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Op-Ed: Doctors' right of conscience should not overshadow the importance of transgender people's access to healthcare

The 14th Amendment promises all U.S. citizens equal protection under the laws (Marshall 2013), so any discriminatory treatment of individuals is a clear violation of this constitutional amendment. And yet, many are subject to discrimination in the face of "conscience clauses": laws that permit people to deny services to others on moral or religious grounds (Prairie, Wrye, and Murfree 2017). Medical conscience clauses were first enacted after the 1973 *Roe v. Wade* ruling to protect healthcare workers' religious freedom, which is legitimized under the 1st Amendment, but these laws have dire implications for individuals seeking healthcare (Marshall 2013), particularly transgender people. While conscience clauses allow doctors the privilege of choosing whose health to improve, they create health inequities that disadvantage transgender individuals—an injustice under an equally salient constitutional right.

Transgender and gender non-conforming people have poorer health in general than cisgender people. In a study by Lagos (2018), while 30.28% of gender-nonconforming individuals, 23.32% of transgender men, and 18.42% of transgender women self-reported poor health, only 16.64% of cisgender men and 18.16% of cisgender women did so. One would think that these statistics would prompt healthcare systems and the government to make facilitating transgender people's access to healthcare a priority, yet transgender people face significantly more barriers to accessing safe, quality healthcare than cisgender people. Accessing healthcare is a challenge for most Americans, but the arduous task is exacerbated for transgender individuals by virtue of their gender identity, specifically due to:

- Being unable to afford care—transgender people are more likely to be in poverty (Carpenter, Eppink, and Gonzales 2020);
- Not having health insurance—transgender people are more are likely to be unemployed (Carpenter et al. 2020), and because jobs provide health insurance, many transgender people don't get access to these health resources;
- Having health insurance that doesn't cover transgender-specific healthcare needs,
- Healthcare providers having little to no knowledge about transgender-specific care,
- Facing discrimination from healthcare systems,
- Encountering hostility, bias, and stigma that often lead to being denied services (Puckett et al. 2017; Roller, Sedlak, and Draucker 2015).

Clearly, transgender people have to put in a significant amount of extra work just to access the quality of healthcare that is readily available to many cisgender people. But no matter how much effort they put in, transgender individuals still may not be able to get the healthcare they need. Structural stigma negatively impacts health outcomes for gender minorities as it deters them from seeking care due to anticipation or experience of clinical errors, poor treatment, discrimination, or care refusal (Grzanka et al. 2020). When the multitude of barriers leads transgender people to avoid seeking healthcare altogether, their health can become worse. Lagos's (2018) findings may be evidence of this effect.

Proponents of conscience rights argue that doctors should not be forced to work with patients that they do not wish to work with. Prairie, Wrye, and Murfree (2017) find that healthcare providers' opinions regarding the right to refuse treatment to LGBT+ patients are divided. Some respondents cited personal autonomy and religious beliefs as valid justifications for refusing services. One respondent claimed: "Medical practitioners have the right and responsibility to refuse to take care of any patients that they deem to be not compatible with their particular practice" (p. 545).

On the other hand, doctors chose a profession whose main goal is to ameliorate people's health. Another respondent from Prairie et al.'s (2017) study claimed it is their duty to serve patients: "We took the Hippocratic Oath to take care of patients regardless of whether or not we agree with their lifestyles, beliefs, or choices...Some people may not understand why/how someone is LGBT, but it is not a provider's role to judge this. It is our role to provide safe, compassionate care" (p. 544).

Some may argue that transgender individuals can just go find doctors that are willing to work with them, but how feasible is this alternative? In a study by Curlin et al. (2007), it was found that while 63% of respondents (practicing physicians) believe that it is ethical for doctors to explain to their patients the reasons for their moral objection, 86% believe that doctors are obligated to disclose information regarding their patients' medical options, and 71% believe that doctors are obligated to refer their patients to other doctors who would be willing to provide the requested service. These results suggest that there may be a significant number of doctors who would take advantage of the right granted to them by conscience clauses to discriminate against LGBT+ patients. Furthermore, even if the doctors don't provide the services themselves, a substantial portion of them believe that they don't have to guide patients towards other options, forcing sexual and gender minorities to find out critical information by themselves, posing yet another barrier to care. One respondent from Prairie et al.'s (2017) study warned that "[i]f everyone could theoretically practice this discrimination, LGBT patients could potentially not receive any care (even with a guarantee to medical care), especially in smaller population centers" (p. 544). There is no silver lining to balance out the barriers that conscience clauses pose.

Research markedly demonstrates the detrimental effects that conscience clauses have on transgender people, who already face a multitude of issues in health and healthcare access, and how conscience clauses exacerbate their circumstances disproportionately compared to cisgender people. The United States preaches freedom of religion and nondiscrimination simultaneously but seems to be unable to fulfill both of these promises. However, there is a clear, skewed injustice that must be addressed. Policymakers must understand how laws like conscience clauses can disproportionately harm certain groups of people. They should not be able to get away with prioritizing conscience rights over equal treatment, catering to religious doctors while leaving gender minorities to suffer.

If politicians are concerned about the religious freedom of America's doctors, they should work to uphold that, but not at the expense of another group of people. As one respondent in Prairie et al.'s (2017) study noted, however, if a doctor who dislikes transgender people is forced to work with them, "the care received would likely be substandard and certainly not compassionate" (p. 546). If conscience clauses are to hold, both to protect doctors' right of conscience and to prevent transgender individuals from receiving substandard care, they should, at the absolute least, require doctors who don't want to work with certain individuals to refer them to doctors who do. This proposed solution does not erase the structural barriers to care, but it is a starting point that proponents of conscience rights would be the most likely to agree to. Ultimately, marginalized groups like transgender individuals should not be forced to choose between facing emotionally distressing discrimination, working unneccessarily hard to find quality care, and not receiving care at all.

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