

Discriminatory Conscientious Objections in Healthcare:

A Response to Ancell and Sinnott-Armstrong

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Abstract: Aaron Ancell and Walter Sinnott-Armstrong (A&SA) propose a pragmatic approach to problems arising from conscientious objections in healthcare. Their primary focus is on private healthcare systems like that in the United States. A&SA defend three claims: (i) many conscientious objections in healthcare are morally permissible and should be lawful, (ii) conscientious objections that involve invidious discrimination are morally impermissible, but (iii) even invidiously-discriminatory conscientious objections should not always be unlawful, as there is a better way to protect patient rights. Pursuant to (iii), A&SA propose a framework that legally allows discriminatory conscientious objections, but that shifts the financial costs associated with such objections from patients to the clinics that employ doctors who discriminate against patients. Though their proposal is controversial, it has attractive features, and merits further discussion. In this paper, I remain neutral on the third claim A&SA advance in support of their proposal, but point out a problem with the two first claims. In the light of my criticisms, I propose to modify their proposal so that costs are shifted to clinics in a broader range of cases.

Keywords: Conscientious objection; private healthcare systems; discrimination; patient rights

The Benitez Case

In their paper ‘We want children, too: how to allow conscientious objection in medicine while protecting patient rights’¹, Aaron Ancell and Walter Sinnott-Armstrong (henceforth A&SA) depart from, and build their arguments around, the Benitez Case.

In 1999, after several unsuccessful attempts to become pregnant through self-insemination with donor sperm, Guadalupe Benitez was referred to her local clinic for fertility treatment. Dr. Brody, her treating gynecologist, advised her that, to increase her chances of becoming pregnant, it would be necessary to undergo intrauterine insemination (IUI). However, Dr. Brody also made it clear that, for religious reasons, she was not prepared to provide this service to Benitez, who was unmarried and in a relationship with a woman. Dr. Brody’s colleague—Dr. Fenton—also refused to provide IUI to Benitez on religious grounds. He referred her to another clinic, where Benitez eventually became pregnant through *in vitro* fertilization (IVF). However, as that clinic did not accept her health

insurance, the treatment cost her much more than it would have cost at her local clinic. Benitez sued her local clinic and, in 2008, the California Supreme Court ruled that freedom of religion could not be invoked to justify discrimination against patients. Almost a decade after she became pregnant, Benitez received compensation.

A&SA agree that the gynecologists' refusals to treat Benitez were wrongfully discriminatory and, therefore, morally impermissible, but disagree that their refusals should be unlawful. They argue that there is a better way to protect patient rights and induce social progress toward less discrimination, at least in a private healthcare system like that of the United States.² Before introducing their proposal, I will explain the claims A&SA advance in support of it. I will point out a problem with two of these claims and suggest that, in light of my criticisms, the proposal should be modified.

Claim One: Many Conscientious Objections are Permissible and Should Be Lawful

The first important claim that A&SA defend is that many, if not most, conscientious objections in healthcare are morally permissible and should be lawful.³ To explain this, they distinguish between two different types of conscientious objection that, they claim, are often conflated:

- 1) Objections against providing a service to a patient because of the nature of that service, and
- 2) Objections against providing a service to a patient because of some characteristic of the patient.

An example of a type (1) objection would be a doctor who refuses to provide an abortion to her patient because she thinks abortion involves murdering a baby. The doctor's objection is against the nature of procedure, not against providing it to patients with particular characteristics.

A&SA argue that type (1) objections are morally permissible and should be legally permitted because they simply fall within doctors' accepted moral and legal freedom to specialize (e.g., as a dermatologist, a gynecologist) and to determine which services to offer in their practices according to their personal preferences or for other self-interested reasons. Currently, doctors are not morally or legally obligated to offer all the services that are lawful and widely accepted in their society, and within their sphere of competence (unless it is in their contract, it is an emergency, or the service is central to their specialization)⁴.

Doctors are also morally and legally permitted to withhold certain services for self-interested reasons such as self-protection. For example, in a society where doctors who perform abortions are frequently attacked or threatened, an obstetrician is permitted to cease offering abortion services out of concern for her safety.

