-of-life controversies.³ In response is an increasingly public and vigorous defense of physicians’ rights that some attribute to the expansion of anti-discrimination regimes to include the activities of private medical clinics, to new contraceptive technologies, and even to doctors’ dissatisfaction with the changing climate of their profession within managed care systems.⁴

An emerging strategy for defenders of medical conscience is to draw a distinction between treatments needed to heal and those elected merely for convenience or to solve some perceived social, as opposed to medical, problem.⁵ This strategy, used previously in the context of voluntary sterilization for social reasons,⁶ is currently in use in private infertility clinics where clinicians may respond to

1. THOMAS MAY, *BIOETHICS IN A LIBERAL SOCIETY: THE POLITICAL FRAMEWORK OF BIOETHICS DECISION MAKING* 9 (2002).

2. See GEORGE J. ANNAS, *AMERICAN BIOETHICS: CROSSING HUMAN RIGHTS AND HEALTH LAW BOUNDARIES* 20-21, 23-24 (2005) (describing a post-WWII climate that gave rise to modern bioethics and the historical human rights components that influenced the modern bioethics movement).

3. See R. Alta Charo, *The Celestial Fire of Conscience — Refusing to Deliver Medical Care*, 352 *NEW ENG. J. MED.* 2471 (2005) (“[I]n recent years, with the abortion debate increasingly at the center of wider discussions about euthanasia [and] assisted suicide . . . nurses and pharmacists have begun demanding . . . a much broader freedom to avoid facilitating a patient’s choices.”); Julian Savulescu, *Conscientious Objection in Medicine*, 332 *BRIT. MED. J.* 294, 295 (2006) (noting that “doctors’ values have reappeared as a right to conscientiously object to offering certain medical services” such as abortion and reproductive services for gay couples); Rob Stein, *A Medical Crisis of Conscience*, *WASH. POST*, Jul. 16, 2006, at A1 (describing medicine’s new practices and controversies arising therefrom).

4. RICHARD E. ANDERSON, *Introduction to MEDICAL MALPRACTICE: A PHYSICIAN’S SOURCEBOOK* ix-x (Richard E. Anderson ed., 2005); David Orentlicher, *The Influence of a Professional Organization on Physician Behavior*, 57 *ALB. L. REV.* 583, 585, 596 (1994) (at time of publication author was Ethics and Health Policy Counsel for the American Medical Association (AMA)); Stein, *supra* note 3.

5. Farr A. Curlin et al., *The Authors Reply*, 356 *NEW ENG. J. MED.* 1891 (2007).

6. See CLIVE WOOD, *VASECTOMY AND STERILIZATION* 102 (1974) (“Some doctors, who naturally regard themselves as healers rather than social workers, do not regard such ‘non-medical’ sterilization as an appropriate operation for them to perform.”).

married couples who cannot conceive or who run the risk of producing genetically compromised offspring as presenting a bona fide medical disorder. These same clinicians may turn away single women or lesbian couples for failing to present with a true medical problem, for presenting with a problem of “medical futility,”⁷ or for being capable only of irresponsible parenthood.⁸ In many jurisdictions, anti-discrimination provisions do not outlaw this refusal of treatment. Moreover, the refusal of treatment is not so easily censurable under existing bioethics principles as is the documented homophobic avoidance behavior of health care providers toward HIV-infected gay men.⁹ Acknowledging the complexity of discriminatory decision-making in infertility clinics, this Article will explore how the commitments of bioethics and human rights can help shape a principled response to the policing of parenthood in the delivery of reproduction-assisting technologies.

A case recently decided by the California Supreme Court, *North Coast Women’s Care Medical Group, Inc. v. San Diego County Superior Court*,¹⁰ tested whether a distinction can be made between prohibited discrimination and protected religious conscience in the delivery of medical treatment. The case involved an infertility clinic that refused to treat a lesbian couple on religious grounds¹¹ and remains a flash-point fueling the ongoing controversy between patient advocates and health care workers who “‘answer to God first.’”¹² The legal

7. GREGORY E. PENCE, RE-CREATING MEDICINE: ETHICAL ISSUES AT THE FRONTIERS OF MEDICINE 162-63 (2000).

8. See Simone Bateman, *When Reproductive Freedom Encounters Medical Responsibility: Changing Conceptions of Reproductive Choice*, in CURRENT PRACTICES AND CONTROVERSIES IN ASSISTED REPRODUCTION: REPORT OF A MEETING ON “MEDICAL, ETHICAL, AND SOCIAL ASPECTS OF ASSISTED REPRODUCTION” HELD AT WHO HEADQUARTERS IN GENEVA, SWITZERLAND 17-21 SEPTEMBER 2001, at 320, 330 (Effy Vayena et al. eds., 2002) (“Most physicians do not restrict their evaluation of a medical indication for treatment to the physical symptoms. The choice of the most adequate treatment often takes into consideration a patient’s finances, family surroundings, mental health, etc.”); M.M. Peterson, *Assisted Reproductive Technologies and Equity of Access Issues*, 31 J. MED. ETHICS 280, 281-82 (2005) (noting that some clinicians purport to use “common sense” to judge what reproduction is “appropriate” and who has adequate parenting ability). A recent study revealed the lack of conformity between programs regarding what factors would compromise one’s fitness to parent or would undermine child welfare. See Andrea D. Gurmankin et al., *Screening Practices and Beliefs of Assisted Reproductive Technology Programs*, 83 FERTILITY & STERILITY 61, 65-66 (2005) (explaining why certain categories of people are turned away). The authors noted that the lack of conformity might be explained by disparities “in local mores, religious beliefs, and religiosity.” *Id.* at 66-67.

9. MEGAN-JANE JOHNSTONE, BIOETHICS: A NURSING PERSPECTIVE 397-98, 403-05 (3d ed. 1999).

10. *N. Coast Women’s Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959 (Cal. 2008).

11. See Bob Egelko, *State High Court to Hear Lesbian’s Case: Doctors Denied Her Infertility Treatment on Religious Grounds*, S.F. CHRON., June 15, 2006, at B5 (providing an overview of the case and commentary).

12. Stein, *supra* note 3.

issue before the court was whether a physician is constitutionally insulated from an anti-discrimination law when the discrimination arises out of the physician's sincerely held religious beliefs.¹³ In addition to the unsuccessful legal arguments they raised, the physician defendants argued that the Code of Medical Ethics governing the medical profession permits doctors to refuse to treat a patient for religious reasons as long as they provide an immediate and effective referral to another physician who will perform the service.¹⁴ Ruling against the physicians, the court took a rigidly doctrinal approach that excluded any examination of the medical ethics arguments that were so prominent in the briefs and at oral argument.¹⁵

This Article explores what medical ethics has to say about physicians who, for sincerely held religious reasons, refuse to treat lesbian couples or single women who wish to pursue parenthood through assisted reproduction. Through a detailed look at the decision in *North Coast* in Part I and how arguments based on the provisions of medical ethics codes were employed by the parties in *North Coast* in Part II, this Article finds that codes of medical ethics embody competing principles that call the anti-discrimination commitments of medical societies into question. While these codes protect physicians in matters of conscience, they also admonish physicians to obey local laws.¹⁶ As state and local anti-discrimination provisions become increasingly comprehensive, the inconsistency in these provisions and the lack of clarity in the codes about how it should be resolved will become more apparent. This Article concludes that the proper balance between these clashing medical ethics commitments, as supported by law, policy, and the pronouncements of medical societies themselves, is to disallow an infertility physician's religious or conscience-based refusal to assist lesbian couples and single women in reaching their reproductive goals.

I. THE CONTROVERSY

North Coast Women's Care Medical Group contracts with insurers to provide infertility treatment to their subscribers.¹⁷ Guadalupe

13. *N. Coast Women's Care Med. Group, Inc.*, 189 P.3d at 962.

14. Petitioners' Answer to Brief for Gay and Lesbian Med. Ass'n et al. as Amici Curiae Supporting Real Party in Interest at 3-4, *N. Coast Women's Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959 (Cal. 2008) (No. S142892) [hereinafter Petitioners' Answer to Brief for Gay and Lesbian Med. Ass'n et al.].

15. *N. Coast Women's Care Med. Group, Inc.*, 189 P.3d at 970-71.

16. CODE OF MED. ETHICS Op. 1.02 (Am. Med. Ass'n 2008-2009) (suggesting that only in the "exceptional circumstance[] of unjust laws" should "ethical responsibilities . . . supercede legal obligations") (emphasis added).

17. *Benitez v. N. Coast Women's Care Med. Group, Inc.*, 131 Cal. Rptr. 2d 364, 367 (Cal. Ct. App. 2003).

