Court of Appeal No. D045438

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
FOURTH APPELLATE DISTRICT
DIVISION ONE

NORTH COAST WOMEN'S CARE MEDICAL GROUP, INC. et al.,
Petitioners,

v.

THE SUPERIOR COURT OF SAN DIEGO COUNTY,
Respondent.

GUADALUPE T. BENITEZ,
Real Party in Interest.

San Diego County Superior Court Case No. GIC 770165
Honorable Ronald S. Prager, Judge

ANSWER TO *AMICUS CURIAE* OF CALIFORNIA MEDICAL ASSOCIATION

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I. INTRODUCTION AND SUMMARY OF THE ARGUMENT

Real Party in Interest Guadalupe T. Benitez hereby replies to the *amicus* brief filed by the California Medical Association ("CMA"). Previously, Ms. Benitez filed a Return To The Order To Show Cause Regarding Petition For Writ Of Mandate ("Return"). CMA has captioned its brief as supporting the Petitioner physicians in this matter. Yet, the *amicus* brief, when read in conjunction with the "Notice of Errata" ("Errata") filed subsequently by CMA (together, "CMA's *Amicus* Brief"), actually endorses the principle upon which the Superior Court ruled in favor of Ms. Benitez: "CMA would never support the claim that a physician's religious freedom authorizes discrimination based on race, nationality or sexual orientation." (Errata ¶3.) Despite its support for this position, CMA's *Amicus* Brief is so replete with contradictory, confusing and erroneous positions and arguments that it provides little assistance in answering the specific questions currently before the Court.

The sole issue decided by the trial Court and the sole issue properly before the Court on this Writ Petition is whether the Superior Court erred in finding that Petitioners do not have a constitutionally based religious affirmative defense to claims under the Unruh Civil Rights Act because physicians engaged in a for-profit medical practice must comply with

neutral, generally applicable civil rights laws, irrespective of any religious beliefs they may hold about those seeking medical treatment from them.

But, rather than address the issue before the Court, CMA's *Amicus* Brief urges the Court to avoid deciding this critical legal issue. Instead, CMA contradicts its own assertion that religious freedom does not permit discrimination and attempts to create a wholly unsupportable distinction between "discrimination" and "abiding by a religious belief." (*Amicus* Brief at 16.) Although CMA adamantly asserts that ethical and legal principals prevent physicians from discriminating based on sexual orientation, nonetheless it asserts, without support, that if discrimination has a religious motive, it somehow ceases to be discrimination at all and is permissible. Thus, CMA apparently seeks to reduce the issue to a supposedly "factual" inquiry as to whether a religious belief is sincere.

CMA's proposal would permit religious ideology, if sincerely held, to trump the needs of patients in virtually every case. To adopt this position, CMA must ignore entirely the federal and state constitutional precedents that apply when a religious adherent seeks a personal exemption from a religiously neutral law that applies to all others in his or her situation. (*See* discussion in the Return at 36; *see generally Employment Division v. Smith* (1990) 494 U.S. 872; *Catholic Charities of Sacramento, Inc. v. Superior Court* (2004) 32 Cal.4th 527; *Smith v. Fair Employment and Housing Comm'n* (1996) 12 Cal.4th 1143.) CMA does not critique the

decisions by the United States and California Supreme Courts in those cases. Nor does it attempt to explain why the free exercise analysis of those cases should yield a different answer here. Instead, CMA completely ignores the United States and California Supreme Court's determination that "[w]hen 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 that activity." (*Catholic Charities*, 32 Cal. 4th at 565.)

For multiple reasons, CMA's position is improper. First, controlling constitutional precedents foreclose CMA's approach of creating a false dichotomy between discrimination and abiding by one's religious views. In both *Catholic Charities* and *Smith v. FEHC*, the Supreme Court assumed that the religious adherent's faith was sincere, yet held that the conduct was impermissible because it was discriminatory. Here, the trial court likewise assumed that Petitioners' religious beliefs were sincere but impermissible because discriminatory. Thus, the question before the Court is the same as that in *Catholic Charities* and *Smith v. FEHC*: does sincerity of belief excuse compliance with civil rights laws? The controlling precedents say no.