A&SA claim that:

“If physicians are free to refrain from offering a service on the basis of their personal preferences or interests, then physicians must also be free to refrain from offering that service on the basis of moral or religious objections to it. The fact that a physician declines to offer a particular service for moral or religious reasons rather than for self-interested reasons cannot make a difference to whether that physician is permitted to refrain from offering it.”⁵

Somewhat more controversially, A&SA develop a similar argument to defend the claim that many type (2) objections—against providing a service because of some characteristic of the patient—are also morally permitted and should be legally allowed. They refer to the fact that doctors are usually also free to work with *a certain patient population* on the basis of their personal preferences or for self-interested reasons. For example, a doctor is allowed to choose to become a pediatrician simply because she likes children, or a gynecologist because she simply prefers to treat women. A&SA conclude that if doctors are free to restrict their services to a certain patient population on the basis of personal preferences or for other self-interested reasons, they should also be free to do this for religious or moral reasons.

So why then was the decision of doctors Brody and Fenton not to treat Benitez morally impermissible, according to A&SA? After all, they simply chose to serve a particular patient population: one that excludes unmarried lesbians.

Claim Two: Invidiously Discriminatory Objections are Impermissible

To explain why the refusal to treat Benitez was morally impermissible, A&SA make two further distinctions. Type (2) objections can be either:

- 2a) Objections against providing a service to a patient because of some negative attitude or judgment about some characteristic of the patient.
- 2b) Objections against providing a service to a patient because of some *unjustified* negative attitude or judgment about some characteristic of the patient.

The Benitez case falls under type (2b) objections. The reason why doctors Brody and Fenton acted impermissibly, according to A&SA, is that they refused a treatment on the basis of an *unjustified* negative attitude or judgment about one or more of Benitez’ characteristics: being unmarried and/or lesbian. Refusing a treatment for that reason amounts to invidious discrimination, and doctors, just like anyone else, should not engage in invidious discrimination. Thus, their second claim is that invidiously discriminatory conscientious objections in healthcare are morally impermissible.

Note that A&SA seem to think there is nothing special about *conscientious* objections. It is irrelevant whether a doctor's objection to providing a service is grounded in mere preferences or other self-interested reasons, or in deeply held religious or moral beliefs. Regardless of the nature of the objection, if it involves invidious discrimination, it is morally impermissible. Importantly, A&SA state that (conscientious) objections only involve invidious discrimination when they are based on an *unjustified negative attitude or judgment* about some characteristic of the patient (type 2b objections). I will return to this.

Claim Three: Discriminatory Conscientious Objections Should Not Be Unlawful

A&SA then go on to argue that legally prohibiting invidiously discriminatory conscientious objections is not always the best approach to protecting patient rights and interests. This is because it might lead to a situation in which patients are treated by reluctant doctors who hold unjustified negative attitudes or judgments about the patient, and this may not be in the patient's best interests. Such a doctor may fail to act in the patient's best interests, or the patient may fear that this will be the case, thus undermining her trust in the doctor-patient relationship. In addition, they argue that legally forcing doctors to act against their conscience may actually reinforce their prejudices. The alternative approach that A&SA propose arguably better protects patient rights and interests, while also preserving doctors' freedom.

The Proposal

A&SA's proposal contains three key elements, the third of which is the most original but also the most controversial. The first two elements are 'the publicity requirement' (any doctor/clinic that refuses to treat a particular patient population must publicly announce that fact), and 'the information requirement' (the refusing doctor/clinic must provide information about where the patient can receive the requested treatment.) The third element is the 'paying cost' requirement. Suppose that both the publicity and the information requirements are met. Seeking the appropriate treatment elsewhere may still impose extra financial costs on the patient. For example, the other clinic may be far away or may not take the patient's health insurance, as was the case with Benitez. According to A&SA, the extra financial costs should be shifted away from the patient and on to the clinic whose clinicians are refusing to provide the treatment, as, ultimately, what brings about these costs is the clinic's failure to have a doctor willing to provide the treatment indiscriminately. Thus, if all relevant doctors at clinic A refuse to provide a particular treatment to a patient and these refusals involve invidious discrimination, then clinic A should pay any extra costs imposed on that patient for seeking treatment at clinic B. Importantly, the cost requirement only applies if the conscientious