Benitez, a lesbian, received basic infertility treatment from North Coast under the terms of her employer-provided health insurance plan until the point where it was clear she would require intra-uterine insemination (IUI).¹⁸ At that point, North Coast raised religious objections to helping her become pregnant, referred Benitez to a clinic not covered by her insurance, and offered to reimburse her for the cost of the treatment at the new location.¹⁹ Although her treatment at the new clinic was successful, Benitez brought suit under the Unruh Civil Rights Act,²⁰ a California law specifically prohibiting sexual orientation discrimination in public accommodations.²¹

Benitez's case was initially thrown out of court based on the Employment Retirement Income Security Act (ERISA) law concerning employee health benefit plans.²² The California Court of Appeal overturned this decision, ruling that federal law does not exempt health care providers from state civil rights laws.²³ Upon a motion for summary judgment, the trial court ruled in favor of Benitez on the grounds that religious freedom did not vest the physicians with an exemption from California's anti-discrimination law.²⁴ It rejected North Coast's motion for summary judgment, ruling that there were triable issues of fact as to North Coast's proffered reasons for discontinuing Benitez's treatment.²⁵ On appeal, the court of appeal decided that the trial court had been hasty in granting Benitez's motion and that a hearing on the issue of North Coast's religious exemption claim would be needed to determine if Benitez's civil rights had actually been violated.²⁶ The California Supreme Court granted review,²⁷

18. *N. Coast Women's Care Med. Group, Inc.*, 189 P.3d at 963-64.

19. *N. Coast Women's Care Med. Group, Inc. v. Super. Ct.*, 40 Cal. Rptr. 3d 636, 640-41 (Cal. Ct. App. 2006), *rev'd*, 189 P.3d 959 (Cal. 2008).

20. CAL. CIV. CODE § 51 (West 2006).

21. *N. Coast Women's Care Med. Group, Inc.*, 189 P.3d at 964.

22. *Benitez v. N. Coast Women's Care Med. Group, Inc.*, No. GIC770165 (Cal. Super. Ct. Apr. 15, 2002), *rev'd*, 131 Cal. Rptr. 2d 364 (Cal. Ct. App. 2003). ERISA sets minimum standards for private employers' retirement and health benefit plans. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 29 U.S.C.).

23. *Benitez v. N. Coast Women's Care Med. Group, Inc.*, 131 Cal. Rptr. 2d 364, 372-74 (Cal. Ct. App. 2003).

24. *Benitez v. N. Coast Women's Care Med. Group, Inc.*, No. GIC770165, at 1, 3 (Cal. Super. Ct. Oct. 28, 2004), *vacated sub nom. N. Coast Women's Care Med. Group, Inc. v. Super. Ct.*, 40 Cal. Rptr. 3d 636 (Cal. Ct. App. 2006), *rev'd*, 189 P.3d 959 (Cal. 2008).

25. *Id.* at 2. At the time of the alleged discrimination, "the Unruh Act did not prohibit discrimination based on marital status." *N. Coast Women's Care Med. Group, Inc.*, 40 Cal. Rptr. 3d at 643.

26. *N. Coast Women's Care Med. Group, Inc. v. Super. Ct.*, 40 Cal. Rptr. 3d 636, 638, 648 (Cal. Ct. App. 2006), *rev'd*, 189 P.3d 959 (Cal. 2008).

27. *N. Coast Women's Care Med. Group v. Super. Ct.*, 139 P.3d 1 (Cal. 2006).

framing the issue as follows: whether a physician is constitutionally insulated from the law when the discrimination arises out of sincerely held religious beliefs.²⁸ In a unanimous decision, the court ruled that a free exercise defense was ineffective against a claim of sexual orientation discrimination brought under the Unruh Act.²⁹ A little over a year later, the parties settled the lawsuit for an undisclosed sum of money.³⁰

Several factors in *North Coast* rendered the free exercise clause claim doctrinally weak. First, a free exercise claim is essentially one positing that the constitutionally guaranteed right to freedom of religion has been abridged.³¹ Freedom of religion is a guarantee of freedom of religious belief;³² it does not guarantee an absolute freedom to act pursuant to one's religion.³³ Older cases held that to burden the freedom of religion, the government must have acted to advance a compelling public interest and must possess no less restrictive means at its disposal.³⁴ In *North Coast*, there was no dispute that anti-discrimination statutes advance several compelling public interests.³⁵

28. Issues Ordered Limited, Docket Entry of June 28, 2006, *N. Coast Women's Care Med. Group, Inc.*, 139 P.3d 1 (No. D045438) (citing CAL. R. CT. 29(A)(1) (2006) (renumbered 2007)).

29. *N. Coast Women's Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959, 962, 971 (Cal. 2008). The justices discussed the defendant physicians' free exercise claims under the Federal Constitution, U.S. CONST. amend. 1, as well as the California Constitution, CAL. CONST. art. I, § 4. *N. Coast Women's Care Med. Group, Inc.*, 189 P.3d at 965.

30. Greg Moran, *Lesbian's Suit Over Procedure is Settled*, SAN DIEGO UNION-TRIBUNE, Sept. 30, 2009, at B1; Press Release, O'Melveny & Myers LLP, O'Melveny Reaches Settlement in Landmark Discrimination Suit (Oct. 5, 2009), available at <http://www.omm.com/newsroom/News.aspx?news=1298>.

31. EDWIN CHERMERINSKY, CONSTITUTIONAL LAW PRINCIPLES AND POLICIES 1200-01 (2d ed. 2002).

32. *Employment Div., Dep't of Human Res. v. Smith*, 494 U.S. 872, 877 (1990).

33. See *Cantwell v. Connecticut*, 310 U.S. 296, 304 (1940) (holding that the free exercise of religion "remains subject to regulation for the protection of society"); *Faheem-El v. Lane*, 657 F. Supp. 638, 645 (C.D. Ill. 1986) (finding that inmates' free exercise of religion is "subject to restriction when the limitations placed upon the right[] further a legitimate governmental purpose"); *Smith v. Fair Employment & Housing Comm'n*, 913 P.2d 909, 929 (Cal. 1996) (finding that property owner's refusal to rent apartment to an unmarried cohabitating couple violated the California Fair Employment and Housing Act (FEHA), CAL. GOV'T CODE §§ 12900-12966 (1980) (current version at §§ 12900-12966 (2008)), and that compliance with FEHA's anti-discrimination provisions did not substantially burden the owner's free exercise of religion).

34. *Scott v. Rosenberg*, 702 F.2d 1263, 1273, 1276 (9th Cir. 1983), cert. denied, 465 U.S. 1078 (1984).

35. *N. Coast Women's Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959, 968 (noting that "[t]he [Unruh] Act furthers California's compelling interest in ensuring full and equal access to medical treatment irrespective of sexual orientation"); see also *Catholic Charities of Sacramento, Inc. v. Super. Ct.*, 85 P.3d 67, 92 (Cal. 2004)

Today, Supreme Court jurisprudence holds that laws of general applicability tend to fall beyond the reach of the free exercise clause,³⁶ as such, claims brought under this clause are strongest when leveled against attempts to circumscribe institutional sacred rituals and practices.³⁷ Since the Unruh Civil Rights Act does not inhibit religious beliefs or ritualistic practices, it does not receive heightened scrutiny under the free exercise clause.

Second, although anti-discrimination provisions sometimes explicitly exempt the activities of religious institutions from their ambit,³⁸

(declaring elimination of gender discrimination a compelling state interest). Other municipalities also recognize the interest that inheres in anti-discrimination legislation. *See, e.g.*, LEXINGTON-FAYETTE, KY., CODE OF ORDINANCES § 2-33(2) (1999) [hereinafter FAYETTE CODE] (prohibiting “discrimination on the basis of sexual orientation or gender identity within Fayette County”); PITTSBURGH, PA., CITY CODE § 651.01(e) (1997) (“Discrimination in places of public accommodations . . . causes humiliation, embarrassment and inconvenience to residents and visitors . . . [and] tends to create breaches of the peace, intergroup tensions and conflicts and similar evils . . .”). There is also much to be said about the individual toll discrimination exacts. *See, e.g.*, *Broome v. Biondi*, 17 F. Supp. 2d 211, 225-26 n.9 (S.D.N.Y. 1997) (exploring research on the effects and social impact of racial discrimination); Charles Dewey, *In the Life Examines Doctors and Anti-Gay Bias*, WINDY CITY TIMES (Jan. 20, 2007), available at <http://www.windycitymediagroup.com/gay/lesbian/news/ARTICLE.php?AID=15274> (“I had no idea the depths that [discrimination] reaches. Personally and psychologically, it destroys you.” (quoting Joanne Clark, Benitez’s partner, on the effect of discrimination notwithstanding whether one ultimately receives medical treatment)).

36. *Employment Div.*, 494 U.S. at 878-79, 890, *superseded by statute*, Religious Freedom Restoration Act of 1993, Pub. L. No. 103-141, 107 Stat. 1488, *as recognized in* *Gonzales v. O Centro Espirita Beneficente Uniao Deo Vegetal*, 546 U.S. 418, 424, 435-36 (2006); *cf. Catholic Charities*, 85 P.3d at 93 (Cal. 2004) (“When followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in this activity.” (quoting *United States v. Lee*, 455 U.S. 252, 261 (1982))); *see also* John Mikhail, *The Free Exercise of Religion: An American Perspective*, in *EIN NEUR KAMPF DER RELIGIONEN? STAAT, RECHT UND RELIGIOSE TOLERANZ* 271, 277 (Matthias Mahlmann & Hubert Rottleuthner eds., 2006) (discussing the history of the establishment clause and comparing it to German and other European free exercise of religion questions).

37. *See Gonzales*, 546 U.S. at 423 (finding on behalf of a religious sect that utilized hallucinogenic tea in rituals that the federal government failed in its burden to demonstrate under the Religious Freedom Restoration Act (RFRA) that “[the government] ha[d] a compelling interest in the *uniform* application of the Controlled Substances Act, such that no exception to the ban on use of the hallucinogen [could] be made to accommodate the sect’s sincere religious practice”); *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 534-35 (1993) (finding that city ordinance directly attacked sacrificial rituals of Santería religion).