Second, by urging the Court to "avoid a bright line rule by leaving it to the jury to decide" whether a defendant was acting improperly in

violation of a given statute "or" innocently abiding by their religious faith (*Amicus* Brief at 12), CMA tacitly proposes an open-ended religious exemption to any generally applicable law. CMA's "solution" impermissibly would elevate an individual's religious belief as superior to the law of the land. (*See Catholic Charities*, 32 Cal. 4th at 548, *quoting Employment Division v. Smith*, 494 U.S. at 879.)

Indeed, the CMA proposal contains no limiting principles. Thus, it would permit Orthodox Jewish restaurant owners who believe women and men should not sit together in public to refuse to seat different-sex couples or co-ed groups at the same table, while readily accommodating sex-segregated groups.[1] It would permit traditionalist Muslim shopkeepers to refuse to serve female customers who are not wearing a head covering and veil. And it would permit fundamentalist Christian business owners to exclude gay people. The only pertinent question would be the sincerity of the businessperson's religious belief. The consequences of such a proposal to members of the public who do not fit those religious views would be widespread inequality by business establishments in our state.

Finally, CMA's brief fails to address at all the key distinction recognized by the Superior Court in rejecting the physicians' argument and granting Ms. Benitez's summary adjudication motion. That is the

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[1] This sex-based discrimination is to be distinguished from a Kosher restaurant that will not serve milk and meat together to any patrons.

difference between a physician's potentially protected right to object to performing a medical ***procedure*** (such as abortion or euthanasia), and the lack of any similar protection for those who would provide or withhold a procedure in an invidious manner based on medically irrelevant personal characteristics of the ***patient*** (such as race, national origin, religion or sexual orientation).[2]

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[2] For reasons that are unclear, CMA devotes the bulk of its brief to two issues that are not before this Court at all. First, CMA discusses whether, as a factual matter, Petitioners withheld medical treatment from Real Party Benitez because she is a lesbian, or because she is not married to a man. But Petitioners moved for summary adjudication on this issue, lost, and ***chose not to seek review of that order***. Accordingly, the jury will have the opportunity to compare the doctors' multiple sworn statements that they denied Ms. Benitez her treatment due to her "sexual preference" (*see, e.g.,* Declaration of Dr. Christine Brody, Pet. Ex. 7 at p. 95 ¶ 4; Supplemental Declaration of Dr. Christine Brody, Pet. Ex. 7 at p. 134 ¶ 3; and Declaration of Dr. Douglas Fenton, Pet. Ex. 7 at p. 153 ¶ 5), against their more recent claims that they meant "marital status" when they said "sexual preference."

Second, CMA addresses whether the Unruh Act prohibits marital status discrimination – an issue that likewise is not before this Court, and was not even briefed to the Superior Court. Surprisingly, for an organization ostensibly dedicated to patients' welfare, CMA joins Petitioners' contention that the Unruh Act does not prohibit such discrimination, without acknowledging that the question is open and pending now before the California Supreme Court. In fact, the high court heard argument in *Koebke v. San Bernardo Heights Country Club*, Case No. S 124179 on May 26, 2005.

Even more perplexing, is that CMA acknowledges that the California Business and Professions Code prohibits marital status discrimination by licensed professionals – including Petitioners (*see* Bus. & Prof. Code § 125.6), but elsewhere repeats at length that its members are free to refuse patients on this basis. Inconsistent and confusing are fair descriptions of CMA's argument of these points. But none of it is relevant to the sole legal question before the Court now on review of Judge Prager's ruling as to the viability or not of Petitioners' claimed affirmative defense to Real Party Benitez's discrimination claim.

In sum, the trial court properly ruled that neither the United States Constitution nor the California Constitution permit Petitioners to discriminate against their patients in violation of the Unruh Act. That is the sole legal issue ripe for review in this proceeding. CMA agrees that religious motivation – however sincere – does not excuse unlawful discrimination. Nothing offered by CMA or Petitioners justifies a different conclusion. Accordingly, the Court should affirm Judge Prager's ruling that there is no religious free exercise affirmative defense to the Unruh Act in the circumstances alleged in this case.[3]

II. CMA SUPPORTS THE SUPERIOR COURT'S RULING THAT SINCERE RELIGIOUS BELIEFS DO NOT GIVE DOCTORS AN AFFIRMATIVE DEFENSE TO A PATIENT'S UNRUH ACT CLAIM OF SEXUAL ORIENTATION DISCRIMINATION IN A FOR-PROFIT MEDICAL PRACTICE.

