S142892

IN THE

Supreme Court

OF THE STATE OF CALIFORNIA

NORTH COAST WOMEN'S CARE MEDICAL GROUP, INC., DR. CHRISTINE Z. BRODY and DR. DOUGLAS K. FENTON,

Petitioners,

vs.

SUPERIOR COURT FOR SAN DIEGO COUNTY,

Respondent.

GUADALUPE T. BENITEZ,

Real Party in Interest.

BRIEF IN SUPPORT OF REAL PARTY IN INTEREST BY *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM; ASIAN PACIFIC AIDS INTERVENTION TEAM; ASIAN PACIFIC AMERICAN LEGAL CENTER OF SOUTHERN CALIFORNIA; BIENESTAR HUMAN SERVICES; CALIFORNIA LATINAS FOR REPRODUCTIVE JUSTICE; CALIFORNIA PAN-ETHNIC HEALTH NETWORK; CALIFORNIA WOMEN'S LAW CENTER; COALITION FOR HUMANE IMMIGRANT RIGHTS OF LOS ANGELES; JORDAN RUSTIN COALITION; KHMER GIRLS IN ACTION; LATINO COALITION FOR A HEALTHY CALIFORNIA; MERGER WATCH PROJECT; MEXICAN AMERICAN LEGAL DEFENSE AND EDUCATION FUND and ZUNA INSTITUTE

AFTER DECISION BY THE COURT OF APPEAL
FOURTH APPELLATE DISTRICT, DIVISION ONE
D045438

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APPLICATION FOR LEAVE TO FILE AMICUS CURIAE BRIEF

To the Honorable Chief Justice and Associate Justices:

Under Rule 8.200(c) and 8.520(f) of the California Rules of Court, the National Health Law Program; the Asian Pacific AIDS Intervention Team; the Asian Pacific American Legal Center of Southern California; Bienestar Human Services; California Latinas for Reproductive Justice; the California Pan-Ethnic Health Network; the California Women's Law Center; the Coalition for Humane Immigrant Rights of Los Angeles; the Jordan Rustin Coalition; Khmer Girls in Action; the Latino Coalition for a Healthy California; the MergerWatch Project; the Mexican American Legal Defense and Education Fund; and Zuna Institute (together, "Community Health Amici") respectfully request permission of this Court to file the accompanying *amici curiae* brief in support of Real Party In Interest Guadalupe T. Benitez.

IDENTITY AND INTERESTS OF *AMICI CURIAE*

The **National Health Law Program** ("NHeLP") is a public interest law firm working to improve access to quality health care on behalf of limited-income people and others who experience health care disparities, by providing legal and policy analysis, advocacy, information and education. Since its founding more than 30 years ago, NHeLP has developed expertise in both federal and state law bearing on the ability of poor and disenfranchised people to obtain the medical care they need despite their economic status or sociological barriers such discrimination based on race, sex, national origin, religion, sexual orientation, or marital status. With its

headquarters in Los Angeles, NHeLP is especially knowledgeable regarding the health needs of, and the challenges facing, California residents. In particular, it has long been committed to effective enforcement of the laws promising all of this state's residents equal access to medical care services. Consequently, NHeLP has expertise in this area that is relevant and will be helpful to the Court as it considers the issues presented in this appeal.

As an organization that aims to positively affect the quality of life for Asians and Pacific Islanders living with HIV/AIDS by providing a continuum of prevention, health and social services, community leadership and advocacy, the **Asian Pacific AIDS Intervention Team** ("APAIT") wholeheartedly supports the amicus brief in this case. As a health care provider, APAIT practices and believes in the importance of delivering fair and equitable delivery of culturally competent health care regardless of age, race, religion or sexual orientation.

Founded in 1983, the **Asian Pacific American Legal Center of Southern California** ("APALC") is the largest non-profit, public interest law firm in the nation devoted to the Asian and Pacific Islander community. APALC provides direct legal services to indigent members of its community and uses impact litigation, policy advocacy, community education and leadership development to obtain, safeguard, and improve the civil rights of Asians and Pacific Islanders. APALC has long focused its civil rights work on combating race and national origin discrimination, in sectors as diverse as employment, education, healthcare, and government programs. APALC also believes that the struggle for civil rights includes

advocating for the rights of the lesbian, gay, bisexual and transgender community, and APALC helped found and continues to support API Equality-LA, a local Asian American coalition advocating for marriage equality rights. APALC has the expertise and interest in commenting on this case because, as part of its extensive work to ensure that all Californians receive linguistically and culturally competent health care, APALC believes it is critical that no health provider be allowed to discriminate in the provision of health care services.