38. *See, e.g.*, FAYETTE CODE § 2-33(7) (exempting certain religious institutions from compliance with the county’s sexual orientation and anti-discrimination ordinance); *see also Catholic Charities*, 85 P.3d at 84 (citing other examples of religious activities explicitly exempted from federal and state anti-discrimination statutes). Internationally, a new Belgian law covering assisted reproduction gives infertility clinics the right to refuse treatment for reasons of religious conscience. Guido Pennings, *Decision-making Authority*

the Unruh Act does not. The Act forbids discrimination by business establishments, and applies to business establishments of all kinds.³⁹ It is thus a law of general application that requires no heightened standard of review.⁴⁰ Finally, although it is still an open question whether the California Constitution embodies a stronger free exercise guarantee than does the U.S. Constitution, the compelling justification for the Unruh Act and the ease with which North Coast could opt out of performing IUI for any patient meant that applying the Unruh Act to North Coast's treatment of Benitez survived strict scrutiny in any event.⁴¹ In terms of a less restrictive alternative, the California Supreme Court has opined that "any broader exemption increases the number of women affected by discrimination in the provision of health care benefits."⁴² Similarly, a special exemption for religious doctors who object to serving gay and lesbian patients would simply increase the number of people affected by discrimination on the basis of sexual orientation. The court arguably believed it was simply disingenuous for the clinic to assert that, since Benitez in the end received the service she had originally sought, there should be no cognizable claim of discrimination at all.

To place *North Coast* in context, it is important to understand that the refusal of fertility treatment centers to serve lesbian couples and single women is a notable problem.⁴³ In the United States, where most aspects of infertility clinics' practice are not governmentally regulated, studies indicate that many infertility clinics will deny access to

of Patients and Fertility Specialists in Belgian Law, 15 REPROD. BIOMED. ONLINE 19, 21-22 (2007). This provision was included as a concession to Catholic clinics. *Id.* at 22.

39. CAL. CIV. CODE § 51.5(a) (West 2007).

40. CHEMERINSKY, *supra* note 31, at 1212.

41. *N. Coast Women's Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959, 968-69 (Cal. 2008).

42. *Catholic Charities of Sacramento, Inc. v. Super. Ct.*, 85 P.3d 67, 94 (Cal. 2004).

43. See Patricia Baetens, *Reproductive Services with Lesbian Couples*, in GUIDELINES FOR COUNSELLING IN INFERTILITY 109, 109-12 (Jacky Boivin & Heribert Kentenich eds., 2002), available at <http://www.eshre.com/binarydata.aspx?type=doc/psyguidelines.pdf> (explaining that many fertility centers do not accept lesbian couples for treatment); Jacky Boivin, *Reproductive Services with Single Women Without Partners*, in GUIDELINES FOR COUNSELLING IN INFERTILITY, *supra*, at 113, 113-16 (exploring cases in which conception is prevented by a person's social circumstances, such as being a single woman without a partner, rather than one's medical status); *MPs Challenge Fertility Clinic Ban on Lesbians*, THE GUARDIAN, July 3, 2006, at 7, available at <http://www.guardian.co.uk/uk/2006/jul/03/politics.gayrights> (highlighting the political response to fertility clinics' refusal to treat single women and lesbians); *Lesbian Denied Fertility Treatment Wins Complaint*, CTVGLOBEMEDIA, Oct. 1, 2005, http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20050930/invitro_lawsuit_050930/20050930?hub=Health (reporting on a ruling of the Quebec Human Rights Commission that ordered a fertility clinic to pay thousands of dollars of compensation to a woman who was refused fertility treatments because she was not accompanied by a man).

single men, gay couples and poor couples.⁴⁴ This form of discrimination in reproduction-assisting technologies has received some scholarly treatment⁴⁵ but has been the subject of very little reported litigation.⁴⁶ As a practical matter, prohibitions on sexual orientation and marital status are still uncommon,⁴⁷ health clinics are sometimes exempt from the ambit of public accommodations statutes,⁴⁸ and screening

44. Gurmankin, *supra* note 8, at 65; Judy E. Stern et al., *Access to Services at Assisted Reproductive Technology Clinics: A Survey of Policies and Practices*, 184 AM. J. OBSTETRICS & GYNECOLOGY, 591, 596-97 (2001).

45. See, e.g., Bernard M. Dickens, *Reproductive Health Services and the Law and Ethics of Conscientious Objection*, 20 MED. & L. 283, 284 (2001) (noting that “[t]he area of medically assisted conception has more recently become a focus of conscientious objection” among physicians); John H. Pearn, *Gatekeeping and Assisted Reproductive Technology: The Ethical Rights and Responsibilities of Doctors*, 167 MED. J. AUSTRALIA 318, 318 (1997) (arguing that anti-discrimination legislation in Australia obligates doctors to provide “elective service[s] in circumstances that go against their conscience”); John A. Robertson, *Gay and Lesbian Access to Assisted Reproductive Technology*, 55 CASE. W. RES. L. REV. 323, 325 (2004) (analyzing “the procreative liberty of gays and lesbians, the right to use ARTs to form families, and the implications of such rights for family law and access to ART services”).

46. In addition to *Benitez*, a Minnesota court has granted summary judgment to a clinic accused of refusing to inseminate a lesbian because of her sexual orientation. Holly J. Harlow, *Paternalism Without Paternity: Discrimination Against Single Women Seeking Artificial Insemination by Donor*, 6 S. CAL. REV. L. & WOMEN'S STUD. 173, 208-10 (1996). In Massachusetts, parties settled a similar lawsuit before trial. *Id.* at 212-13. For further discussion of similar cases, see also *Sheils v. Univ. of Pa. Med. Ctr.*, No. CIV.A. 97-5510, 1998 WL 134220, at *2-*3 (dismissing a suit brought against a clinic for violating statutory prohibitions on disability discrimination because the plaintiffs had not been denied infertility treatment); John A. Robertson, *Procreative Liberty and Harm to Offspring in Assisted Reproduction*, 30 AM. J.L. & MED. 7, 30 (2004) (describing a case brought by a blind unmarried woman in Denver who was refused fertility treatment, because the clinic determined that she had no partner to help her raise the child); Elizabeth Weil, *Breeder Reaction*, MOTHER JONES, Jul.-Aug. 2006, at 32 (discussing the dearth of public policy with respect to fertility clinics' screening processes); N.Y. STATE TASK FORCE ON LIFE AND THE LAW, EXECUTIVE SUMMARY OF ASSISTED REPROD. TECHS.: ANALYSIS AND RECOMMENDATIONS FOR PUB. POL'Y (1998), available at <http://www.health.state.ny.us/nysdoh/taskfcr/execsum.htm> (providing an overview of the state of assisted reproductive technology nationwide and in New York in the late 1990s).

47. Indeed, some statutes may exclude all but heterosexual married couples from access to assisted reproduction. See, e.g., OKLA. STAT. ANN. tit. 10, § 553 (West 2006) (mandating that artificial insemination can only be performed if a husband and wife request the use of the technique); see also Am. Soc'y for Reprod. Med., *IFFS Surveillance 07*, 87 FERTILITY & STERILITY S1, S17-S18 (Supp. I 2007) (reporting survey results that show the majority of societies either formally or informally appear to prefer a traditional heterosexual family when administering fertility treatments and restrict assisted reproductive technology accordingly).

48. See Ethics Comm. of the Am. Soc'y of Reprod. Med., *Child-Rearing Ability and the Provision of Fertility Services*, 82 FERTILITY & STERILITY 564, 566 (2004) [hereinafter *Child-Rearing Ability*] (noting that “[r]eproductive rights protected under the United States and state constitutions are rights *against* state interference, not rights to *have* physicians or the state provide requested services”). Compare *Duffy v. Ill. Dep't of Human Rights*, 820 N.E.2d 1186, 1189 (Ill. App. Ct. 2004) (holding that the provisions of the public

practices vary widely from clinic to clinic.⁴⁹ As is true in many areas of medicine, infertility physicians prefer to self-regulate.⁵⁰ There exists little downward pressure on infertility clinics at present, however, to adhere to any particular set of ethical guidelines, even those promulgated by groups of specialty physicians. For example, the voluntary accreditation program run by the American Society of Reproductive Medicine (ASRM) and its affiliate the Society for Assisted Reproductive Technology does not require adherence to its own explicit ethical commitment to nondiscrimination in the delivery of infertility treatment.⁵¹ In combination, these factors mean that, when refused treatment at one clinic, applicants do not sue but instead merely proceed to another.⁵²

The issue of conscientious objection in medical care is sure to arise with greater frequency as more state legislatures enact prohibitions on sexual-orientation and marital-status discrimination.⁵³ Currently, sexual-orientation and marital-status discrimination in public accommodations is prohibited as follows:

accommodations statute in question do not apply to medical facilities or clinics, doctors' offices, or health care facilities), with U.S. DEP'T OF JUSTICE, AMERICANS WITH DISABILITIES ACT: ADA TITLE III TECHNICAL ASSISTANCE MANUAL III-1.2000, available at <http://www.usdoj.gov/crt/ada/taman3.html> (last visited Nov. 13, 2009) (indicating that the public accommodations section of the Americans with Disabilities Act only applies to an exhaustive list of facilities that do not specifically include health clinics, but does include offices of health care providers and hospitals). The Illinois Human Rights Act was amended in 2007 and now explicitly covers the professional offices of health care providers. 775 ILL. COMP. STAT. ANN. 5/5-101 (West 2007). *But see* Pennings, *supra* note 38, at 21-22 (describing a new Belgian law covering assisted reproduction that gives infertility clinics the right to refuse treatment for reasons of religious conscience).