A. Despite Having Captioned Its Brief As Supporting Petitioners, CMA Actually Supports Real Party Benitez By Condemning Sexual Orientation Discrimination Against Patients, Whether Motivated By Religion Or Not.

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[3] Inappropriately seeking an advisory opinion from the Court, CMA argues that, should this Court find that Petitioners cannot assert a religious defense to the Unruh Act, they still should be permitted to present the reason for their discrimination to the jury. That issue however is not ripe for consideration in this proceeding. It was never noticed or briefed and was only mentioned during oral argument. Significantly, the trial court specifically refused to decide the issue, leaving the question open. (Pet. Ex.24, p. 432 l. 9.) Moreover, CMA has presented no reason why the trial court should not be permitted to decide this question in the first instance, after appropriate briefing and argument to it.

As noted above, the issue here is the legal question whether a defendant physician can assert a religious freedom affirmative defense to an Unruh Act claim.[4] Although CMA's *amicus* presentation is confusing, the Errata makes clear that the organization supports the trial court's ruling in Ms. Benitez's favor. (Errata at 2, ¶3.) CMA also supports Real Party Benitez's position by providing extensive authorities showing the strong legal and medical consensus against discrimination based on sexual orientation. Contrary to Petitioners' assertion than the trial court's ruling is "inconsistent with ethical standards set by the American Medical Association" and therefore will "create confusion" for physicians (Pet. at 13), CMA's brief shows there is no conflict whatsoever between CMA's ethical rules, those of the AMA, and the trial court's ruling. For example, "Physicians may not decline to accept patients because of . . . sexual orientation." (*Amicus* Brief at 5, quoting *California Physician's Legal Handbook*, California Medical Association, 2003, p. 1:83.) Further, CMA's non-discrimination policy is the same as that of the AMA. Indeed, CMA quotes an AMA ethical opinion that specifically contradicts

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[4] Additionally, the Court has asked whether a physician may refuse to perform a procedure that violates his religious views. As fully discussed in Real Party's Return, the issue before the Court on the undisputed facts of this case is whether or not a physician may chose to perform a procedure selectively based on patient's protected personal characteristics, as there is no dispute concerning the fact that Petitioners routinely perform the medical procedure Ms. Benitez needed (intrauterine insemination, or "IUI")

Petitioners' position: "Physicians who offer their services to the public may not decline to accept patients because of . . . sexual orientation." (*Amicus* Brief at 4, quoting Opinion E-9.12 of the AMA Code of Medical Ethics.)

Similarly, CMA confirms that California law prohibits discrimination based on sexual orientation, noting that "Sexual orientation has been interpreted as a protected classification, even though it is not expressly enumerated in the Unruh Act. (*Amicus* Brief at 6.) As discussed more fully in the Return, California law indeed provides that lesbians and gay men are entitled to equal access to and equal treatment by, all businesses. (*See, e.g., Curran v. Mount Diablo Council of the Boy Scouts* (1998) 17 Cal. 4th 670, 686-87, 703 (affirming California's commitment to the ban on sexual orientation discrimination). Doctors are considered businesses and are bound to obey the Unruh Act. (*See, e.g., Leach v. Drummond Med. Group* (1983) 144 Cal. App. 3d 362, 372 (a hospital or medical group is a business serving a public interest that must serve all persons "on reasonable terms without discrimination"); *Washington v. Blampin* (1964) 226 Cal. App. 2d 604 (holding that a white doctor's refusal to treat a black patient because the patient's race made the doctor "uncomfortable" violated the Unruh Act).)

– but only for patients who conform to Petitioners' church's teachings concerning who should become parents and under what circumstances.

Thus, notwithstanding that the cover of its brief purports to support Petitioners, CMA makes clear that Judge Prager's ruling is consistent with the national and state rules of medical ethics and governing standards of care. The *Amicus* Brief confirms beyond dispute that physicians may not withhold treatment or otherwise discriminate based on their patients' sexual orientation, regardless of the doctors' religious views.

