
RECENT CASES

FIRST AMENDMENT — CALIFORNIA SUPREME COURT HOLDS THAT FREE EXERCISE OF RELIGION DOES NOT GIVE FERTILITY DOCTORS RIGHT TO DENY TREATMENT TO LESBIANS. — *North Coast Women's Care Medical Group, Inc. v. San Diego County Superior Court*, 189 P.3d 959 (Cal. 2008).

Ever since reproductive technology made childbearing a viable option for those who cannot otherwise conceive, doctors have been limiting access to that technology by deciding who can receive treatment.¹ Women over the age of forty, unmarried women, and lesbians have all been denied access.² Recently, in *North Coast Women's Care Medical Group, Inc. v. San Diego County Superior Court*,³ the California Supreme Court held that the right to religious freedom did not exempt medical clinic physicians from complying with the California Unruh Civil Rights Act,⁴ which prohibits discrimination based on a person's sexual orientation.⁵ The court found that the Free Exercise Clause of the Federal Constitution did not mandate an exemption from the Act for religious expression and that the burden on doctors' religious beliefs was clearly outweighed by the state's interest in granting full and equal access to medical treatment. The court created two exceptions to its holding: doctors could stop offering access to that treatment altogether or could refer the patient within the practice. Although the court in *North Coast* tried to effectuate "California's compelling interest in ensuring full and equal access to medical treatment irrespective of sexual orientation,"⁶ the decision can more accurately be viewed as a realistic compromise between access to and quality of health care.

In August of 1999, plaintiff Guadalupe Benitez and her partner, Joanne Clark, were referred to defendant North Coast Women's Care Medical Group for fertility treatment.⁷ In her first meeting with de-

¹ For an opinion on the judgment involved in allowing access to reproductive technology, see ELIZABETH BARTHOLET, *FAMILY BONDS* 33 (Beacon Press 1999) (1993) ("No one asks [those capable of natural reproduction] to prove that they are fit to parent."). See also *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (describing the right to marry and procreate as "one of the basic civil rights of man").

² See BARTHOLET, *supra* note 1, at 192–93; Andrea D. Gurmankin, Arthur L. Caplan & Andrea M. Braverman, *Screening Practices and Beliefs of Assisted Reproductive Technology Programs*, 83 *FERTILITY & STERILITY* 61, 65 (2005); Robyn S. Shapiro, *Bioethics Issues Surrounding the Beginning of Life: Legal Aspects in the United States*, in *LEGAL PERSPECTIVES IN BIOETHICS* 126, 131 (Ana S. Iltis, Sandra H. Johnson & Barbara A. Hinze eds., 2008).

³ 189 P.3d 959 (Cal. 2008).

⁴ CAL. CIV. CODE § 51 (West 2007).

⁵ *North Coast*, 189 P.3d at 970.

⁶ *Id.* at 968.

⁷ *Id.* at 963.

fendant Dr. Christine Brody, Benitez told Brody that she was a lesbian.⁸ Dr. Brody advised Benitez that fertility treatment might ultimately include intrauterine insemination (IUI), but explained that she would not perform this procedure for Benitez because of her religious beliefs.⁹

After almost a year of basic medication and testing failed to result in pregnancy, Benitez decided to try IUI. Dr. Brody went on vacation in the midst of this decision, so Dr. Douglas Fenton, another physician in the practice, took over Benitez's care.¹⁰ Dr. Fenton had the same religious objection as Dr. Brody to performing IUI for Benitez, but the other two doctors in the clinic had no objection. Dr. Fenton mistakenly believed that Benitez wished to use fresh sperm rather than sperm from a sperm bank for the IUI procedure. Since he was the only doctor in the clinic licensed to prepare fresh sperm, he referred Benitez to an outside physician.¹¹ Benitez brought suit against North Coast, Dr. Brody, and Dr. Fenton on the basis of sexual orientation discrimination in violation of California's Unruh Civil Rights Act, which provided that "[a]ll persons[,] . . . no matter what their sex, race, color, religion, ancestry, national origin, disability, or medical condition are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever."¹² Defendants countered that their actions were "protected by the rights of free speech and freedom of religion set forth in the federal and state Constitutions."¹³ A factual dispute also arose: Dr. Brody asserted that she had objected to inseminating any unmarried woman, whereas Benitez claimed that the refusal was due to her sexual orientation.¹⁴

Before trial began, Benitez moved for summary adjudication of the freedom of religion defense, stating that it contained no triable issue of

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.* at 964.