objection constitutes invidious discrimination. A&SA stress that the strength of their proposal is not only that it would simultaneously protect patient rights (the patient would receive treatment—though at another clinic) and doctors’ freedoms (doctors are legally allowed to refuse); it would also induce social progress. This is because the proposed system would create a financial incentive for clinics to hire doctors who are willing to treat all patients, without invidious discrimination. This would allow them to avoid paying the extra costs of patients having to seek the refused treatment elsewhere. Doctors who are willing to treat all patients indiscriminately would have a market advantage. Over time, the number of doctors who engage in discrimination would decrease. Thus, A&SA’s proposal would arguably protect patient rights, both immediately, by ensuring access to medical care, and in the longer term, by inducing social progress toward the equal treatment of all patients—and this, without restricting doctors’ freedoms. Moreover, one can see how such a system could be a politically attractive option in the United States, where ‘free market’ solutions are highly valued.

Having explained A&SA’s proposal, and the three claims advanced in support of it, I will now point out a problem with the first two claims (‘many conscientious objections in healthcare are morally permissible and should be lawful’, and ‘conscientious objections that involve invidious discrimination are morally impermissible’). I will, for the sake of argument, accept the third claim (‘making invidiously discriminatory conscientious objection unlawful is not the best option to tackle discrimination’), though I realize this claim merits discussion too.

One Freedom is Not the Other

A&SA’s first claim is that many cases of conscientious objection in healthcare are morally permissible and should be legally allowed because they fall within the moral and legal freedom of doctors to specialize, define the scope of their practice, and treat a particular patient population according to their personal preferences, or for self-interested reasons such as self-protection. According to A&SA, whether a refusal is based on personal preference, or grounded in deeply held religious or moral values cannot make a difference to its permissibility. They don’t provide an argument for this claim.

There are, however, reasons to believe that there is a morally relevant difference between refusals for moral or religious reasons on the one hand, or for self-interested reasons on the other, and thus, it is not *automatically* true that there should be no legal difference.

Indeed, this discussion is at the heart of the debate about conscientious objection. Those in favor of allowing (some) conscientious objections often take this position partly on the basis that it is

important to protect the objector's conscience. Hence, it is important to ensure that the objector's objections are grounded in deeply held moral or religious values.⁶

I think an argument could also be made for the opposite view. One could argue that it is morally *more* problematic to refuse treatment if one's objections are grounded in deeply held moral or religious values.

Imagine three different gynecologists who refuse to provide abortion services:

- Dr. A does not perform abortions because each time she performs the procedure she becomes nauseous and faints.
- Dr. B does not perform abortions because she feels too passionate about many other aspects of obstetrics and gynecology; it is impossible for her to offer all the services obstetricians and gynecologists could offer.
- Dr. C does not perform abortions because she thinks abortion amounts to murdering persons with full moral status.

Drs. A and B refuse to provide abortion services out of personal preference or for self-interested reasons, whereas Dr. C refuses to provide these services for religious or moral reasons. It seems to me that the refusals of Drs. A and B could have effects that are different in a morally relevant way from Dr. C's refusal.

First, Dr. C's refusal is likely to have different effects on the patient to whom she refuses to provide abortion. This is because her refusal expresses, or may be seen as expressing, strong moral disapproval of the patient's decision to abort, perhaps even of her whole personality (e.g. the patient may be considered a murderer). This may directly affect the patient, who might feel worse about her decision to abort, or feel under pressure to change her mind. It could also be expected to damage the doctor-patient relationship as the patient may wonder whether Dr. C will continue to provide her with the best possible care after she had an abortion. Importantly, Dr. C's refusal may also have more widespread effects. Doctors are often (mistakenly) regarded as having special moral authority on medical matters. If gynecologists publicly refuse to perform abortions for moral or religious reasons this is likely to add credence to the view that abortion is morally wrong, and this may adversely affect women, for example, by stigmatizing them.