49. Gurmankin, *supra* note 8, at 66-67.

50. William R. Keye, Jr. et al., *A Survey of the Practices and Opinions of the Domestic Members of the American Society for Reproductive Medicine*, 82 FERTILITY & STERILITY 536, 539 (2004).

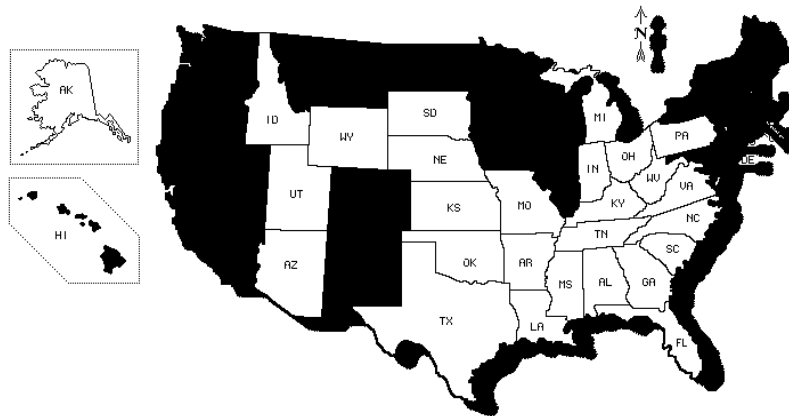
51. David Adamson, *Regulation of Assisted Reproductive Technologies in the United States*, in REPRODUCTIVE TECHNOLOGIES: A READER 1, 8 (Thomas A. Shannon ed., 2004) (describing the ASRM's ethical pronouncements as "creat[ing] standards for self-regulation"); Ethics Comm. of the Am. Soc'y of Reprod. Med., *Access to Fertility Treatment by Gays, Lesbians, and Unmarried Persons*, 86 FERTILITY & STERILITY 1333 (2006) [hereinafter *Access to Fertility*] (articulating ethical commitment to non-discrimination but not requiring adherence). Eighty-three percent of respondents to a survey of ASRM members reported following ASRM Ethics Committee opinions. Keye, *supra* note 50, at 537.

52. Laura Josephs, *Therapist Anxiety About Motivation for Parenthood*, in FROZEN DREAMS: PSYCHODYNAMIC DIMENSIONS OF INFERTILITY AND ASSISTED REPRODUCTION 33, 37 (Allison Rosen & Jay Rosen eds., 2005).

53. See Jack S. Vaitayanonta, *In State Legislatures We Trust?: The "Compelling Interest" Presumption and Religious Free Exercise Challenges to State Civil Rights Laws*, 101 COLUM. L. REV. 886, 887-88 (2001) (describing the growing role of courts in the application of anti-discrimination laws).

SEXUAL ORIENTATION AND MARITAL STATUS DISCRIMINATION
PROHIBITIONS

- – both outlawed
- – sex. orient. only
- – marital status only



11/23/09

Notes: Washington, DC, prohibits both sexual orientation and marital status discrimination in public accommodations.

What distinguishes a claim brought against an objecting physician under an anti-discrimination law from controversies involving physicians who refuse to perform abortions or sterilizations is that the former involves a physician's refusal to provide a specific patient with treatment that the physician regularly provides to others.⁵⁴ This means that the many laws that specifically allow religious physicians or other health care personnel to refuse to perform abortions, sterilizations, or other procedures that violate their religious consciences⁵⁵

54. See Jacob M. Appel, *May Doctors Refuse Infertility Treatments to Gay Patients?*, HASTINGS CENTER REP., Jul.-Aug. 2006, at 20 (observing that society is unwilling to tolerate physicians who single out entire classes of patients, "even when they act out of sincere religious beliefs," but is more tolerant of doctors who refuse to perform specific procedures on anyone due to religious belief).

55. See, e.g., 42 U.S.C. § 300a-7 (2006) (prohibiting public officials from requiring individuals or institutions to perform abortion and sterilization procedures, despite receipt of federal funds, when doing so would violate the individual's moral convictions or religious beliefs); 43 PA. CONS. STAT. ANN. § 955.2(a) (West 2009) (providing immunity to individuals and institutions who refuse to perform sterilization or abortion procedures on moral or religious grounds); 18 PA. CONS. STAT. ANN. § 3213(d) (West 2000) (providing that refusal to perform an abortion or administer an abortifacient "shall not be a basis for any civil,

do not apply in this case.⁵⁶ Nor are regulations requiring pharmacists to dispense prescribed medications particularly analogous.⁵⁷ Instead,

criminal, administrative or disciplinary action”). For other state statutes, see AMERICANS UNITED FOR LIFE, 2009 STATE LEGISLATIVE SESSIONS IN REVIEW 1 (2009), available at http://www.aul.org/xm_client/client_documents/2009_State_Legislative_Session_Report.pdf (categorizing relevant state legislative action across the fifty states). Such statutes began to be passed in the wake of *Roe v. Wade*, 410 U.S. 113 (1973). See Rachel Benson Gold & Adam Sonfield, *Refusing to Participate in Health Care: A Continuing Debate*, THE GUTTMACHER REP. ON PUB. POL’Y, Feb. 2000, at 8 (discussing how the states have responded to conscientious objections to perform abortions after *Roe v. Wade*); CATHERINE WEISS ET AL., ACLU REPRODUCTIVE FREEDOM PROJECT, RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS 1 (2002) (discussing the emergence of refusal clauses pertaining to certain reproductive health services following *Roe v. Wade*).

56. Other recent controversies in this vein include pharmacists who refuse to dispense emergency contraception, see, for example, *Stormans, Inc. v. Selecky*, 524 F. Supp. 2d 1245, 1248 (W.D. Wash. 2007) (involving two pharmacists and one corporate pharmacy that refused to dispense “Plan B” contraceptives due to religious and moral objections), and religious institutions that resist mandates to cover prescription contraceptives for their employees, see, for example, *Catholic Charities of Sacramento, Inc. v. Super. Ct.*, 85 P.3d 67, 73 (Cal. 2004) (analyzing “a church-affiliated employer’s constitutional challenges to the Women’s Contraception Equity Act[,]” which required that certain health insurance contracts cover contraceptives). The rights of pharmacists to refuse to dispense emergency contraception is currently subject to laws and regulations that vary widely from state to state. See Denise Hopkins & Marsha Boss, *Pharmacists’ Right to Refuse to Dispense Prescriptions Based on Moral Grounds: A Summary of State Laws and Regulations*, 41 HOSP. PHARMACY 1176 (2006) (summarizing state laws and regulations concerning pharmacists’ rights to refuse to dispense prescriptions based on moral grounds).

Even though this Article wrestles with whether public policy supports special consideration for medical practice, I do not here explore whether clinics are exempt from anti-discrimination laws because they are not “public accommodations.” See *supra* note 48 and accompanying text. Such arguments have repeatedly failed. Although it is tempting to judge the medical profession as sufficiently honorable so as not to constitute a mere business, it is nonetheless fair to say that business ethics now permeate the conduct of large numbers of physicians in the United States. See Alycia C. Regan, *Regulating the Business of Medicine: Models for Integrating Ethics and Managed Care*, 30 COLUM. J.L. & SOC. PROBS. 635, 635-36 (1997) (examining the different models for integrating “business . . . and medical ethics within a regulatory framework that governs” managed care organizations); Edward B. Hirschfeld & Gail H. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX J.L.-MED. 3, 5 (1996) (arguing that business judgment, especially with respect to health plan coverage decisions, plays an increasing role in medical decision-making).

Nor do I focus my discussion on how clinics might manage employees who refuse to assist in the provision of certain treatments which, while constituting a refusal to provide treatment, might not result in a patient being forced to go without care or seek treatment elsewhere. For discussion of this subject, see Anne M. Dellinger & Ann Morgan Vickery, *When Staff Object to Participating in Care*, 28 J. HEALTH & HOSP. L. 269, 269 (1995) (describing the issues at play when “some aspect of a patient’s treatment offend[s] the religious or ethical sensibility of a hospital staff member or employee”). The issue is prominent in the provision of abortion but was also foreshadowed by the AIDS crisis, when some nurses who deemed homosexuality immoral refused to attend to HIV-infected gay men. See JOHNSTONE, *supra* note 9, at 402-03.