With centers in Los Angeles, San Bernardino, and San Diego counties, **Bienestar Human Services** ("Bienestar") is the largest Latino non-profit, community-based agency in the United States. It meets the social service, health prevention, and education needs of Latinos living with HIV and at risk of HIV and other health problems. Bienestar was founded due to the lack of HIV services for the Latino community, and the mistreatment Latinos commonly experienced in mainstream medical settings. The agency's early focus on AIDS education has broadened to address myriad health and social service issues facing Southern California's Latino community, especially gay, lesbian, bisexual and transgender Latinos, including many Mexican immigrants, such as Real Party. Bienestar's staff and clients are all too familiar with the relationship between anti-gay bias and HIV stigma, and with how national origin discrimination, language barriers, and particular sectarian views can combine with sexual orientation bias to impede access to medical services. Its experience teaches that a religious exception to California's anti-discrimination laws effectively would end equal health care access for all,

putting vulnerable patients at increased risk, and very likely increasing HIV/AIDS stigma, with serious adverse repercussions. For these reasons, Bienestar opposes all health care discrimination, whether or not motivated by religion.

The **California Latinas for Reproductive Justice** ("CLRJ") is a statewide policy and advocacy organization whose mission is to advance California Latinas' reproductive health and rights within a social justice and human rights framework while striving to ensure that policy developments reflect the needs of Latinas, their families and their communities. CLRJ seeks to influence and enforce statewide laws and policies that affect Latinas' reproductive and sexuality health and rights. CLRJ is committed to ensuring that all members of the Latino community – including individuals who are lesbian, gay, bisexual, and transgender – have access to comprehensive, accurate, and unbiased reproductive and sexuality health and rights information and to comprehensive reproductive and sexuality health services that are culturally and linguistically appropriate to improve their quality of life and ensure healthy communities.

The **California Pan-Ethnic Health Network** ("CPEHN") works to reduce racial and ethnic health disparities and to ensure that all Californians have access to health care and can live healthy lives. Formed in 1992 by the Asian & Pacific Islander American Health Forum, the California Black Health Network, the California Rural Indian Health Board, and the Latino Coalition for a Healthy California, CPEHN now is an established leader in multicultural health, advocating for public policies and sufficient resources to meet the needs of California's large, diverse communities of color. The

health of people of color in California continues to lag behind that of the overall population because of many institutional and societal factors. CPEHN champions approaches that can eliminate these disparities. In particular, by holding health care systems accountable to treat all patients with equal respect and concern, CPEHN helps to ensure that everyone in California, regardless of ethnicity, race or cultural background, can access quality health care and live a healthy life.

The **California Women's Law Center** ("CWLC") is a private, nonprofit public interest law center specializing in the civil rights of women and girls. Established in 1989, CWLC works in the following priority areas: sex discrimination, women's health, race and gender, women's economic security, exploitation of women, and violence against women. Since its inception, CWLC has placed a strong emphasis on addressing both discrimination affecting women and women's reproductive rights and has authored numerous *amicus* briefs, articles, and legal education materials on these issues. Because this case raises important questions within its areas of core concern, the CWLC has the requisite interest and expertise to join in this *amicus* brief.

The **Coalition for Humane Immigrant Rights of Los Angeles** ("CHIRLA") is a nonprofit organization founded in 1986 to advance the human and civil rights of immigrants and refugees in Los Angeles. As a multiethnic coalition of community organizations and individuals, CHIRLA aims to foster greater understanding of the issues that affect immigrant communities, provide a neutral forum for discussion, and unite immigrant groups to advocate more effectively for positive change. Toward those

goals, CHIRLA provides legal representation, extensive referral services, and a support network for immigrants and refugees; educates and organizes community members; and works to improve race and ethnic human relations throughout Southern California. With reference to this case, CHIRLA underscores the significant health and related challenges facing immigrants in California and its advocacy at the local, state, and federal levels for nondiscriminatory, respectful, and culturally competent health and social service policies and services.