Another hypothetical case may help to make my point:

A pregnant couple visits their gynecologist, who informs them that the genetic test they chose to undergo shows their child will have Down Syndrome. In a neutral way, she explains various options to the couple (including abortion). She also, in a very friendly and neutral tone, informs them that she conscientiously objects to bringing children with disabilities into

the world, and that, should they choose to continue the pregnancy (which is entirely up to them), another gynecologist will have to follow up the pregnancy and bring the baby into the world. The gynecologist provides them with the contact details of a colleague who is prepared to bring babies with Down Syndrome into the world.

Contrast this with a variant of the case in which the gynecologist informs the couple that she will go on parental leave for two years and will, therefore, not be able to follow-up the pregnancy and deliver the baby.

I think most would agree that there is a significant moral difference between these scenarios. As a result, it does not *automatically* follow from the fact that the doctor would be allowed to refuse continuation of treatment in the parental leave case, that she is also legally allowed to refuse continued treatment in the Down syndrome case. This requires further argument.

My point here is that A&SA are too quick in claiming that in cases where doctors are allowed to choose their specialty, subspecialty, and patient population on the basis of their personal preferences or for other self-interested reasons, it should also automatically be morally permissible and lawful to do all of these things for moral or religious reasons. The fact that it is a *conscientious* objection may make a morally (and thus potentially legally) relevant difference.

This point is important as the crux of A&SA's proposal—the paying costs requirement—only applies to morally impermissible conscientious objections, and according to A&SA, generally,⁷ the only objections within this category (with a few exceptions, like in the case of an emergency) are those that involve invidious discrimination. But, if my arguments above are sound, A&SA cannot exclude other types of conscientious objections from the scope of their proposal as easily as they claim. We may have good reason to include such conscientious objections in the proposal as well. I will return to this point.

Discrimination

A&SA's first claim—that most conscientious objections are morally permissible and should be lawful because they fall within the moral and legal limits we already accept for objections grounded on self-interested reasons—is a first step toward defending their second claim, which narrows down the types of conscientious objection that are morally impermissible to those that involve invidious discrimination. An important aspect of this claim is that the only objections that are invidiously discriminatory⁸ are those based on an unjustified negative attitude or judgment about some characteristic of the patient to whom the service is refused. These are the type (2b) objections described above. Such an account of wrongful discrimination is, however, very narrow and excludes an important type of discrimination: indirect discrimination. Here is an example of indirect discrimination: a doctor is prepared to provide

treatment to anyone who needs it, but her practice is inaccessible to patients in a wheelchair (and this is not due to thoughtlessness on the doctor's part).⁹ Indirect discrimination is not necessarily grounded on a negative judgment or attitude, or indeed, on any other mental state, yet many would accept that indirect discrimination can be morally impermissible and ought, at least in some cases, to be illegal.

Are there conscientious objections that do not involve invidious (or, what some would refer to as 'direct') discrimination, as defined by A&SA (type 2b objections), but that do involve wrongful indirect discrimination?

This is a difficult question. I do not have a fully-developed account of indirect discrimination. However, on one plausible account developed by Kasper Lippert-Rasmussen,¹⁰ it is likely that there are such conscientious objections. According to Lippert-Rasmussen, criteria for an action to involve indirect discrimination are that the alleged victims are part of a socially salient group,¹¹ that has suffered, or still suffers from direct discrimination (or 'invidious' discrimination as A&SA define it), that the alleged discriminatory act makes the alleged victims worse off than they would otherwise have been, and that it does so because it interacts with past or ongoing direct discrimination in a way that produces disadvantage.¹² This last criterion points to the fact that indirect discrimination perpetuates disadvantages resulting from (past or ongoing) direct discrimination; in other words, indirect discrimination is parasitic on direct discrimination.¹³

Such an account of indirect discrimination does not imply that acts of indirect discrimination are always all-things-considered wrong insofar as they harm certain individuals in the way described above. It might be that the harm some people suffer as a result of a discriminatory act is morally outweighed by competing considerations. It also does not rule out that instances of indirect discrimination may be wrong for reasons other than that they harm people, e.g., that a particular act of discrimination is a violation of a promise not to discriminate. For example, discrimination could *also* be wrong because the doctors have sworn an oath that states one will not discriminate against patients.