57. Hopkins & Boss, *supra* note 56, at 1176-77; see *Stormans*, 524 F. Supp. 2d at 1251 (interpreting a statute that allowed a pharmacist to decline to fill a prescription but prohibited obstruction of patient’s effort to obtain it).

the theory advanced by the objecting physicians in *North Coast* was that the right to express one's religious beliefs is so central to our democracy that it takes priority even over important anti-discrimination laws.⁵⁸ As a matter of good public policy, the claim was also made that exempting religious doctors from anti-discrimination laws will lead to greater openness in doctor-patient interactions and to increased availability of medical services overall.⁵⁹ As we have already seen, the idea that the interests of those who desire non-discriminatory access to public accommodations as guaranteed by the Unruh Act must be balanced against the religious interests of those who choose to offer services for profit in the public marketplace was vigorously rejected by the California Supreme Court.⁶⁰ Given the strength of federal and California precedent on this issue, it was not surprising that *North Coast* and their amici attempted to bolster their arguments with references to codes of medical ethics.⁶¹ Although codes of medical ethics in general "have no force and effect outside of the private, voluntary associations in which they are adopted,"⁶² the courts on many occasions have been deferential to the customs and ethical practices of physicians, and often cite codes of medical ethics as trustworthy and authoritative support for legal decision-making in cases involving the practice of medicine.⁶³ The next section explores the unexpected lack of clarity within medical codes of ethics on the issue of whether religious physicians may discriminate against their patients.

58. *N. Coast Women's Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959, 967 (Cal. 2008).

59. Brief for Christian Med. and Dental Ass'ns as Amicus Curiae Supporting Petitioner's Writ of Mandate at 2, 13-14, *N. Coast Women's Care Med. Group, Inc. v. Super. Ct.*, 40 Cal. Rptr. 3d 636 (Cal. Ct. App. 2006) (No. D045438) [hereinafter Brief for Christian Med. and Dental Ass'ns].

A new Belgian law covering assisted reproduction gives infertility clinics the right to refuse treatment for reasons of religious conscience. Pennings, *supra* note 38, at 21-22. This provision was included as a concession to Catholic clinics. *Id.* at 22.

60. *N. Coast Women's Care Med. Group Inc.*, 189 P.3d at 966-67.

61. Brief for Christian Med. and Dental Ass'ns, *supra* note 59, at 5-7; Petitioners' Answer to Brief for Gay and Lesbian Med. Ass'n et al., *supra* note 14, at 3-7.

62. Petitioners' Answer to Brief for Gay and Lesbian Med. Ass'n et al., *supra* note 14, at 6. This statement is overbroad, as it overlooks the fact that individual boards of medical licensure sometimes condition the retention of a medical license upon adherence to the AMA's Code of Medical Ethics. See, e.g., OHIO REV. CODE ANN. § 4731.22(B)(18) (West 2009) (describing the state medical board's power and authority to "limit, revoke, or suspend an individual's certificate to practice," subject to certain limitations, for failing to adhere to the AMA Code of Medical Ethics).

63. See AM. MED. ASS'N, CODE OF MEDICAL ETHICS 376-83 (2008-2009) (compiling cases that have cited to provisions of the AMA Code of Medical Ethics); JOSÉ MIOLA, MEDICAL ETHICS AND MEDICAL LAW: A SYMBIOTIC RELATIONSHIP 9, 13 (2007) (discussing the trend of judges deferring to the tenets of codes of medical ethics).

II. CODES OF MEDICAL ETHICS

What is initially intriguing about the use of medical ethics codes to defend physicians is that principles of medical ethics were developed to protect patients, and this continues to be the governing sense of why medical ethics rules exist in the first place. Indeed, the preamble to the American Medical Association's Code of Medical Ethics states that the "body of ethical statements [was] developed primarily for the benefit of the patient," and emphasizes physician "responsibility" and "honorable behavior."⁶⁴ It is difficult to find vindication of physicians' rights as against their responsibility to their patients in the AMA Code. It is perhaps understandable as a result that there is fear that protecting patients may at times come at the expense of protecting physicians.

Although codes of medical ethics were a prominent feature of *North Coast* in the arguments of both the parties and the many amici,⁶⁵ what, if any, guidance they provide for the resolution of a case like *North Coast* remains nebulous. Given their prominence in the many submissions to the court, it is at first surprising that the supreme court's unanimous decision makes absolutely no mention of these codes. What is more surprising, however, is that the briefs of the various medical society amici exhibit such striking disagreement about what the ethics rules governing their profession require.

None of the parties or the amici could ignore the prominent prohibition on discrimination against potential patients that appears in the AMA's Code of Medical Ethics.⁶⁶ Nor was it a matter of dispute that a religious physician could permissibly refuse to provide a potential patient with a procedure to which he had a religious objection,⁶⁷ as long as the objection was to the procedure itself and not motivated by some protected status of the potential patient.⁶⁸ It is

64. CODE OF MED. ETHICS pmb1. (Am. Med. Ass'n 2008-2009).

65. Brief for Christian Med. and Dental Ass'ns, *supra* note 59, at 5-7; Petitioners' Answer to Brief for Gay and Lesbian Med. Ass'n et al., *supra* note 14, at 3-7.

66. See CODE OF MED. ETHICS Op. 9.12 (2009), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9012.shtml> (prohibiting physician's discrimination against potential patients on the basis of "race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination"); see also CODE OF MED. ETHICS Op. 10.05(2)(b) (prohibiting physician's discrimination against potential patients on the basis of "race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination").

67. See CODE OF MED. ETHICS Op. 10.05(3)(c) (stating that physicians may decline a potential patient when "[a] specific treatment sought by an individual is incompatible with the physician's personal, religious, or moral beliefs").

68. See *id.* Op. 10.05(3) (making clear that the objection to a procedure on religious or moral grounds is not permitted when it is based on a criterion "that would constitute invidious discrimination" against the patient).

thus unsurprising that the religious organizations and other amici that filed amicus briefs in support of North Coast frequently emphasized the point that “medical ethics standards . . . consistently maintain that a physician should be allowed to refuse to provide specific medical treatment or procedures.”⁶⁹ None of these provisions, however, applied to Benitez. She was already a patient of North Coast, not merely a potential patient, at the time her cause of action arose,⁷⁰ and North Coast did not have any general religious objections to IUI as a procedure.⁷¹ North Coast’s specific objection was to providing IUI to someone like Benitez.⁷²

The question then became which, if any, of the provisions of the Code of Medical Ethics *did* apply to the facts of *North Coast*. In one instance, North Coast argued that medical ethics codes are so general that they do not apply when doctors object on religious grounds

Unsurprisingly, as a matter of advocacy, North Coast pulled Opinion 10.05(3)(c) out of its context to claim that it gave a physician an absolute right to refuse to perform a treatment if it conflicted with his religious beliefs. Petitioners’ Answer to Brief for Gay and Lesbian Med. Ass’n et al., *supra* note 14, at 4.

69. Brief for Christian Med. and Dental Ass’ns, *supra* note 59, at 5; Brief for Cal. Med. Ass’n Supporting Petitioners at 7-11, *N. Coast Women’s Care Med. Group, Inc. v. Super. Ct.*, 40 Cal. Rptr. 3d 636 (Cal. Ct. App. 2006) (No. D045438) [hereinafter Brief for Cal. Med. Ass’n]. The Christian Medical and Dental Associations cited its own tenets and those of the Islamic Medical Association of North America as support for the proposition that religious doctors have a right to refuse specific treatments to specific patients. The Christian group admonishes its members to offer in vitro fertilization only to married couples; the Islamic group, in keeping with the dictates of Islam, permits doctors to provide assisted reproduction only to married couples who can use their own gametes and uterus. Brief for Christian Med. and Dental Ass’ns, *supra* note 59, at 7. The Roman Catholic Church is also mentioned in this brief, but of course that church rejects all reproduction-assisting technologies. *Id.* at 8; *See also* Martin L. Cook, *Guest Editorial: Reproductive Technologies and the Vatican*, ISSUES IN ETHICS (Spring 1988), available at <http://www.scu.edu/ethics/publications/iie/v1n3/homepage.html> (explaining that the Vatican opposes “all technological interventions into the process of human reproduction”). There is disagreement within the church as to whether the techniques of gamete intrafallopian transfer and tubal ovum transfer are consistent with church doctrine. *See* Richard C. Sparks, *Helping Childless Couples Conceive*, ST. ANTHONY MESSENGER (Apr. 1997), available at <http://www.americancatholic.org/Messenger/Apr1997/feature1.asp> (“[T]he Catholic Church has made no definitive or official universal pronouncement about these two procedures.”).

70. *N. Coast Women’s Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959, 963 (Cal. 2008) (indicating Benitez had been in North Coast’s care for almost a year).