B. CMA's Brief Ignores the Critical Distinction Between Objection to a Procedure and Objection to a Patient.

CMA inexplicably ignores a clear-cut distinction between a categorical refusal to perform a procedure and a refusal to perform a procedure for particular types of people for medically irrelevant reasons. Real Party does not dispute that there are federal and state statutory protections for medical providers who do not wish to perform certain services such as abortion, and that California law expressly protects providers who do not wish to provide certain end-of-life care.[5] But this case is not about practitioners who wish to avoid involvement in specified medical treatments and who decline consistently to provide them to any

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[5] Real Party has no quarrel with the sections of the California Probate Code on which CMA relies (*see Amicus* Brief at 7-8), which provide statutory guarantees of physicians' right of conscience regarding whether to provide requested end-of-life treatment to a patient. But surely CMA would not contend that it is a "generally accepted health care standard" (*id.* at 8) for physicians to cloak as protected matters of conscience decisions to offer or withhold such treatment in an invidiously discriminatory manner based on the patient's race or a similar personal characteristics, rather than on the patient's medical condition.

patients, with the appropriate advance notice of such objection so that patients can plan accordingly.

Instead, the issue in this case is that no amount of advance notice or promptness of a referral can authorize physicians to select when they will perform a procedure and when they will assert a religious objection and attempt to refer a patient elsewhere based on the patient's race, sexual orientation or any other characteristic with regard to which discrimination is prohibited. As the California Supreme Court made clear in *Smith v. FEHC*, one who is engaged in commercial activity subject to our state's civil rights laws may not avoid a duty to treat members of the public equally by referring away some individuals based on their personal characteristics on grounds barred by statute. (12 Cal. 4th at 1170.) Such referrals impermissibly diminish the dignity of those individuals, as well as impermissibly reducing the services or other opportunities available to them. (*Id.*) Thus, in *Smith*, the Court stressed the significance of these harms to third parties in any test of when a religious objector may violate laws that apply generally to everyone else. (*Id.* at 1171)

The courts' concern for the interests of third parties is not new. The Unruh Act has long been understood to prohibit businesses, including physicians, from using "referrals" to segregate customers or patients on invidious grounds. (*See, e.g., Blampin*, 226 Cal.App.2d at 606-7.) And contrary to CMA's warning that requiring physicians to offer equal

treatment to all patients will drive good doctors from medical practice (*Amicus* Brief at 13), no such loss of medical talent followed application of the civil rights law to forbid racial discrimination by health care providers.

Thus, although referrals may be commonplace in medicine based on medical competence, insurance coverage and consistent conscientious objections to particular procedures, CMA offers no support for its view that doctors may refer patients for invidious, group-based reasons unrelated to any legitimate medical concern, based solely on the doctors' personal religious views.[6] Consequently, because Petitioners routinely provide intrauterine insemination ("IUI") to patients who have a medical need for that procedure, they would not be allowed to withhold the treatment because, for example, a particular patient is in an interracial relationship, no matter how sincerely either of them may believe it is against "God's plan" for interracial couples to have children and that it is a sin for a doctor to

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[6] *Compare* AMA Policy E-10.015, which provides in relevant part: "The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare. Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount."

Because Petitioners were not at liberty to refer their patient elsewhere based on her sexual orientation, CMA's discussion of who should bear the cost of legitimate referrals is entirely beside the point. Yet their suggestion that, in any conceivable circumstances, a victim of a discriminatory referral might have to bear the financial cost of an out-of-network referral in addition to the emotional cost of discrimination, adds

help such couples to conceive and bear bi-racial children. Precisely the same principle applies here.[7]

C. CMA's Proposed New Legal Test Ignores The Controlling Federal and State Constitutional Tests And Miscasts Questions Of Law As Questions of Fact.

The proposed new "test" – whether a refusal to treat was religiously motivated – raises many troubling questions, just three of which will be addressed here. First, as the controlling cases make clear, sincerity of an adherent's belief is the beginning, not the end, of the inquiry. The California Supreme Court decisions in *Catholic Charities* and *Smith v. Fair Employment and Housing Commission* acknowledge the obvious fact that conduct can be ***both*** discriminatory ***and*** motivated by sincere religious

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injury to the insult of their failure to appreciate the dignitary and public health issues at the core of this case.