Focusing on harmful effects of discrimination has the advantage that it can explain why cases of differential treatment, that we find intuitively problematic but that do not involve any negative attitudes or judgments, may be morally impermissible. Consider the following hypothetical scenario:

Coin Toss. A doctor working in a private healthcare system wishes to restrict the number of patients she treats. She decides to toss a coin; if it is heads, she will only treat heterosexuals, if it is tails, she will only treat lesbians. She is indifferent about the outcome. She tosses the coin and the result is heads. She will only treat heterosexuals.

Though it would arguably be morally worse if the doctor's decision to only treat heterosexuals from now on were based on an unjustified negative attitude or judgment about lesbians, it still seems

morally problematic to deny treatment to lesbians on the basis of a coin toss. There are various reasons why this could be wrong, but one plausible reason is that, without good reason, it disadvantages a socially-salient group that was already disadvantaged because of direct discrimination; the refusal thus arguably involves indirect discrimination and is therefore presumptively impermissible. The coin toss case is, of course, not a case of a *conscientious* objection. But one can think of conscientious objections that may be indirectly discriminatory via similar mechanisms. It is, for example, plausible that a refusal to provide abortion services may result in indirect discrimination, for example, against underprivileged women from a minority group to whom the abortion services are (also) refused—even if the refusal is not grounded on any unjustified negative attitude or judgment about, or bias against these women (the services are refused to all women). Refusal of abortion services is likely to exacerbate the effects of any direct discrimination underprivileged women from that minority group have suffered or still suffer (e.g., it may make it even harder for them to find a job), and to, thereby, make them worse off than they would otherwise have been. I believe this would make the conscientious objection to providing abortion services morally impermissible in this context. I thus propose including indirectly discriminating conscientious objections in A&SA’s proposal. More precisely, I think the cost requirement should apply to indirectly-discriminating conscientious objections, too, and not only to ‘invidiously’ discriminatory conscientious objections, as defined by A&SA. Both types of conscientious objections are morally impermissible, and it is widely agreed that the type of discrimination underlying both types of objections may need to be restricted through regulations.

In the remainder of the paper, I would like to briefly explore the option of including another type of conscientious objection in A&SA’s proposal as well, though I think the case for doing so is rather weak, so this is just a tentative argument in favor of including it.

It is worth noting that the fact that the *effects* of differential treatment are very important, and may determine whether there is discrimination, is in fact, acknowledged by A&SA. They write:

“if all or a large number of physicians refuse to perform abortions, resulting in inadequate or unfair health services for women, then one can say that there is discrimination against women at the level of the system—that the system fails to adequately provide a service that many women need. Still, so long as the individual physicians refuse because of the nature of the procedure rather than because of the gender of the patients, the grounds for the individual physicians’ refusal are not invidiously discriminatory.”¹⁴

Thus, it seems that A&SA believe that whether there is wrongful discrimination at the level of ‘the system’ is determined by the effects, whereas discrimination by the individual doctor is determined by mental states. An alternative, perhaps more plausible, interpretation is that the concern at the level of ‘the system’ is not so much about wrongful discrimination, but about whether healthcare

services are adequate and fairly distributed, regardless of whether this constitutes discrimination. A&SA seem to assume that the adequate and fair distribution of healthcare resources is the system's responsibility, whereas the avoidance of wrongful discrimination—as they define it—is that of the individual doctor.

But can the system's failure to provide adequate and fairly distributed healthcare on the one hand and doctors' refusals to offer certain medical services or offer these services to certain patient populations, on the other, be morally separated so easily?