The **Jordan Rustin Coalition** ("JRC") is a Los Angeles-based group of organizations and individuals committed to doing grassroots organizing in African-American communities to combat homophobia, build support for equal marriage rights and an end to all forms of discrimination against LGBT individuals and families through community education, advocacy and dialogue. The group's name honors the memory of Barbara Jordan and Bayard Rustin: two extraordinary African Americans who were instrumental in the fight for civil rights for all Americans. Barbara Jordan and Bayard Rustin were also members of the lesbian and gay community. Their work reflects the contributions African-American LGBT citizens can, have, and will make to insure equal rights for all Americans, regardless of race or sexuality. In light of our mission and the importance of the principles at stake in the Benitez case (that non-discriminatory access to public accommodations in California should not be trumped by any particular religious belief) the Jordan Rustin Coalition joins this amicus brief.

A Southern California community-based young women's organization, **Khmer Girls in Action** ("KGA") fosters young Southeast Asian women's leadership and organizing skills, and engages them in community work to advance immigrant rights, refugee rights and reproductive freedom. KGA is interested in the outcome of this case because its members already have experienced significant restrictions on health care access – and reproductive health care access in particular – because of organized religious efforts to limit available care, as well as persistent discrimination based on race, ethnicity, language, and other factors. KGA addresses these severe access problems by organizing and educating our community on these issues, combating discrimination in a pro-active way, and promoting the provision of culturally competent health care to ensure that quality health care is provided to all patients regardless of race, color, national origin, gender or sexual orientation.

The **Latino Coalition for a Healthy California** ("LCHC") – the only statewide organization with a specific emphasis on Latino health – was founded in 1992 by health care providers, consumers and advocates to improve Latino health through enhanced information, policy development, and community involvement. LCHC works in three key strategic areas – access to health care, health disparities, and community health – through public policy and advocacy, community education and research. LCHC places special focus on how inequities in quality of health care contribute to disparities in the health status of our population, and on the role of culturally sensitive and linguistically appropriate services in reducing those disparities. Through its Rapid Response Network of 1,700 community-

based organizations and its Regional Networks in San Diego, Los Angeles and the Bay Area, LCHC affiliates mobilize to affect public policies, services, and conditions that affect Latino health.

The **MergerWatch Project** ("MergerWatch") is a national nonprofit organization dedicated to addressing the problem of medical care that is restricted by institutional religious doctrine and/or providers' moral beliefs. MergerWatch was founded in 1996 at the Education Fund of Family Planning Advocates of New York State after a merger between religious and secular hospitals in Troy, NY, caused the loss of contraceptive services at an outpatient clinic that had been operated by the secular hospital. The project has worked with grass roots coalitions in more than 50 communities, including several in California, to protect patients' rights and access to care when religious/secular hospital mergers are proposed. The project has expanded its work to address a wide range of religiously-based restrictions on health care, including pharmacists' refusal to fill contraceptive prescriptions, hospital restrictions on end-of-life choices and discrimination against gay and lesbian patients based on the provider's moral beliefs. In 2005, the project moved to New York City and is now an affiliated of Community Catalyst, a national consumer health advocacy organization.

Established in 1968, the **Mexican American Legal Defense and Educational Fund** ("MALDEF") is the leading national civil rights organization representing the 40 million Latinos living in the United States through litigation, advocacy, and educational outreach. With its headquarters in Los Angeles and offices in Atlanta, Chicago, Houston,

Sacramento, San Antonio and Washington, D.C., MALDEF's mission is to foster sound public policies, laws and programs to safeguard the civil rights of Latinos living in the United States and to empower the Latino community to participate fully in our society. MALDEF has litigated many cases under state and federal law to ensure equal treatment under the law of Latinos, and is a respected public policy voice in Sacramento and Washington, D.C. on issues affecting Latinos. MALDEF sets as a primary goal defending the right of Latinos to be free of discrimination in public accommodations, including health care services.