¹¹ *Id.* Dr. Fenton claimed that he told Benitez that North Coast would pay for any additional costs she would incur as a result of the referral. *North Coast Women's Care Med. Group, Inc. v. Superior Court*, 40 Cal. Rptr. 3d 636, 640 (Ct. App. 2006). The referred physician's IUI was unsuccessful, but a subsequent procedure, in vitro fertilization (IVF), resulted in pregnancy. *North Coast*, 189 P.3d at 964.

¹² CAL. CIV. CODE § 51(b) (West 2000) (current version at CAL. CIV. CODE § 51(b) (West 2007)). Although sexual orientation was not explicitly listed in the Unruh Act until 2005, the court noted that, "before 1999, California's reviewing courts had, in a variety of contexts, described the Act as prohibiting sexual orientation discrimination." *North Coast*, 189 P.3d at 965; see also *In re Cox*, 474 P.2d 992, 995 (Cal. 1970) ("That the act specifies particular kinds of discrimination . . . serves as illustrative, rather than restrictive, indicia of the type of conduct condemned.").

¹³ *North Coast*, 189 P.3d at 964.

¹⁴ *Id.* at 963 n.1.

material fact.¹⁵ The trial court granted the motion, relying on *Employment Division v. Smith*¹⁶ to hold that defendants were not exempted from the obligations of the Unruh Act.¹⁷ Under strict scrutiny review,¹⁸ the trial court found that the Act served the “compelling interest of eliminating discrimination by business establishments.”¹⁹

The California Court of Appeal issued a writ of mandate setting aside the trial court’s ruling.²⁰ The court reasoned that there was still an issue of material fact as to whether the discrimination was a result of Benitez’s sexual orientation or her status as an unmarried woman.²¹ While sexual orientation was a protected class at the time of the event, marital status was not, so the Court of Appeal vacated the trial court’s order granting summary adjudication on the affirmative defense.²²

The California Supreme Court reversed. Writing for the court, Justice Kennard examined both federal and state constitutional law and held that the right to religious freedom did not give doctors an exemption from compliance with the Unruh Act. “[A] religious objector has *no federal constitutional right* to an exemption from a neutral and valid law of general applicability on the ground that compliance with that law is contrary to the objector’s religious beliefs.”²³ The court held that since the Unruh Act was “a valid and neutral law of general applicability,”²⁴ the doctors had to comply “even if compliance pose[d] an incidental conflict with defendants’ religious beliefs.”²⁵ The court also rejected the defendants’ argument that *Smith* created a class of “hybrid rights” that could exempt defendants from compliance if free speech was implicated in addition to religion, noting not only that such

¹⁵ Benitez v. North Coast Women’s Care Med. Group, No. GIC770165, slip op. at 2–3, 2004 WL 5047112 (Cal. Super. Ct. Oct. 28, 2004).

¹⁶ 494 U.S. 872 (1990).

¹⁷ Benitez, No. GIC770165, slip op. at 3. *Smith* held that Oregon had the right to deny unemployment compensation to Native Americans fired for using illegal drugs, even if for religious purposes. *Smith*, 494 U.S. at 890.

¹⁸ “Under strict scrutiny, ‘a law could not be applied in a manner that substantially burden[ed] a religious belief or practice unless the state show[ed] that the law represent[ed] the least restrictive means of achieving a compelling interest.’” *North Coast*, 189 P.3d at 968 (quoting *Catholic Charities of Sacramento, Inc. v. Superior Court*, 85 P.3d 67, 91 (Cal. 2004)).

¹⁹ Benitez, No. GIC770165, slip op. at 4.

²⁰ *North Coast Women’s Care Med. Group, Inc. v. Superior Court*, 40 Cal. Rptr. 3d 636, 648 (Ct. App. 2006).

²¹ *Id.* at 647.

²² *Id.* at 647–48.

²³ *North Coast*, 189 P.3d at 966.

²⁴ *Id.* (quoting *Employment Div. v. Smith*, 494 U.S. 872, 879 (1990)) (internal quotation marks omitted).

²⁵ *Id.* at 967.

an exception would swallow the rule, but also that free speech was not at issue.²⁶

The court determined that the California Constitution did not exempt defendants from the Unruh Act either.²⁷ Although the court acknowledged that it had not yet set out a standard of review for religion-based challenges under the state's constitution, it found no need to determine the applicable standard because the defendants' claim would fail even under strict scrutiny.²⁸ Even though the Unruh Act substantially burdened defendants' religious beliefs, it "further[ed] California's compelling interest in ensuring full and equal access to medical treatment irrespective of sexual orientation, and there [were] no less restrictive means for the state to achieve that goal."²⁹ The court observed that this holding would not actually force Drs. Brody and Fenton to perform IUI for Benitez: to avoid the conflict, they could either stop offering IUI as a procedure or "ensur[e] that every patient requiring IUI receives 'full and equal' access to that medical procedure through a North Coast physician lacking defendants' religious objections."³⁰ The court noted that the defendants were not precluded from presenting evidence that the discrimination was actually the result of Benitez's marital status, an unprotected classification.³¹