Wrongful Complicity

If it is morally impermissible for the system to fail to provide important medical services adequately and fairly, presumably it is also morally impermissible for an individual doctor to significantly contribute to the state's failure to provide important medical services adequately and fairly. This could make the doctor wrongfully complicit in this failure (and in the discrimination it involves, if it involves discrimination at the level of the system). Complicity roughly captures the idea that one can do wrong by being associated in some way with the wrongdoing of others, including the collective one is part of. The sort of association required for complicity is disputed, but most agree that if one *causally contributes* to others' wrongdoing, one can be complicit in that wrongdoing.¹⁵ Complicity is not all-things-considered wrong, and whether it is wrong, will depend on how bad the principal's wrongdoing is, the degree of the complicity, and the moral weight of any competing considerations.¹⁶ If a doctor refuses to provide abortion services, for example, her degree of complicity in the system's failure to provide adequate and fairly distributed healthcare will depend on how bad this failure is, and on how central her contribution to it is (which, e.g., will depend on how many other easily accessible doctors are prepared to offer abortion services).

If the system's failure is serious, the degree of the doctor's complicity in the system's failure is high, and there are no morally weightier competing considerations, then the doctor's refusal is morally impermissible and, arguably, should be restricted in some way, for example by ensuring the paying costs requirement of A&SA's proposal applies to such cases as well.

One could, perhaps, object on the ground that the doctor's wrongdoing, *if* she is wrongfully complicit in the state's failure to provide important medical services adequately and fairly, is less serious than either the system's wrongdoing, or, the wrongdoing of a doctor who engages in discrimination; so there is no particularly strong reason to restrict it through regulatory measures. I think this would be a fair point, though it should be noted that even if (serious) complicity in an unjust healthcare system is less morally problematic than the system's failure to provide just healthcare, it could still be a serious wrong that should be restricted, or discouraged, in some way.

One could also object to my tentative proposal by arguing that doctors in a private healthcare system are not under any moral obligation to contribute to a just healthcare system. They are like agents in any other private business. They are, for example, more similar to the cake shop owner who refuses to bake a cake for a wedding of a homosexual couple than to a doctor serving in a public healthcare system.

Again, I think this would be a fair point to make, though it could also be argued that health, and especially reproductive care (where most conscientious objections take place), is a matter of social justice. So even in the private healthcare sector, doctors have moral obligations that other sectors, like bakeries, do not have. Another point to note is that even doctors working in a private healthcare system owe something to society, as their medical education will have been partially paid for with taxpayer's money. One could thus argue that it is, in part, thanks to society that they can do the job they are doing, and, thus, should give something in return.

However, as I mentioned earlier, I think the case for including conscientious objections that involve wrongful complicity in the system's failure to provide adequate and fairly distributed healthcare can only be made tentatively. There is a strong case for restricting such conscientious objections in some way, but I'm not confident that including them in A&SA's proposal is the best way to do so. I believe that this suggestion merits further discussion.

Conclusion

In this paper, I have proposed to modify A&SA's pragmatic proposal for dealing with discriminatory conscientious objections in private healthcare systems so that it includes a wider range of morally impermissible conscientious objections. I remained neutral on whether the third claim A&SA defend is correct. I assumed for the sake of argument that legalizing discriminatory objections is a better way to reduce discrimination in the long term. Whether this is so, is, in part, an empirical question. I instead challenged the first two claims A&SA defend. I first argued that whether a doctor's refusal to provide a medical service/provide a medical service to a particular patient population is based on deeply held moral or religious values, or grounded in self-interested reasons, *can* make a morally relevant and thus, potentially, legal difference. Thus, A&SA can't narrow down the types of morally impermissible conscientious objections to those involving invidious discrimination as easily as they claim. Secondly, I argued that their account of wrongful discrimination is too narrow and should include instances of indirect discrimination. Since indirectly discriminatory conscientious objections may be morally impermissible, and, indirect discrimination (in general) is something many think ought to be restricted through regulations, there is reason to include such objections in A&SA's proposal. I suggested that the paying costs requirement should also apply to indirectly discriminatory conscientious objections, and not only to invidiously