Zuna Institute is a national non-profit organization that advocates for the needs of Black lesbians in the areas of health, public policy, economic development, and education. Through community organizing, training, and networking, Zuna works to eliminate the barriers that Black lesbians face on a daily basis, including barriers within the Black community based on sexual orientation and in the LGBT community based on race. With particular reference to this case, Zuna places a high priority on improving access to quality health care for Black lesbians, and to reducing health disparities that affect them caused by discriminatory insurance and health plan policies, cultural insensitivity and bias on the part of health professionals, and economic factors that restrict health care options. Diminished quality health care causes great harm to Black lesbians and their families. When it results from personal bias or gross insensitivity on the part of health care providers, it is demeaning to patients in ways that are harmful and entirely preventable. Because of its

commitment to improving the quality of Black Lesbians' health and lives, Zuna Institute joins this amicus brief in support of Real Party in Interest.

THE ASSISTANCE AFFORDED BY THE PROPOSED AMICUS BRIEF

Applicants are familiar with the question involved in this case and the scope of its presentation by the parties and believe that there is a necessity for additional argument on those matters. As set forth in the accompanying brief, the denial of medical care on grounds forbidden by the Unruh Civil Rights Act that is challenged in this proceeding is of great concern to the Applicants and the constituents whose interests they represent and falls squarely within the Applicants' expertise.

More specifically, Applicants wish to articulate clearly for the Court that the positions that Petitioners advocate follow neither accepted health care principles nor well settled law. Indeed, the positions set forth by Petitioners would, if accepted by the Court, condone discrimination and degrade health care. Lesbian, gay, bisexual, and transgender ("LGBT") people already are medically underserved – having less access to insurance and health care, visiting the doctor less, and often receiving lower quality care when they do – because of historical animus and discrimination. Legally sanctioning such discrimination by the medical community would only worsen the healthcare disparities that the LGBT communities face.

Thus, Applicants seek to address the misleading claim by Petitioners that the ability to discriminate would somehow result in better health care through more open communication between doctors and their patients. In

fact, the opposite is true. While doctors might be more willing to communicate their anti-gay views, patients would be more likely to withhold potentially relevant information from their doctors. Because of the public interest in proper health care and because of doctors' mission to heal and to help, unrestricted communication by patients must take precedence over discriminatory treatment by doctors. Indeed, as Applicants explain to the Court, medical professionals share this opinion.

Applicants also explain that they concur in the legal analysis set forth by Real Party. In short, both federal and California law are clear that the federal and state constitutional rights to the free exercise of religion do not permit a doctor engaged in a commercial enterprise to refuse treatment to a patient on the basis of medically irrelevant personal characteristics in a manner that violates a religiously neutral law of general applicability. Moreover, Applicants highlight for the Court the disastrous consequences that the position favored by Petitioners and their amici would have, setting a precedent for patchwork or wholesale exclusions from any generally applicable law for individual religious beliefs. Based on their collective experience addressing invidious discrimination and the health care needs of minority populations, Applicants believe it would be highly problematic if the court were to take such a dramatic departure from settled law – especially in the context of health care, in which individual patients experience dependence and vulnerability – when the courts already have developed a sound, functional framework for addressing the intersection of free exercise of religion and civil rights laws.

Although Applicants concur in Real Party's legal analysis, Applicants' discussion of the issues does not duplicate the parties' briefing but does draw on Applicants' extensive knowledge of health care policy and practice and of the relevant law. Applicants use that knowledge to show the Court that the position of Petitioners is simply contrary to the generally accepted practice in the medical profession and all controlling legal authority.

Because Applicants represent the interests of a great many Californians whose well being could be adversely affected by the Court's decision in this case, Applicants wish to assist the Court in its consideration of the important questions presented. Accordingly, Applicants request leave to file the accompanying brief amici curiae.

The proposed brief follows this application.