Justice Baxter concurred. He noted that he did "not necessarily believe the state has a compelling interest in eradicating every difference in treatment based on sexual orientation."³² However, Justice Baxter agreed with the majority because the burden imposed on the right to freedom of religion did not overcome the state's interest in enforcing its civil rights statute under these facts, particularly because someone in the practice lacking the defendants' religious objections could provide IUI and satisfy the "full and equal" requirement.³³ But the test might have come out the other way, according to Justice Baxter, in the case of a sole practitioner who was not able to refer the patient to another member of the same practice.³⁴ In his view, forcing such a phy-

²⁶ *Id.* (citing *Catholic Charities of Sacramento, Inc. v. Superior Court*, 85 P.3d 67, 87–88 (Cal. 2004)).

²⁷ The California Constitution states in relevant part that "[f]ree exercise and enjoyment of religion without discrimination or preference are guaranteed." CAL. CONST. art. I, § 4.

²⁸ *North Coast*, 189 P.3d at 968. Defendants advocated a standard even stricter than strict scrutiny, which the court rejected as having no basis in law. *Id.* at 969.

²⁹ *Id.* at 968.

³⁰ *Id.* at 968–69 (citing CAL. CIV. CODE § 51(b) (West 2000) (current version at CAL. CIV. CODE § 51(b) (West 2007))).

³¹ *Id.* at 970.

³² *Id.* at 971 (Baxter, J., concurring).

³³ *Id.*

³⁴ *Id.* "At least where the patient could be referred with relative ease and convenience to another practice," the state might not have sufficient interest "in full and equal medical treatment"

sician to do the procedure might not be the “least restrictive” means for reaching full and equal treatment.

While *North Coast* is an admirable step toward the stated goal of “full and equal access” to medical treatment, in practice the result is not perfect access but a necessary balance of interests. In holding as it did, the court made several contributions to access. First, the court’s holding means that, notwithstanding the exceptions, doctors cannot object on religious grounds to a patient’s request for a procedure.³⁵ This may prompt certain doctors to find that their religious convictions are not worth the difficulty of refusing treatment. Second, an objecting doctor is now required to do the legwork that was previously the patient’s responsibility — that is, finding another doctor in the practice to take over treatment.³⁶ Third, those doctors who do choose to refuse treatment will be permitted to refer patients only to other doctors *within* their practice. No patient will be forced to transfer to an outside physician, who might not be covered by the patient’s insurance, or whose offices might be in a more distant location.³⁷ This preserves a measure of convenience for the patient inconvenienced by the doctor’s refusal to treat. The benefits of improved access will be most apparent in rural areas, where the medical market is less competitive³⁸ and thus a doctor’s refusal to treat a patient could leave her with few alternatives. However, the court did not hold that doctors could be *forced* to perform a procedure. Instead, the doctor could stop offering that procedure completely or refer the patient to another doctor in the practice who did not share the religious objection. These exceptions reflect the realistic compromise the court struck between patients’ interests in access on one hand and religious freedom and the interest in quality care on the other.

While *North Coast* certainly improves access for patients whose doctors had previously refused to treat them, making access fuller for those patients and more equal across the general population, the holding might have the unintended effect of making general access to medical care less “full.” If doctors find that their religious conviction

to “compel a physician in sole practice to provide a treatment to which he or she has sincere religious objections.” *Id.*

³⁵ See *id.* at 968 (majority opinion).

³⁶ *Id.* at 968–69. But see Farr A. Curlin et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 NEW ENG. J. MED. 593, 593 (2007) (reporting that 71% of U.S. physicians already believe that they are obligated to refer patients to other physicians who would not object to the requested procedure).

³⁷ See *North Coast*, 189 P.3d at 969.

³⁸ See Jonathan Choslovsky, Note, *Agency Review of Health Care Industry Mergers: Proper Procedure or Unnecessary Burden?*, 10 ADMIN. L.J. AM. U. 291, 295 (1996) (“In some areas an overabundance of technologically advanced equipment and highly trained medical personnel exists, while other, typically rural areas, face a shortage of doctors and facilities.”).

in refusing to perform a procedure on certain patients outweighs their economic interest in offering a full array of services, they may cease offering procedures like IUI altogether.³⁹ If the number of doctors who stop providing treatment altogether is greater than the number who start providing treatment in spite of their religious beliefs, access to such procedures will decrease even as the equality of access experienced by traditionally disadvantaged groups improves.⁴⁰ This is not necessarily a negative result; it merely signifies distributive justice taking precedence over full access.⁴¹ Moreover, the effect of this first exception may be mitigated by the second, which is itself not a perfect solution but merely an effective compromise.