discriminatory conscientious objections, as suggested by A&SA. Thus, when all doctors in a patient's local clinic refuse to provide a particular treatment/provide a treatment to a certain patient population, and this refusal involves indirect discrimination, then the financial costs associated with having to find the treatment elsewhere should be shifted from the patient to the clinic. One disadvantage of the modification I propose is that there may be disagreement about which conscientious objections involve indirect discrimination. However, such disagreement may also exist in cases of direct discrimination, especially because it is very difficult, if not impossible, to prove that a doctor's refusal to provide a medical service/provide a medical service to a particular patient population is grounded on an unjustified attitude or judgment about some characteristic of the patient. In this respect, the modified proposal is more practically feasible as it is easier to prove certain effects on patients than it is to prove particular mental states of doctors. I ended by tentatively suggesting that another type of morally impermissible conscientious objections could be included in A&SA's proposal as well: those that make the doctor wrongfully complicit (to a high degree) in the system's failure to provide adequate and fairly distributed healthcare, though I admitted that the case for doing so is weak. There might be better ways to restrict such conscientious objections; how, is a topic for another article.

¹ Ancell A, Sinnott-Armstrong W. How to allow conscientious objection in medicine while protecting patient rights. *Cambridge Quarterly of Healthcare Ethics* 2017;26(1):120–31.

² Though the proposal is tailored to private healthcare systems, Sinnott-Armstrong has stressed that their arguments are also relevant for dealing with conscientious objections in public healthcare systems. See this video-interview with Katrien Devolder and Walter Sinnott-Armstrong, 'Walter Sinnott-Armstrong on Conscientious Objection in Healthcare', *The Practical Ethics Channel* 2016; available at <https://www.youtube.com/watch?v=l0rPb-CRIUs> (last accessed 12 Jul 2018).

³ A&SA regularly switch between moral and legal permissibility, and it is not always clear when they are focusing on one or the other, though they do make clear that *ultimately* they are interested in when conscientious objections should be lawful.

⁴ See note 1, Ancell, Sinnott-Armstrong 2017:123–4.

⁵ See note 1, Ancell, Sinnott-Armstrong 2017:123.

⁶ See, for example, Wicclair MR. Conscientious objection in medicine. *Bioethics* 2000;14:205–27; Clarke S. Conscientious objection in healthcare, referral and the military analogy. *Journal of Medical Ethics* 2017;43(4):218–21.

⁷ On the one hand, A&SA admit toward the end of their paper that there may be other types of conscientious objections that are morally impermissible, but on the other hand, the combination of their first two claims, clearly narrows down the types of morally impermissible conscientious objections to those that involve invidious discrimination.

⁸ Note that 'invidious discrimination' is an ambiguous concept, the meaning of which is contested by legal (and other) scholars. It could be narrowly defined as discrimination that requires bad intent, or more broadly, as discrimination that is wrongful. See, for example, The Legal Information Institute of Cornell Law School, Definition of invidious discrimination; available at https://www.law.cornell.edu/wex/invidious_discrimination (last accessed 24 July 2018).

⁹ According to Lippert-Rasmussen, any bias on the part of the discriminator against a salient group, on account of them being members of that group, makes the discriminating direct as opposed to indirect. Lippert-Rasmussen K. *Born Free and Equal? A Philosophical Inquiry into the Nature of Discrimination*. Oxford: Oxford University Press, 2013:60–2.

¹⁰ See note 9, Lippert-Rasmussen 2013.

¹¹ Note that the harm involved in disadvantageous differential treatment based on membership of socially-salient groups is likely to spread across individual acts and to accumulate across individual acts. The same is not true of disadvantageous differential treatment based on membership of socially nonsalient groups or individual properties.

¹² See note 9, Lippert-Rasmussen 2013:54–79.

¹³ See note 9, Lippert-Rasmussen 2013:54–79, 74.

¹⁴ See note 1, Ancell, Sinnott-Armstrong 2017:125–6.

¹⁵ Devolder, K. *Complicity*. International Encyclopedia of Ethics. Wiley-Blackwell 2017; available at <https://onlinelibrary.wiley.com/doi/abs/10.1002/9781444367072.wbice832> (last accessed 24 July 2018).

¹⁶ Lepora C, Goodin RE. *On Complicity and Compromise*. Oxford: Oxford University Press 2013.