Dated: April 2, 2007

Respectfully submitted,

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I.
INTRODUCTION AND SUMMARY OF ARGUMENT

> When Jamie Beiler went to the doctor's office in Kissimmee Florida, the last thing she expected to receive was a packet of anti-gay propaganda referring to homosexuality as "sinful" and "impure" and advising lesbians and gay men to change their sexual orientation. ... [The doctor's] office manager ... informed Beiler that their office routinely disseminates the anti-gay materials to patients.[1]

> In 1995, Tyra Hunter was injured in an automobile accident. When first-responding EMT personnel discovered she had male genitalia, they stopped treating her and stood back, making derogatory comments. She died later that night.[2]

> "I've gotten used to Blacks and Jews, but I can't get used to the homos."
>
> –A Vermont medical faculty member to a student.[3]

The scientific research, newspapers, and court dockets are full of experiences such as those recounted above, each growing out of the bias and prejudice against lesbian, gay, bisexual, and transgender ("LGBT") people by members of the medical community. Restricting healthcare services based on a person's medically irrelevant (and legally protected) characteristics such as sexual orientation violates civil rights laws designed

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[1] Mautner Project, Lesbian Files Complaint Against Doctor for Prescribing Anti-Gay "Treatment" <http://mautnerproject.org/home/766.cfm> [as of March 30, 2007].

[2] Gay & Lesbian Med. Assoc., Healthy People 2010, Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health (2001), p. 66 (hereafter Healthy People LGBT Companion).

[3] Schatz & O'Hanlan, Anti-Gay Discrimination in Medicine: Results of a National Survey of Lesbian, Gay and Bisexual Physicians. (Am. Assoc. of Physicians for Human Rights, 1994) p. 14.

to prohibit such discrimination,[4] and professional standards of ethical conduct.[5] Moreover, the expression by medical professionals of anti-gay opinions and beliefs violates the dignity of LGBT patients and fosters a climate of anxiety and vulnerability among them that contributes to disparities in access to and use of healthcare by those populations who need it most. It is these healthcare disparities, and the way in which Petitioners' claimed right to voice and then to act on anti-gay religious tenets would exacerbate them, that the Community Health Amici address in this brief.

Although the free-exercise precedents of this Court and the United States Supreme Court have made clear that third parties must not be made to pay the price of others' religious liberty, Petitioners here have argued that the State's interests in enforcing its anti-discrimination laws must yield when the discrimination is motivated by religious belief. They have argued further that the rules permitting doctors to object on religious grounds to a number of specific medical procedures medical procedures should be expanded to permit broad religious "objections" in discrimination cases like this one, involving discrimination against a patient because she is a lesbian. They argue that it is an open question whether and how the existing state and federal precedents should apply. For those who experience such discrimination, or fear experiencing it if they reveal their sexual orientation to their health care provider, that notion is troubling indeed, for under the rubric Petitioners advance, sincerely held religious beliefs would seem to

[4] *Washington v. Blampin* (1964) 226 Cal.App.2d 604, 606-08 [38 Cal.Rptr. 235].

[5] See, e.g., GLBT Advisory Committee, Am. Med. Assoc., GLBT Policy Compendium (Sept. 2005) <http://www.ama-assn.org/ama1/pub/upload/mm/42/glbt_policy0905.pdf> [as of April 1, 2007].

excuse even the shockingly discriminatory and harmful conduct recounted at the start of this brief.

The problem presented is potentially widespread, with many studies suggesting that civil rights statutes like the Unruh Civil Rights Act are holding back very significant religiously motivated discrimination. In a survey released only last month, researchers ascertained that "when a patient requests a legal medical procedure to which the doctor objects for religious or moral reasons, most physicians believe it is ethically permissible for the doctor to describe that objection to the patient (63%) and that the doctor is obligated to present all options (86%) and to refer the patient to someone who does not object to the requested procedure (71%)." (Farr A. Curlin, et al., *Religion, Conscience, and Controversial Clinical Practices* (Feb. 2007) 356 New Engl. J. of Med. 593, 595.) And physicians who are more religious are more likely to believe that doctors may state their objections to patients and are less likely to believe that physicians must present all medical treatment options and refer patients to someone who does not object to the procedure. (*Ibid.*) The researchers noted the possible gravity of the findings:

> If physicians' ideas translate into their practices, then 14% of patients – more than 40 million Americans – may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable. In addition, 29% of patients – or nearly 100 million Americans – may be cared for by physicians who do not believe they have an obligation to refer the patient to another provider for such treatments. (*Id.* at p. 597.)

These figures suggest difficulties for patients with limited options of where to obtain care. But when the religious objection is to providing health care to a particular group of patients while providing it to others, these figures suggest that Petitioners' proposed exception to the Unruh Civil Rights Act would have significant negative ramifications for all minority populations, and not just in the health care arena.