71. *Id.*

72. Benitez and her supporters made this point several times in their various submissions. Answer of Real Party in Interest Guadalupe T. Benitez to Brief for Christian Med. and Dental Ass’ns as Amicus Curiae Supporting Petitioners’ Writ of Mandate at 4, *N. Coast Women’s Care Med. Group, Inc. v. Super. Ct.*, 40 Cal. Rptr. 3d 636 (Cal. Ct. App. 2006) (No. D045438) [hereinafter Answer of Real Party in Interest to Brief for Christian Med. and Dental Ass’ns]; Brief for Anti-Defamation League et al. as Amicus Curiae Supporting Real Party in Interest at 44, *N. Coast Women’s Care Med. Group, Inc.*, 40 Cal. Rptr. 3d 636 (No. D045438) [hereinafter Brief for Anti-Defamation League et al.].

to performing a specific procedure for a specific patient and provide the patient a referral for the same procedure.⁷³ North Coast conceived of this refuse-and-refer mechanism as striking the proper balance between the “legal rights of a patient and the legal and ethical rights of a physician” in such a case.⁷⁴ Moreover, it characterized this mechanism as the one most medical ethicists prefer.⁷⁵ The California Medical Association (CMA) agreed, adding that the physician should be responsible for any additional cost arising from the refusal-and-referral mechanism only if he had agreed to pay or had contracted with a managed care organization to provide care.⁷⁶ Despite their agreement on the proper balance to be struck in the case, the CMA and North Coast did not see the collision between refuse-and-refer balancing and anti-discrimination law in the same way. Whereas the CMA perceived a conflict between a physician’s conscience and anti-discrimination prohibitions,⁷⁷ North Coast’s position was that any discrimination inherent in the refuse-and-refer mechanism would *not* run afoul of anti-discrimination law, since it would not be “discriminatory against gay people *per se*” but would have a mere “incidental impact on [a physician’s] ability to provide one treatment, IUI, to the aforementioned group of people.”⁷⁸ Despite this disagreement on the exact interplay between refuse-and-refer and anti-discrimination law, both North Coast and the CMA agreed that the use of the refuse-and-refer device by North Coast should excuse the clinic from liability.⁷⁹

Like North Coast, the CMA found little support for the refuse-and-refer approach beyond those provisions cited *supra*⁸⁰ that apply only to potential patients. The CMA sought, however, to bolster its support for this balance by explaining how the approach would enhance communication between doctors and their patients and would ensure the greatest availability of health care to the public, since religious physicians would not be compelled to limit their practices.⁸¹ These themes were similarly prominent in North Coast’s appellate

73. Petitioners’ Answer to Brief for Gay and Lesbian Med. Ass’n et al., *supra* note 14, at 1, 3-4, 6.

74. Petitioners’ Answer to Brief for Anti-Defamation League et al. as Amici Curiae Supporting Real Party in Interest at 2, *N. Coast Women’s Care Med. Group, Inc.*, 40 Cal. Rptr. 3d 636 (No. D045438) [hereinafter Petitioners’ Answer to Brief for Anti-Defamation League et al.].

75. Petitioners’ Answer to Brief for Gay and Lesbian Med. Ass’n et al., *supra* note 14, at 6 (citing Farr A. Curlin et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 NEW ENG. J. MED. 593, 599-600 (2007)).

76. Brief for Cal. Med. Ass’n, *supra* note 69, at 15-16.

77. *Id.* at 11.

78. Petitioners’ Answer to Brief for Anti-Defamation League et al., *supra* note 74, at 12.

79. *Id.* at 11-13; Brief for Cal. Med. Ass’n, *supra* note 69, at 1, 14.

80. See *supra* notes 66-72 and accompanying text.

81. Brief for Cal. Med. Ass’n, *supra* note 69, at 12-13.

brief submitted to the California Supreme Court and the Christian Medical and Dental Association's (CMDA) amicus brief submitted in the court of appeal.⁸²

In her response to the CMA brief, Benitez expressed dismay at the many contradictions it contained.⁸³ But in fact, the CMA amicus brief was consistent with North Coast's position as described above. It was understandable that the CMA perceived North Coast's "conundrum" as how to "balance their own religious beliefs and their non-discrimination obligations,"⁸⁴ while Benitez perceived it as a case about the primacy of nondiscrimination obligations.⁸⁵ The value of the CMA brief for understanding medical ethics lies in its clear revelation of the contradiction in the AMA Code of Medical Ethics itself: physicians must not discriminate, but are entitled to exercise their religious conscience when practicing medicine.⁸⁶ The CMA saw the resolution of the conflict as one requiring balancing.⁸⁷ Benitez saw the issue as determining which tenet controlled, nondiscrimination obligations or religious conscience, with no need for balancing once it was determined that nondiscrimination obligations control.⁸⁸ In contrast to Benitez's allegation that it was being contradictory, the CMA *did* recognize "the overlap and potential conflict of both issues"⁸⁹ but was not ready to make a blanket statement "that religious freedom does not permit discrimination."⁹⁰ Admittedly, the CMA did misstate the facts of *North Coast* in stating that the ultimate factual issue in the case was "whether the defendants were discriminating against plaintiff based upon her sexual orientation or abiding by their religious beliefs."⁹¹ Benitez and the Anti-Defamation League (ADL) felt

82. See Answer Brief on the Merits at 52-53, *N. Coast Women's Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959 (Cal. 2008) [hereinafter Answer Brief on the Merits] (regarding greater access to care); Brief for Christian Med. and Dental Ass'ns, *supra* note 59, at 11-14 (regarding open and honest communication).

83. Answer of Real Party in Interest Guadalupe T. Benitez to Brief for Cal. Med. Ass'n as Amicus Curiae Supporting Petitioners at 1, *N. Coast Women's Care Med. Group, Inc. v. Super. Ct.*, 40 Cal. Rptr. 3d 636 (Cal. Ct. App. 2006) (No. D045438) [hereinafter Answer of Real Party in Interest to Brief for Cal. Med. Ass'n].

84. Brief for Cal. Med. Ass'n, *supra* note 69, at 2.

85. See Answer of Real Party in Interest to Brief for Christian Med. and Dental Ass'ns, *supra* note 72, at 5 ("Even the sincerest of beliefs do not authorize those engaged in commercial enterprises to implement those beliefs by harming third parties.").

86. Brief for Cal. Med. Ass'n, *supra* note 69, at 4, 6.

87. *Id.* at 19.

88. See Answer of Real Party in Interest to Brief for Christian Med. and Dental Ass'ns, *supra* note 72, at 8-10 (focusing on the anti-discrimination tenet as controlling without discussing the need for balance).

89. Brief for Cal. Med. Ass'n, *supra* note 69, at 11.

90. Answer of Real Party in Interest to Brief for Cal. Med. Ass'n, *supra* note 83, at 2.

91. Brief for Cal. Med. Ass'n, *supra* note 69, at 12. In another iteration of this either/or formulation, the CMA characterized the ultimate issue for the jury as whether "religious belief was the basis for the refusal, or if defendants were *merely* discriminating against

it necessary to emphasize that expression of religious beliefs sometimes assumes discriminatory forms,⁹² but the North Coast physicians had never very forcefully denied that their religious refusal was discriminatory. They simply felt that their particular way of discriminating could not be the subject of any legal sanction.⁹³

In contrast to the positions taken by North Coast and its amici, the medical societies and other organizations supporting Benitez characterized medical ethics as vigorously vindicating nondiscrimination in the delivery of medical care without exception.⁹⁴ This was a salient feature of briefs filed in the court of appeal by the ADL and fifteen other associations and advocacy groups, and in the supreme court by the Gay and Lesbian Medical Association (GLMA) and three other physician and medical student groups, concerned that a decision for North Coast would have a negative impact on access to health care.⁹⁵ In essence, these briefs took the CMA and the CMDA to task for omitting specific language in the AMA's policies that a physician's conscience deserves respect, but not to the extent of permitting discrimination against patients on the basis of "race, color, religion, national origin, sexual orientation, or any other basis that would constitute invidious discrimination."⁹⁶ The briefs effectively underscore the selective use of language in the CMDA brief, but do so merely by referring to the same inapplicable provisions described above.⁹⁷ The ADL and the GLMA made inconsistent statements about whether the CMA prohibits discrimination against potential patients or all patients.⁹⁸ Beyond this, both briefs make reference to other AMA Code

plaintiff?" *Id.* at 16 (emphasis added).

92. Answer of Real Party in Interest to Brief for Christian Med. and Dental Ass'ns, *supra* note 72, at 5-6; Answer of Real Party in Interest to Brief for Cal. Med. Ass'n, *supra* note 83, at 12-13; Brief for Anti-Defamation League et al., *supra* note 72, at 5.

93. Answer Brief on the Merits, *supra* note 82, at 38-43.

94. Brief for Gay and Lesbian Med. Ass'n et al. as Amici Curiae Supporting Real Party in Interest at 6-15, *N. Coast Women's Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959 (Cal. 2008) (No. S142892) [hereinafter Brief for Gay and Lesbian Med. Ass'n et al.]; Brief for Anti-Defamation League et al., *supra* note 72, at 18-20.

95. The fifteen other associations and advocacy groups are: American Academy of HIV Medicine, American Medical Students Association, Asian Pacific American Legal Center of Southern California, Bienestar Human Services, California Latinas for Reproductive Justice, California Pan-Ethnic Health Network, California Women's Law Center, Coalition for Humane Immigrant Rights of L.A., Gay and Lesbian Medical Association, International Association of Physicians in AIDS care, Latino Coalition for a Healthy California, Mautner Project: The National Lesbian Health Organization, Mexican American Legal Defense and Educational Fund, National Center for Lesbian Rights, and National Health Law Program. Brief for Anti-Defamation League et al., *supra* note 72, at 1. The three other physician and medical student groups are: American Medical Student Association, American Academy of HIV Medicine, and International Association of Physicians in AIDS Care. Brief for Gay and Lesbian Med. Ass'n et al., *supra* note 94, at 1.