North Coast also falls short of the goal of complete equality by allowing doctors to refer patients to other doctors in their practice.⁴² The decision makes access to medical *procedures* constant between groups, but still places restrictions on access to specific providers; the homosexual unmarried woman will not have her choice of all doctors

³⁹ While data on the subject are hard to come by, it seems likely that some doctors would refuse to treat. Cf. Gurmankin, Caplan & Braverman, *supra* note 2, at 64 (“[O]f those [Assisted Reproductive Technology] programs that report that they do not collect information on sexual orientation, 48% report being very or extremely likely to turn away a gay couple and 17% a lesbian couple.”). This practice already occurs with abortions. See, e.g., CAL. HEALTH & SAFETY CODE § 123420(a) (West 2006) (stating that physicians cannot be required to perform abortions); CAL. PROB. CODE § 4734(a) (Deering 2004) (“A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience.”). Since abortion, unlike IUI, is generally offered or refused to *all* patients, regardless of sexual orientation, marital status, or any other individual characteristic, it does not raise the same equality issues.

⁴⁰ This assumes that the doctors who stop providing treatment are not clustered in a geographic or socioeconomic community. Additionally, the decrease in access might not occur if doctors without a religious objection perceive this market gap and change their specialty to fill it.

⁴¹ This may not be enough for those who object to conscience clauses completely. As Professor Martha Swartz argues, state-granted medical licenses give doctors a monopoly on medical practice and should carry an obligation to provide any procedure that is requested by the patient so long as it is not medically inappropriate or illegal. Martha S. Swartz, “Conscience Clauses” or “Unconscionable Clauses”: *Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL’Y L. & ETHICS 269, 277–78 (2006); see also Julian Savulescu, *Conscientious Objection in Medicine*, 332 BRIT. MED. J. 294, 294 (2006) (“If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.”). Professor Swartz’s outcome would likely be acceptable under *Employment Division v. Smith*, 494 U.S. 872 (1990), as the Unruh Act is still a “valid and neutral law of general applicability.” *Id.* at 879 (quoting *United States v. Lee*, 455 U.S. 252, 263 n.3 (1982) (Stevens, J., concurring in the judgment)) (internal quotation mark omitted). However, while the court did not go into any such analysis, it may have assumed that a holding without exceptions would not have withstood the “least restrictive means” prong of the California test.

⁴² The majority never explicitly states that interoffice referrals are prohibited, but the holding clearly implies a prohibition for multidocor offices. As the concurrence observes, sole practitioners may be exempt from compliance as the burden on their religious freedom is too high. *North Coast*, 189 P.3d at 971 (Baxter, J., concurring). Doctors could potentially reorganize as sole practitioners to take advantage of this possible exemption, but the startup costs and risk of future suits make this quite unlikely.

within a practice.⁴³ This exception from the *North Coast* rule essentially means that individual doctors can still discriminate so long as someone in the same building can do the procedure instead.⁴⁴ Equal access would truly be maximized, one would think, if every patient walking into a medical practice could receive the procedure she wanted from whichever doctor she wanted, assuming the procedure was consistent with medical ethics.⁴⁵ One might even think that the “separate but equal” fallacy dispensed with in *Brown v. Board of Education*⁴⁶ might be applicable here. A doctor’s office seems to be no different from any other place of public accommodation where discrimination is unacceptable.⁴⁷ The analogy breaks down, though, because of the intimate role doctors play and the competing constitutional right to freedom of religion.⁴⁸ True *Brown* equality is not the appropriate goal when equality of access must compete against quality of care.

Indeed, doctors who perform identical procedures are not fully interchangeable, and the most equal access is not necessarily the best access.⁴⁹ The inconvenience of going to one doctor in a practice rather than another is not great, and the harm to dignity suffered in being treated by an unwilling doctor might actually decrease access to quality care.⁵⁰ The court explicitly noted that “defendant physicians re-

⁴³ Since medical practices employing only doctors with religious objections would have to provide treatment or stop offering the procedures, they are likely to respond to *North Coast* by hiring a nonobjecting doctor to deal with problematic cases.

⁴⁴ In other words, had there been no miscommunication within *North Coast*, one of the other doctors in the practice could have done the IUI and Drs. Brody and Fenton would not have been subject to suit.