Research shows that minority populations already experience disparities in access to and use of healthcare services. Decades of research on the experiences of racial and ethnic minorities has proven that those populations receive lower quality healthcare than non-minorities, and that historical and contemporary inequities – including stereotyping, biases, and uncertainties on the part of healthcare providers – contributes to those disparities in avoidable ways. A growing body of newer research shows that the LGBT population is on a parallel path to that of racial and ethnic minorities: due to historical discrimination, negative experiences in the healthcare setting, and disproportionate distrust of the medical profession, LGBT people have less access to healthcare; delay or avoid seeking medical care more than non-LGBT people; and, when they do seek care, frequently conceal medically relevant information (such as sexual orientation itself) because of the fear that disclosure will result in discrimination. The case before the Court illustrates why such fear too often is warranted. But even if sometimes understandable, this tendency to avoid doctors and to conceal personal information has adverse medical consequences, further exacerbating the healthcare disparities that LGBT people experience.

Accordingly, the Community Health Amici seek to dispel the misleading impression that allowing doctors to discriminate, as Petitioners advocate, would somehow result in better health care through more open communication. Exactly the reverse is true because, while doctors might be free to convey and act on their discriminatory beliefs, that behavior would mean some patients would not receive care they need, some would withhold potentially relevant information, and some patients would not return for further medical care. Given the general public's interest in expanded access to health care and the public's reliance on doctors to heal and to help, any personal, religious interests the doctors claim must give way.

From a healthcare policy standpoint, then, placing a legal imprimatur on discrimination in the delivery of healthcare services, as Petitioners here request, would only aggravate the disparities already recognized in medically underserved populations, including LGBT people. Allowing doctors to "refer" patients to other doctors based on religiously motivated objections to treating those patients would reduce the number of doctors available to treat patients who are already underserved. Moreover, when a doctor communicates bias to a patient, that communication does not enhance the doctor-patient relationship but, in fact, discourages the open, honest communication ***from the patient*** that is necessary for quality healthcare. LGBT patients will be discouraged from revealing medically important facts when they anticipate a judgmental response, disapproval, or other adverse reaction, and that restriction of information impedes the quality of care.

And from a legal policy standpoint, the principle Petitioners hope to implement will wholly undermine civil rights statutes, in that any exception to the Unruh Civil Rights Act for religiously motivated discrimination would swallow the rule. A religious exception to the Act could excuse discrimination against any patient based on his or her protected, personal characteristics. In addition, there does not seem to be any principled way to limit such a religious objection only to medical contexts. Thus, accepting Petitioners' arguments likely would foster discrimination not just against LGBT people but also against other vulnerable groups, and in all business contexts covered by the Act. Because court generally hesitate to probe the details of religious faith,[6] the consequences of the seemingly boundless exception that Petitioners urge are even more worrisome given that religious views so readily can be asserted post hoc to support a claim the explanation that something the statute does not forbid actually prompted a defendant's discriminatory conduct.

As Real Party's briefs fully demonstrate, the law already has achieved a sound, proper framework that permits free exercise of religion subject to civil rights statutes and other neutral, generally applicable laws that protect third parties. Petitioners' position is contrary not just to this controlling legal authority but also to the generally accepted practice of the medical profession. When a physician discriminates because of religious beliefs, it is still discrimination and it is still poor health care practice – and it is still unlawful. For these reasons, the Community Health Amici respectfully request that the Court reverse the order of the Court of Appeal.

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[6] *Catholic Charities v. Superior Court* (2004) 32 Cal.4th 527, 548 [109 Cal.Rptr.2d 176].