96. Brief for Anti-Defamation League et al., *supra* note 72, at 20-24.

97. See *supra* notes 66-72 and accompanying text.

98. Brief for Gay and Lesbian Med. Ass'n et al., *supra* note 94, at 12 (stating the CMA's

of Medical Ethics opinions and AMA House of Delegates resolutions having to do with a physician's duty to respect the law, uphold human rights, and work to promote patients' welfare and best interests,⁹⁹ all of which reflect the AMA's high degree of respect for patients and its commitment to human rights and nondiscrimination but none of which, unfortunately, is pointed enough to dispose of a case like *North Coast*. As if recognizing this, the ADL admonished the court to "read together" the various code provisions and proclamations in order to come up with "clear principles of non-discrimination."¹⁰⁰

The confusion over the AMA's position is best reflected in the CMA's abrupt reversal of position shortly after its original submission supporting *North Coast* created a stir in the media.¹⁰¹ The CMA's Notice of Errata recanted its earlier position that discrimination on the basis of religious belief placed physicians in a legal and ethical conundrum that required balancing the interests of the physician and the patient through a refuse-and-refer mechanism.¹⁰² Its new position was unequivocal: "CMA would never support the claim that a physician's religious freedom authorizes discrimination based on race, nationality or sexual orientation."¹⁰³ The CMA explained its abrupt turnabout as the result of careless editing of the original brief.¹⁰⁴ In its errata, the CMA also stated that an outcome adverse to Benitez could still be squared with the nondiscrimination principle, since *North Coast* alleged it had refused to treat Benitez because of her marital status, a classification the CMA stated was not protected

position as "physicians may not refuse to care for patients based on race, gender, sexual orientation or any other criteria that would constitute invidious discrimination") (internal quotation marks omitted); Brief for Anti-Defamation League et al., *supra* note 72, at 24 (stating the CMA's position as "physicians may not decline to accept patients because of . . . sexual orientation, or any other basis that would constitute invidious discrimination") (internal quotation marks omitted).

99. Brief for Gay and Lesbian Med. Ass'n et al., *supra* note 94, at 7-10; Brief for Anti-Defamation League et al., *supra* note 72, at 21-24.

100. Brief for Anti-Defamation League et al., *supra* note 72, at 22. The ADL also argued that there is a professional consensus within medicine that is condemnatory of discrimination. In support, it cited the policies of several hospitals, medical societies, and other groups working in the area of health care delivery. *Id.* at 24-28.

101. Wyatt Buchanan, *Sights Set on State High Court in Case of Lesbian Refused Treatment: Appellate Judges Said Doctors Could Cite Their Religious Beliefs*, S.F. CHRON., Dec. 8, 2005, at B3; Greg Moran, *Court to Hear Insemination Case: Lesbian's Suit Spurred by Denial of Treatment*, SAN DIEGO UNION-TRIBUNE, May 27, 2008, at A1, available at http://www.signonsandiego.com/uniontrib/20080527/news_ln27insem.html; Kenneth Ofgang, *State Supreme Court Agrees to Hear Lesbian Insemination Case*, METROPOLITAN NEWS-ENTERPRISE, June 15, 2006, at 1.

102. *See supra* notes 76-81 and accompanying text.

103. Notice of Errata Regarding Amicus Brief of Cal. Med. Ass'n at 2, *N. Coast Women's Care Med. Group, Inc. v. Super. Ct.*, 40 Cal. Rptr. 3d 636 (Cal. Ct. App. 2006) (No. D045438).

104. *Id.* at 4.

under California law.¹⁰⁵ This statement by the CMA contained at least two erroneous statements, one of which required correction by an additional notice of errata.¹⁰⁶

Benitez was in an ongoing physician-patient relationship at the time her cause of action arose.¹⁰⁷ North Coast's discontinuation of her treatment at the point it did was arguably neglect or even abandonment. It is thus odd that none of the parties to or amici in this case considered the applicability of the AMA Code of Medical Ethics provisions having to do with the neglect of patients and when a physician may ethically refuse to treat a patient but must refer her elsewhere. Opinion 8.11 reads, "[p]hysicians are free to choose whom they will serve. The physician should, however, respond to the best of his or her ability in cases of emergency where first aid treatment is essential. Once having undertaken a case, the physician should not neglect the patient."¹⁰⁸

Opinion 10.01 describes the fundamental character of a physician-patient relationship as a "collaborative effort" and a "mutually respectful alliance" in which the parties share the responsibility for making health care decisions.¹⁰⁹ Within this framework, patients have the right to be treated with courtesy and dignity and have the right to continuity of health care. "The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care."¹¹⁰ Added to this is the understanding from Opinion 10.015 that a doctor-patient relation-

105. *Id.* at 2-3.

106. Notice of Additional Errata Regarding Amicus Brief of Cal. Med. Ass'n at 2-3, *N. Coast Women's Care Med. Group, Inc.*, 40 Cal. Rptr. 3d 636 (No. D045438) (clarifying that while the Unruh Act did not explicitly outlaw marital status discrimination at the time Benitez's cause of action arose, other statutory provisions in California do prohibit marital status discrimination). The second erroneous statement concerned North Coast's characterization of its refusal as marital status discrimination. North Coast's initial answer did not raise the affirmative defense of marital status discrimination. *See* Petition for Review of Real Party in Interest Guadalupe T. Benitez at 3, *N. Coast Women's Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959 (Cal. 2008) (S142892), available at <http://www.lambdalegal.org/in-court/cases/benitez-v-north-coast-womens-care-medical-group.html> (noting that "defendants asserted in an initial motion for summary adjudication that they refused to treat plaintiff because she is a lesbian. . . . Later, however, when it became beneficial for defendants to change their story, they claimed in a subsequent motion for summary adjudication that that had not been the reason and that, instead, they refused to treat plaintiff because she is unmarried."). North Coast might have been legally estopped from raising this theory at trial. *See* Petition for Review of Real Party in Interest, *supra*, at 17-24 (discussing the theory of judicial estoppel).

107. *N. Coast Women's Care Med. Group, Inc.*, 189 P.3d 959, 963-64.

108. CODE OF MED. ETHICS Op. 8.11 (Am. Med. Ass'n 2008-2009).

109. *Id.* Op. 10.01.

110. *Id.* Op. 10.01(5).

ship is a fiduciary relationship in which the physician's self-interest is subordinate to his duty to promote the patient's best interests and advocate for her welfare.¹¹¹

It may be possible to read into these provisions the anti-discrimination language of Opinions 9.12 and 10.05, the Opinions that captured the attention of the various players in *North Coast*, but one cannot do so directly, since those provisions apply to the acceptance or denial of potential patients by their own explicit terms.¹¹² It may be a good idea to assume from the specific language of the AMA Code of Medical Ethics Principles that a physician who decides to discriminate in the course of an ongoing physician-patient relationship is not respectful of the law, respectful of human rights and dignity, or even supportive of access to medical care for all people.¹¹³ Or perhaps the Principles' Preamble can be read together with Opinions 10.01 and 10.015 to conclude that it is simply not honorable or respectful for a physician to discriminate, because it is of no benefit to a patient, does not promote her best interests and welfare, and arguably exacerbates rather than alleviates her suffering.¹¹⁴ Unfortunately, the vague and general language of these provisions when contrasted with the forceful nondiscrimination language embodied in the provisions applicable to potential patients raises doubt, as *North Coast* noted,¹¹⁵ about whether any of this is suited to assist a court, or an AMA disciplinary board for that matter,¹¹⁶ in resolving a case like *North Coast*.

Consider as well how divergently physicians themselves may be tempted to interpret these provisions. A religious physician might be tempted to invest the language of AMA Opinion 10.015, for example, with an admonition not to "assist [patients] in harming themselves If we truly believe that a given procedure violates patients' intrinsic human dignity, then our responsibility to our patients mandates that we not help them procure that procedure."¹¹⁷ Consider as

111. *Id.* Op. 10.015.

112. *See supra* notes 66-72 and accompanying text.

113. CODE OF MEDICAL ETHICS princs. I, III, and IX (Am. Med. Ass'n 2008-2009).

114. *Id.* at pmb., Op. 10.01, Op. 10.015.

115. Petitioners' Answer to Brief for Gay and Lesbian Med. Ass'n et al., *supra* note 14, at 6-7.

116. The AMA's Council on Ethical and Judicial Affairs is vested with the power to "censure, or place on probation the accused physician[,] or suspend or expel him or her from AMA membership as the facts may justify." COUNSEL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, RULES OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS IN ORIGINAL JURISDICTION CASES (2009), available at <http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-ethical-judicial-affairs/governing-rules/rules-cases-original-jurisdiction.shtml>.

117. Patrick O'Connell, M.D., & Jacques Mistrot, M.D., To the Editor, 356 NEW ENG. J. MED. 1891 (2007).

well that the wording of both Opinions 10.01 and 10.015 speak in terms of “medical problems,” “medical condition,” and “alleviate suffering.”¹¹⁸ Such terms do not disable physicians from concluding that those presenting with “social” infertility may not present with a “medical” problem. Under this reasoning, even a referral would not be necessary.¹¹⁹

Exacerbating the problem is that physicians are very used to refuse-and-refer as a way to address having to deal with many sorts of “problem” patients.¹²⁰ Bioethicists writing on physician conscience have likewise endorsed refuse-and-refer.¹²¹ One of these, writing specifically about *North Coast*, described refuse-and-refer as the proper way to resolve Benitez’s lawsuit.¹²² In short, the CMA is not a mere outlier in suggesting balancing as the proper resolution of *North Coast*.