[7] CMA gives assurances throughout its brief that it complies with the AMA's ethical policies and does not condone unlawful or invidious discrimination. *See, e.g.,* AMA Policy 8.132 (providing that "arbitrary" discrimination is different treatment of a patient based on a personal characteristic that is not medically relevant). Nonetheless, in defending discrimination based on marital status, CMA appears to have made several oversights in its zeal to support its members. In addition to the Business and Professions Code's requirements that professional licensees not discriminate based on marital status, physicians who practice in health care service plans are subject to a similar rule (*see* Health & Saf. Code § 1365.5), as are health insurance policies and plans. *See* Ins. Code § 679.71. In fact, the California Legislature has gone on record repeatedly that it considers marital status discrimination to be arbitrary and presumptively invidious. In addition to the cited licensing, health plan and insurance statutes, marital status is expressly included in the state's statutory bans on discrimination in employment (Gov. Code § 12940), housing (*id.* § 12955), credit and other financial transactions (Civ. Code § 1812.30, Fin. Code §

belief, and that the latter negates neither the former nor the application of laws barring such discrimination.

The individuals prosecuted for consuming peyote in *Employment Division v. Smith*, (1990) 494 U.S. 872, were sincere in their belief that they should use this drug as part of their traditional religious ritual. Similarly, Evelyn Smith was assumed to have been sincere in her belief that it would be sinful for her to rent an apartment to an unmarried heterosexual couple. There was also no question in *Catholic Charities* that the religiously affiliated agency was sincere in its belief that its employees should not use contraceptives. In precisely the same way, Judge Prager assumed for sake of deciding the summary adjudication motion that Drs. Brody and Fenton were sincere in their belief that the teachings of their church do not support a lesbian woman creating a family with her same-sex life partner, rather than in a heterosexual marriage. In each of these cases, despite the sincerity of the religious adherents' faith, the courts correctly found no basis to create an exception to a neutral statute.

Moreover, both *Catholic Charities* and *Smith v. FEHC* addressed the additional limits on the freedom of religious adherents when imposition of their religious views on others in commercial settings in violation of applicable anti-discrimination laws would harm third parties. Both cases

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40101), education (Ed. Code § 230), and public social services. Welf. & Inst. Code § 10000.

specifically confirmed that the civil rights statutes are neutral laws serving the compelling public purposes of protecting third parties from the harms of discrimination in commercial settings. (*Catholic Charities*, 32 Cal.4th at 564-65; *Smith v. FEHC*, 12 Cal.4th at 1170.) These cases already provide the constitutionally correct "balance" that CMA seeks to reset at a radically different point. And both cases underscore that, in business settings, a "religious adherent may not impose on others the restrictions he accepts for his own conduct. Otherwise is to make that person's beliefs superior to the law of the land." (*Catholic Charities*, 32 Cal. 4th at 548, *quoting Employment Division v. Smith*, 494 U.S. at 879.) Accordingly, CMA's disregard of these controlling precedents is misguided.

Second, CMA's proposed new "test" would create an open-ended religious exemption to any generally applicable law that would apply in any business context. As noted above, CMA seems to misunderstand the central inquiry in this and similar cases, which is to determine the proper result in the business context when one person's conduct, even in furtherance of a sincere religious belief, causes harm to another person.

But CMA's brief does not simply miss the point. Rather, it proposes a new approach to cases like this, and one that would have drastic consequences for patients and the general public if adopted. Despite the opening pages of its brief condemning discrimination against patients, the legal approach CMA proposes for these cases would permit any religious

adherent to ignore any civil rights law or any other neutral, generally applicable rule, as long as the adherent's religious belief is sincere.

This approach effectively strips any customer or patient of protection whenever a jury finds the business proprietor or service provider credible as to their religious motive for mistreating another. Thus, if sincere religious belief on the part of a person conducting a business can trump civil rights laws, then African American would-be guests would have had no basis for complaint if turned away from the Heart of Atlanta Motel based on a proprietor's belief that God intended the races not to live under the same roof. (*See Heart of Atlanta Motel* (1964) 379 U.S. 241.) Likewise, women and girls would have no grounds to object to a religiously motivated rule excluding females from a public swimming pool being used by males. Similarly, a tenant evicted from her apartment for working on the Sabbath would have no option but to start packing.