⁴⁵ See Swartz, *supra* note 41, at 350. *But see* HOLLY FERNANDEZ LYNCH, CONFLICTS OF CONSCIENCE IN HEALTH CARE 10 (2008) (“If we treat physicians merely as sophisticated medical vending machines, we risk further damage to medical professionalism and the doctor-patient relationship Arguably, patients would lose a great deal if we forced doctors to completely abandon their own morality in the clinical setting — and physicians most certainly would.” (footnote omitted)).

⁴⁶ 347 U.S. 483 (1954).

⁴⁷ LYNCH, *supra* note 45, at 155 (“Physicians are expected, as professionals, to be model citizens and to behave exceptionally well. Why, then, would we allow them to discriminate on invidious grounds when we do not allow barbers, restaurateurs, or landlords to do so?”).

⁴⁸ Jacob M. Appel, *May Doctors Refuse Infertility Treatments to Gay Patients?*, HASTINGS CTR. REP., July–Aug. 2006, at 20, 21 (“The nature of the doctor-patient relationship is fundamentally more intimate than the sorts of interactions that occur between landlords and tenants or innkeepers and guests.”); *see also* W. GRANT THOMPSON, THE PLACEBO EFFECT AND HEALTH 192 (2005) (“[A doctor’s] appearance and demeanor, the attitude and life experience she brings to the encounter, and the empathy and clarity with which she teaches her patient what he needs to know about his illness contribute to the success of the doctor/patient relationship.”).

⁴⁹ LYNCH, *supra* note 45, at 203–04 (noting not only that it is impractical to compel a physician to perform a procedure, but also that “most patients would likely not want care from a doctor compelled to provide it”).

⁵⁰ *Cf.* THOMPSON, *supra* note 48, at 185 (“Patients are more likely to experience placebo effects if they like and have confidence in the doctor and if treatment is prescribed enthusiastically.”); Michael W. Kahn, *Etiquette-Based Medicine*, 358 NEW ENG. J. MED. 1988, 1988 (2008)

main free to voice their objections, religious or otherwise, to the Act's prohibition against sexual orientation discrimination."⁵¹ A doctor would have every right to voice that objection to a patient, resulting in a potentially acrimonious relationship. A patient's quality of care, then, is likely to improve if she can be transferred to a physician down the hall who does not object and can provide helpful counsel. Accordingly, allowing a doctor to decline to treat certain patients for certain procedures, so long as she provides an easy alternative, might actually increase the quality of affected groups' medical care.⁵²

Full and equal access is not truly attained in *North Coast*, but the resulting access might nevertheless be optimal. Most people would prefer to be treated by a willing doctor who approves of the procedure being performed and of the lifestyle being promoted. While being referred down the hall can be hurtful to a patient, the same might be true of being treated by someone who does not approve of the patient's lifestyle choices. With these two considerations to weigh, and with freedom of religion in the background, the court came down on the side of convenience. Some convenience is certainly lost in allowing doctors to refer patients within the practice and in certain doctors choosing to stop offering certain procedures altogether. But such minimal losses in convenience may be offset by gains in religious freedom protections and overall quality of patient care, producing the optimal result in a difficult case.

("Patients ideally deserve to have a compassionate doctor, but might they be satisfied with one who is simply well-behaved?"). The Unruh Act does not explicitly mention the type of access granted, so it could be said that equal access to a positive emotional experience is not required. The court may be reading a notion of quality care into the Act, or it may be departing from the Act altogether and using its own definition of the state's compelling interest.

⁵¹ *North Coast*, 189 P.3d at 967.

⁵² The two exceptions also bring an obvious benefit to religious freedom when the harm to access is low. Commentators have argued in favor of the religious freedom rationale in the pharmacist context. See, e.g., Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 *FORDHAM URB. L.J.* 221, 242 (2002) ("Conscientious objection implies the physician's right not to participate in what she thinks morally wrong, even if the patient demands it."); Mary K. Collins, *Conscience Clauses and Oral Contraceptives: Conscientious Objection or Calculated Obstruction?*, 15 *ANNALS HEALTH L.* 37, 59-60 (2006) ("Conscientious objectors should be free to practice in accordance with their beliefs, but should have to give employers and patients reasonably advanced notice that they may not be reliable in certain situations. . . . The health professional should not be required to actively participate in actions that violate personal morals."); Nell O. Kromhout, Note, *Crushed at the Counter: Protection for a Pharmacist's Right of Conscience*, 6 *AVE MARIA L. REV.* 265, 286 (2007) ("Living out one's moral position according to the conscientious choice of good over evil cannot and should not be prevented by positive law. Such law would be a violation of the very dignity of the human person.").