Although the AMA’s position on religious refusals that constitute unlawful discrimination remains unclear, it is important to note that other medical societies have stronger admonitions and warnings with respect to discrimination against lesbians and single women in the treatment of infertility. The relevant ethical pronouncements of the ASRM, for example, specifically state that physicians should conform their conduct to local anti-discrimination laws. They also disapprove of failing to offer infertility treatments to gays, lesbians and the unmarried on the same terms as those offered to married heterosexual couples.¹²³ The Ethics Committee Report

118. CODE OF MED. ETHICS Op. 10.01, Op. 10.015 (Am. Med. Ass’n 2008-2009).

119. Curlin et al., *supra* note 5, at 1891-92 (taking the position that while doctors should not refuse to treat sick people on the basis of sexual orientation, there are some conditions that are not sicknesses and in such cases there need be no referral, even though the physician should let the patient know he objects).

120. See, e.g., Rahul K. Parikh, *Showing the Patient the Door, Permanently*, N.Y. TIMES, June 10, 2008, at F6 (claiming that a physician has a right to dismiss a patient, if reasonable notice and other treatment options are given to the patient).

121. Adrienne Asch, *Two Cheers for Conscience Exceptions*, HASTINGS CENTER REP., Nov.-Dec. 2006, at 11; see Savulescu, *supra* note 3, at 295-96 (arguing that conscientious objection by a physician is acceptable provided the method of refuse-and-refer is used); see also MARY BRIODY MAHOWALD, *BIOETHICS AND WOMEN: ACROSS THE LIFE SPAN* 96 (2006) (endorsing conscience-based refusal to treat in cases where risks overwhelm benefits, including consideration of the ability of potential parents to care for potential children).

122. Appel, *supra* note 54, at 20-21.

123. See *Child-Rearing Ability*, *supra* note 48, at 566 (“Unless the conditions of their employment require otherwise, physicians providing fertility services are generally free not to provide those services to individuals as they choose, subject only to federal and state laws against unjustified discrimination on the grounds of race, religion, ethnicity, or disability.”); *Access to Fertility*, *supra* note 51, at 1335 (acknowledging that refusal to treat is sometimes “based on religious or personal moral views about the propriety or desirability of unmarried persons or gays and lesbians having children[,]” but concluding that fertility programs must “treat single persons and gay and lesbian couples equally with married couples in determining which services to provide” unless there are “serious

noted that laws banning private discrimination on the basis of sexual orientation in public accommodations are becoming more numerous and also that “moral condemnation of homosexuality or single parenthood is not itself an acceptable basis for limiting child rearing, reproduction, or the activities necessary to bring them about.”¹²⁴ Although it is believed that “most practitioners follow [ASRM’s ethical] guidelines,” the guidelines themselves are in the nature of standards for self-regulation only; non-adherence to them does not affect a clinic’s ability to achieve accreditation under the society’s medical practice standards and laboratory guidelines.¹²⁵

Refuse-and-refer is so much a part of physicians’ conception of good and acceptable practice that the Medical Student Section of the AMA recently queried the Council on Ethical and Judicial Affairs (the “Council”) as to whether there were any limits on refuse-and-refer.¹²⁶ At the height of the controversy over pharmacists who refused to dispense emergency contraception, the students resolved that the right of conscientious objection was available only in “non-emergent situations” and submitted its resolution to the Council.¹²⁷ The resolution also sought clarification that in any instance of conscientious objection “the physician must provide alternatives which include a prompt and appropriate referral.”¹²⁸

The report issued by the Council solidly supported refuse-and-refer as a proper method for discontinuing treatment in many cases.¹²⁹ Its analysis began with Principle I, calling upon physicians to respect human rights and remarked that no physician may decline to accept a patient based on invidious discrimination.¹³⁰ “This is in contrast to a physician who refuses to enter into a relationship with a patient or refuses to provide a treatment on the basis of a conflict with his or her religious or moral beliefs.”¹³¹ Thus, concluded the report, the most ethical justifications for refusal are those that are medically motivated

doubts about whether they will be fit or responsible child rearers or the fact that the program does not offer anyone a desired service”).

124. *Access to Fertility*, *supra* note 51, at 1333-34.

125. Adamson, *supra* note 51, at 8, 9; *see* Keye, *supra* note 50, at 537, 539 (asserting that the ASRM guidelines are useful to physicians as a form of self-regulation and the majority prefer this form of self-regulation over government regulation).

126. AM. MED. ASS’N RES. 5, Proceedings of the 2006 Annual Meeting of the H.D. (June 2006), available at <http://www.ama-assn.org/ama1/pub/upload/mm/38/a-06res.pdf>.

127. *Id.*

128. *Id.*

129. COUNCIL ON ETHICAL AND JUD. AFFAIRS, AM. MED. ASS’N, PHYSICIAN OBJECTION TO TREATMENT IN INDIVIDUAL PATIENT DISCRIMINATION, Rep. 6-A-07, at 1-2 (2007), available at http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_6a07.pdf.

130. *Id.* at 2.

131. *Id.*

rather than motivated by religious beliefs or moral conscience, but at the very least the refusal to accept a new patient should not arise from invidious discrimination.¹³² The report noted that “[t]hese ethical precepts are . . . solidly anchored in anti-discrimination law.”¹³³

The Council then turned to a discussion of ongoing physician-patient relationships¹³⁴ but at this point refrained entirely from addressing discrimination. It noted that the AMA Code of Medical Ethics does not address whether a physician can suddenly decline treatment based on religious or moral belief.¹³⁵ The closest applicable principle is that “[o]nce having undertaken a case, the physician should not neglect the patient.”¹³⁶ The analysis proceeded through a synthesis of Principles I, VI, VIII and IX to the effect that a physician has the freedom to choose whom to treat but, once she is caring for a patient, a physician “must regard [the] responsibility to the [patient] as paramount” and must support access to medical care for all people.¹³⁷ Since physician religious conscience can undermine autonomy and access to health care, the interests must be carefully balanced.¹³⁸ When a physician cannot provide care for a patient because his expertise does not extend to the required treatment or because he is otherwise unavailable, he has the ethical obligation to provide a redirection to other providers.¹³⁹ Given these principles, the Council concluded that, similarly, if a physician wishes to withdraw based on religious objections, there should likewise be an appropriate referral.¹⁴⁰

The Council’s report tells one very little beyond what can be gleaned from a reading of the Code itself. It is disappointing, even perplexing, that it begins with a ringing endorsement of the non-discrimination principle but then declines to explain what the result would be in an ongoing physician-patient relationship if the physician’s religious refusal arises from invidious discrimination. Since the Council understands that religious conscience can undermine autonomy and access to health care, as does discrimination, it is probable, albeit far from explicit, that the Council’s report supports refuse-and-refer as a proper response in a case where a religious refusal also constitutes unlawful discrimination.

132. *Id.* at 1-2.

133. *Id.* at 2.

134. *Id.*

135. *Id.*

136. *Id.* (citing CODE OF MEDICAL ETHICS Op. 8.11 (Am. Med. Ass’n 2008-2009) (Neglect of Patient)).

137. *Id.*

138. *Id.* at 3.

139. *Id.*

140. *Id.*

CONCLUSION

Given that the AMA's policies "are the national touchstone of the core ethical principles that govern medical practice in the United States today," it is dismaying that it is not made more clear in the Code of Medical Ethics "that the AMA explicitly and unequivocally prohibits discrimination on the basis of sexual orientation (and other protected personal characteristics), without exception."¹⁴¹ The existence in *North Coast* of vastly different interpretations of what the Code requires and allows, the existence in the Code of provisions that prohibit the neglect of patients but do not explicitly prohibit discriminatory referrals, and the fact that the California Supreme Court fully ignored all of the medical ethics arguments lodged in *North Coast* are good evidence that, while the AMA Code of Medical Ethics may embody a spirit of nondiscrimination, it does not contain language sufficient to prevent discrimination in practice. The problem may lie in the curious disjunction in the Code between provisions covering potential physician-patient relationships and provisions covering ongoing physician-patient relationships. Perhaps the problem, too, is that the Code is not law, but is merely a set of rules that control the admission to and the retention of membership in what is essentially a private, voluntary association having little to do with a physician's ability to obtain and retain a license to practice.

I would submit that physicians' associations have a great deal to gain by harmonizing their codes of ethics with the rapidly expanding norms of nondiscrimination that are increasingly embodied in statutory provisions at the local, the state and, though less often, the federal levels. Expressing commitments to expanding access to health care, to respecting patients' cultural differences, and to working in the interest of patients' welfare and best interests rings hollow when unaccompanied by strongly worded prohibitions of discrimination that explicitly attach to each and every phase of the physician-patient relationship. This is not to say that the provisions of a code of medical ethics must always be suitable for inclusion in the law pertaining to medical practice. It is to say, however, that since the importance of codes of medical ethics lies in large part in their creation of perceptions among the public about whether they can trust that physicians are guided by a professional code committed to the principle of nondiscrimination, such codes would do well to articulate principles of ethical behavior that do not hold physicians to a lower standard than what is permitted by law.

141. Brief for Anti-Defamation League et al., *supra* note 72, at 19-20.