But the public consequences of such a legal rule would reach far beyond concerns about invidious discrimination. Since this affirmative defense ostensibly is based in the state or federal Constitution, the personal religious exemption CMA proposes could be invoked in the same manner against any other neutral, generally applicable law – from environmental laws, to workplace safety laws, to criminal laws, not just the Fair Employment and Housing Act, the Women's Contraception Equity Act, the Unruh Act and other civil rights laws.

The consequences would be potentially devastating to our diverse, religiously pluralistic society. There could be no uniform application of law and no assurance of equality for all. Such practical concerns are precisely what motivated the United States Supreme Court in *Employment Division v. Smith* to curtail the extent to which religious objections may be presented against neutral laws of general applicability. (494 U.S. at 872.)

Third, contrary to CMA's recommendation against "bright line rules," clear legal guidelines help customers and proprietors of businesses to know how to conform their conduct to the law. CMA critiques "bright line rules" as justification for its suggestion that these cases simply should go to a jury as tangled snares of factual and legal questions. But lack of rules, and CMA's proposal to send everything to a jury, would keep business owners and patrons alike in the dark about their respective rights and duties, would cause discrimination to increase, and would lead to a proliferation of litigation.

D. CMA's Proposed Approach Would Impact Negatively the Health Care Lesbians and Gay Men Can Obtain.

CMA contends that Petitioners' treatment of Real Party Benitez was consistent not just with medical ethics but also with the applicable standards concerning how medical professionals should interact with patients. (CMA *Amicus* Brief at 12-14.) CMA is gravely mistaken.

The organization advances the stunning proposition that the doctor-patient relationship benefits from "open communication" between doctor and patient, even when the doctor's side of the discussion consists of religiously inspired opinions that the patient and others of her social group do not deserve equal access to medical care due to medically irrelevant personal characteristics. This is not a benign error on CMA's part. It is a view that attempts to absolve medical professionals for conduct that causes significant harm to individuals and exacerbates public health disparities affecting lesbians and gay men.

It is well documented that, given the dependence and vulnerability many patients experience in medical settings, discriminatory attitudes on the part of medical personnel not only shut down critical communication from patient to doctor, but also drive patients away. According to Dr. Kate O'Hanlan, a Stanford University Hospital-based gynecologic oncologist and national expert on lesbian health concerns, studies of the health status of lesbians in the United States repeatedly have confirmed that this population has a higher incidence of breast, uterine, ovarian and colon cancers, as well as heart disease and stroke. Dr. O'Hanlan explains that widespread sexual orientation bias among doctors contributes to the elevated incidence of illness because many lesbian patients perceive this bias and become alienated from the medical system, "reducing their utilization of standard screening modalities, potentially resulting in higher

morbidity and mortality from cancers and heart disease." (O'Hanlan, *Lesbian Health and Homophobia: Perspectives for the Treating Obstetrician/ Gynecologist* (1995) 18 Current Probs. Obs. & Gyn. 93, at p. 136; *see also* O'Hanlan, *Do We Really Mean Preventive Medicine For All?* (1996) 12 Am. J. Prev. Med., No. 5, p. 411.)

Dr. Susan Cochran of UCLA's School of Public Health Epidemiology Department, another national expert in this field, came to similar conclusions after studying the data showing elevated mortality and morbidity among lesbians due to various kinds of cancer:

> [L]esbians and bisexual women appear less likely to undergo routine screening procedures, such as mammograms and gynecologic examinations, that would lead to early detection of disease. Whereas many women experience well-known barriers to mammography screening, lesbians face, in addition, unique issues of access and use, including negative experiences with health care practitioners and mistrust of the health care community.
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> Developing effective methods to reach these women raises issues in regard to providing a health care environment in which lesbians and bisexual women are comfortable seeking care and revealing their sexual orientation. At present, many of these women are not. Instead, research has repeatedly documented that lesbians report frequent negative encounters in health care settings, including inappropriate interventions, hostility from providers, and violation of confidentiality. ... If public health is truly for everyone, the results of the current study call for developing culturally competent interventions targeted to the differential risk patterns evidenced by lesbians and bisexual women.