II.
ARGUMENT

A. Long-Standing And Well-Accepted Research Has Connected Invidious Discrimination Against Vulnerable Minorities To Healthcare Disparities

1. Racial and Ethnic Minorities Receive Lower Quality Healthcare

Although the body of research as to the access and use of healthcare by the gay and lesbian population is just beginning to develop, the evidence of health disparities among racial minorities is both large and long-standing. According to decades of research, even controlling for access-related factors such as insurance status and income, racial and ethnic minorities tend to receive lower-quality healthcare than non-minorities. (Committee on Understanding and Eliminating Racial & Ethnic Disparities in Health Care, Institute of Medicine, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2003) p. 1 (hereafter IOM Racial/Ethnic Disparities Report). See also Agency for Healthcare Research and Quality, U.S. Dept. of Health & Human Servs., National Healthcare Disparities Report (2005), at pp. 7-8 [first national comprehensive effort to measure differences in access and use of healthcare services by various populations, which confirmed that disparities related to race, ethnicity, and socioeconomic status continue to pervade the American health care system and that those populations receive lower quality health care] <http://www.ahrq.gov/qual/nhdr05/nhdr05.htm> [as of April 1, 2007].) Provider prejudice or bias is among the causes of these disparities: these studies suggest that patients' race and ethnicity influence the diagnostic and treatment decisions doctors make and the way they feel

about their patients. (IOM Racial/Ethnic Disparities Report, *supra*, at pp. 10-11.) And this existing prejudice, real or perceived in particular cases, couples with minority patients' lack of trust borne from all forms of historical discrimination to cause minorities to delay or avoid medical treatment.

In 2003, the Institute of Medicine of the National Academy of Sciences published a report ("IOM Racial/Ethnic Disparities Report") on racial and ethnic disparities in healthcare.[7] The IOM Racial/Ethnic Disparities Report observed that "[a] large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than are white Americans." (*Id.* at p. 2.) Minorities experience higher rates of morbidity and mortality than non-minorities. (*Id.* at p. 29.) The findings are striking: Among racial or ethnic groups, African Americans are most likely to die from heart disease, cancer, cerebrovascular disease, and HIV/AIDS; American Indians die disproportionately from diabetes, liver disease and cirrhosis, and unintentional injuries; Hispanic Americans are twice as likely as non-Hispanic whites to dies from diabetes; and some Asian American populations experience above-average rates of stomach, liver, and cervical cancers. (*Ibid.*)

[7] The IOM Racial/Ethnic Disparities Report surveyed a subset of peer-reviewed articles and studies published in the previous 10 years – over 100 studies, representing "a fraction" of those published investigating racial and ethnic differences in access to and use of healthcare services. (IOM Racial/Ethnic Disparities Report, *supra*, at p. 39.) It also noted the existence of over 600 such articles in the previous 30 years. (*Ibid.*)

Although, as noted, differences in access play a role in these disparities,[8] the IOM Racial/Ethnic Disparities Report noted a growing concern that, "even at equivalent levels of access to care, racial and ethnic minorities experience a lower quality of health services and are less likely to receive even routine medical procedures than white Americans." (*Id.* at p. 29.) Thus, even absent direct evidence of provider bias in the delivery of healthcare to minority patients, the empirical evidence suggests that race and ethnicity affect treatment:

- Studies consistently found that African-American patients, and other ethnic minorities in some instances, were less likely to be judged appropriate for transplantation, less likely to appear on transplantation waiting lists, and less likely to undergo transplantation procedures, even after insurance status and other factors are considered (*id.* at p. 59);

- African Americans with HIV infection were less likely to receive antiretroviral therapy, less likely to receive prophylaxis for pneumocystic pneumonia, and less likely to receive protease inhibitors than non-minorities with HIV, even after adjusting for age, gender, education, and insurance coverage (*id.* at p. 61);

- The U.S. Surgeon General has found that "more so than in other areas of health and medicine, mental health services are 'plagued by disparities in the availability of and access to its services,' and that 'these disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender.'" (*id.* at p. 70);

- "[W]hen sources of insurance are controlled statistically or by study design, race and ethnicity remain as significant predictors of the quality of care," best illustrated by studies revealing lower rates of use of effective, higher technology diagnostic and therapeutic procedures among minorities and higher rates of less desirable procedures (*id.* at pp. 77-78.);

[8] For example, minorities are less likely to have health insurance, face more problems getting healthcare, and have fewer choices on where to receive care. (IOM Racial/Ethnic Disparities Report, *supra*, at pp. 29, 33.)