(Cochran, *et al.*, *Cancer-Related Risk Indicators and Preventive Screening Behaviors Among Lesbians and Bisexual Women* (April 2001) 91 Am. J. Pub. Hlth., No. 4, p. 591, at 596.)

"Cultural competence," as referenced by Dr. Cochran, is a well-recognized concept in health care delivery. (*See generally* Office of Minority Health, U.S. Dep't of Health and Human Services (2001) *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (hereafter, "OMH CLAS Standards"), available at <www.omhrc.gov/omh/programs/2pgprograms/ finalreport.pdf>.) It includes the principle that medical professionals should treat patients in a sensitive, respectful manner that enhances health outcomes by improving doctor-patient communication, accuracy of diagnosis and patient compliance. (*Id.,* Standard 1, pp. 49-52; *see also* Office of Minority Health, U.S. Dep't of Health and Human Services (2002) *Teaching Cultural Competence in Health Care: A Review of Current Concepts, Policies and Practices*, p. 26 ("Effective Physician-Patient Communication") (explaining that providers must communicate with patients in a respectful, culturally sensitive manner to establish rapport and trust, which is essential for obtaining information about the patient's health needs), available at <www.thinkculturalhealth.org/cccm/papers/Appendix%20B%20-%20Environmental%20Scan.pdf>, hereafter "*Teaching Cultural Competence*"); AMA Ethical Policy 10.015, The Patient-Physician

Relationship, *supra* ("The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups.").)

Although physicians may have a duty to inform patients timely about any relevant limits to their medical competence, or as to procedures they do not perform for anyone, informing patients of one's invidious biases against them due to their race, national origin, sexual orientation, or other medically irrelevant personal characteristics is entirely different. Whether presented as based in religion or not, expression of such attitudes invariably will cause patient distress (as was the case for Ms. Benitez) and will shut down patient communication with the provider, all to the detriment of patient care. (Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds. (2003) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Executive Summary, "The Role of Bias, Stereotyping, Uncertainty," pp. 9-12 (discussing the adverse impacts on patient care of physicians' bias and stereotypes about members of minority groups) (published by the Institute of Medicine of the National Academy of Sciences) (hereafter, "Institute of Medicine Report").[8])

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[8] The Institute of Medicine Report also notes that decreasing provider biases is "important" for improving doctor-patient interaction and reducing group-based health disparities because "the healthcare provider, rather than the patient, is the more powerful actor in clinical encounters." *Id.* at p. 12.

The concept of "cultural competence" pertains to treatment of lesbians and gay men as well as to members of racial and ethnic minority groups. (*Teaching Cultural Competence*, at 7; s*ee generally* Council on Scientific Affairs, American Medical Assoc., *Health Care Needs of Gay Men and Lesbians in the United States* (1996) 275 J.A.M.A. 1354, 1359.[9]) Consequently, and as discussed more fully in Real Party's Return (*see* pages 68-69), Kaiser Permanente has issued guidelines for its medical staff requiring respectful, equal treatment of patients, irrespective of sexual orientation, and instructing doctors to "separate" any critical views they may have of gay people as a group (whether based on religion or not) from their interactions with individual patients. (Kaiser Permanente National Diversity Council, *A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgendered Population* (2000), at 7-8, 16 (hereafter "*Provider's Handbook*").)

CMA turns the notion of cultural competence on its head by proposing that it actually helps lesbian and gay patients to be aware of their

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[9] *See also* Office of Disease Prevention and Health Promotion, U.S. Dept. of Health & Human Services, *Healthy People 2010: A Systematic Approach to Health Improvement* (2000) (explaining that "The second goal of Healthy People 2010 is to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or *sexual orientation*.") (emphasis added), available at <http://www.healthypeople.gov/Document/html/uih/uih_2.htm#goals>; Gay and Lesbian Medical Association, *Healthy People 2010: Companion*

doctors' adverse attitudes about them and others of their sexual orientation. (*Amicus* Brief at 12-13.) Yet, conspicuously absent from CMA's brief is any response to Ms. Benitez's presentation regarding the negative public health consequences of invidious discrimination by medical professionals. Presumably, CMA would acknowledge that civil rights enforcement to stop "referrals" of patients based on race, as in *Blampin*, is consistent with sound public health policy designed to "insure[] the greatest availability to health care for Californians." (CMA's *Amicus* Brief at 14.) CMA does not, and cannot, explain why permitting doctors to discriminate against patients like Ms. Benitez is different. Obviously, a clear anti-discrimination policy expands the medical services available generally to the public rather than limiting those services.

Neither CMA nor Petitioners can deny that California has a compelling interest in maintaining the health and well being of all of its residents, and in ensuring that mothers, prospective mothers, and children all receive quality medical care without fear of reprisal or discrimination. CMA certainly does not dispute the findings of the respected experts who have documented that lesbians and gay men commonly receive disparate medical treatment from their providers.

Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health (2001), available at http://www.glma.org:16080/policy/hp2010/index.shtml.

Nonetheless, CMA argues that doctors should be free to tell their patients of their religious beliefs in order to allow the doctor and patient to discuss the impact and limitations those beliefs may create for the patient's treatment. (CMA's *Amicus* Brief at 12.) In short, CMA asks the Court to sanction a physician's disclosure of a bias against a patient, and claims it is better for the patient to know the discriminatory motive of a "referral" based on the patient's group-membership rather than the doctor's medical competence.

But, as *Smith* makes clear, a person's dignitary interests are sacrificed impermissibly when the proprietor of a business explains why he or she believes that prospective client or customer does not deserve equal treatment due to their personal characteristics. (*Smith v. FEHC,* 12 Cal. 4th at 1170-71.) Indeed, the insult and loss of dignity – the profound feelings Ms. Benitez experienced of deception, humiliation and betrayal by the doctor she had trusted – are precisely why disproportionate numbers of lesbians avoid health care settings, with the inevitably increased negative public health consequences.

Thus, the Court's analysis here necessarily must include the likely negative health implications for lesbians and gay men should the Court reverse the trial court's decision. These third party interests rightly have been at the heart of the California Supreme Court's free exercise analysis and require that Petitioners' religious views be treated the same as those of

other business people required to comply with the Unruh Act. (*Catholic Charities*, 32 Cal. 4th at 565.) As the Court explained in *Catholic Charities*, "We are unaware of any decision in which this court, or the United States Supreme Court, has exempted a religious objector . . . despite the recognition that the requested exemption would detrimentally affect the rights of third parties." (*Id.*)

Accordingly, the *Catholic Charities* Court emphasized the impermissible discriminatory impact of Catholic Charities' plan to delete coverage for women's contraceptives from its insurance plan: "Strongly enhancing the state's interest is the circumstance that any exemption from the WCEA sacrifices the affected women's interest in receiving equitable treatment with respect to health benefits." (32 Cal.4th at 564-65.)

Similarly, in *Smith v. FEHC*, the Court stressed that, "To permit Smith to discriminate would sacrifice the rights of her prospective tenants to have equal access to public accommodations and their legal and dignitary interests in freedom from discussion based on personal characteristics." (*Id.*) In sum, to encourage physicians to express their biases would harm patients. The Unruh Act exists to protect customers – like tenants, customers and others – from such harms. To the extent CMA seeks to allow a religious defense to that law, its arguments threaten to eviscerate that protection, based on neither authority nor sound reason.

III. CONCLUSION

The trial court properly ruled that Petitioners could not assert a constitutional affirmative defense to the Unruh Act. For all of the foregoing reasons, the petition for a writ of mandate or prohibition should be denied.

Dated: June 3, 2005

Respectfully submitted,

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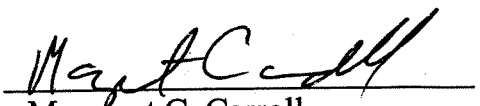
By: 

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PROOF OF SERVICE

I, Evelyn M. Wilson, declare:

I am a resident of the State of California and over the age of eighteen years, and not a party to the within action; my business address is 1999 Avenue of the Stars, 7th Floor, Los Angeles, California 90067.

On June 3, 2005, I served the within document

ANSWER TO *AMICUS CURIAE* OF CALIFORNIA MEDICAL ASSOCIATION

by placing the document in a sealed envelope with postage thereon fully prepaid, in the United States mail at Los Angeles, California addressed as set forth below. I am readily familiar with the firm's practice of collecting and processing correspondence for mailing.

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I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on June 3, 2005, at Los Angeles, California.

_____

Evelyn M. Wilson