The IOM Racial/Ethnic Disparities Report identified several factors that contributed to these disparities. "Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life." (*Id.* at p. 123.) This includes a history of segregated and inferior healthcare delivery for racial and ethnic minority patients and stark racial and ethnic differences in the contexts in which patients receive care. (*Id.* at 102-123.) And despite progress in recent decades, including improvements in attitudes about and toward racial and ethnic minorities, such attitudes are still characterized by bias, prejudice, and stereotyping. Indeed, the IOM Racial/Ethnic Disparities Report specifically acknowledged that "a substantial proportion of white Americans continue to endorse negative stereotypes about minorities." (*Id.* at p. 93.) In short, "[t]here is little doubt among researchers who study discrimination ... that the United States' history of racial discrimination has left a lasting residue, even in a society that overtly abhors discrimination." (*Id.* at p. 95.)

Unfortunately, but perhaps not surprisingly, these racial attitudes are found among healthcare providers. (*Id.* at 12 ["Finding 4-1: Bias, stereotyping and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare"].) The literature suggests several possible sources of disparity, including "systemic (e.g., those related to health system administration, financing, accessibility and geographic location), patient-level (e.g., the clinical appropriateness of care, patients' attitudes, preferences, and expectations regarding

healthcare), and care process-level (e.g., physician biases, stereotyping, and uncertainty) factors." (*Id.* at 126. See also *id.* at 161 [describing mechanisms that "might be operative in producing discriminatory patterns of healthcare for the provider's side"].)

These historical and contemporary inequities exacerbate healthcare disparities by provoking mistrust and suspicion among minority patients. "For many African Americans, doubts about the trustworthiness of physicians and healthcare institutions spring from collective memory of the Tuskeegee experiments and other abuses of black patients by largely white health professionals. This legacy of distrust, which, some argue, contributes to disparities in healthcare provision by discouraging African Americans from seeking or consenting to state-of-the-art medical services, is thus itself a byproduct of past racism." (*Id.* at 131, internal quotation marks and citations omitted. See generally Washington, Medical Aparthied: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present (Doubleday 2007).) Individual negative experiences in the healthcare setting reinforces that legacy:

> Minority patients' negative experiences with care providers in the clinical encounter can also diminish their preferences for robust treatment, and may thereby contribute to racial disparities. It is reasonable to assume that experiences of real or perceived discrimination in healthcare settings, as evidenced by providers' overt behavior ... or more subtle, subjective mistreatment (e.g., healthcare providers' low expectations for compliance or expressions of low empathy for minority patients) can affect patients' feelings about their clinical relationships and thereby dampen their interest in vigorous diagnostic and

therapeutic measures. (IOM Racial/Ethnic Disparities Report, *supra*, at pp. 131-32.)

Indeed, among all ethnic groups, those who experienced discrimination in a healthcare setting were more likely to delay seeking needed care than those who did not, and the effect was nearly uniform among African Americans who reported instances of discrimination. (*Id.* at p. 136.)

In sum, the evidence of healthcare disparities among racial and ethnic minority populations is overwhelming, encompassing over 600 published studies spanning three decades that investigate, survey, and report racial and ethnic differences in access to and use of healthcare services. A large and growing body of this research suggests that historical and contemporary inequities, including stereotyping, biases, and uncertainties on the part of healthcare providers, and minority patients' mistrust of medical professionals borne from historical and contemporary inequities, contribute to these disparities in avoidable ways.[9]

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[9] Due to long-standing awareness of the serious effects of past and continuing racial and ethnic discrimination in healthcare settings, laws exist at both the federal and state levels to prohibit such discrimination, including Title VI of the 1964 Civil Rights Act, which prohibits discrimination by recipients of federal funding, including healthcare providers receiving Medicare, Medicaid, or State Children's Health Insurance Program funding. (See 110 Cong. Rec. 1658 (1964).) According to the IOM Racial/Ethnic Disparities Report, enforcement of such prohibitions is important for reducing healthcare disparities. The Report thus recommends providing greater resources to the U.S Dept. of Health and Human Services' Office for Civil Rights to enforce civil right statutes, principally Title VI. (See IOM Racial/Ethnic Disparities Report, *supra*, at p. 15.) Similarly, the Hill-Burton Act, which provided funds to build and upgrade thousands of healthcare facilities nationally, imposed a permanent "community service" assurance that includes an anti-discrimination

2. Like Racial and Ethnic Minorities, LGBT People Are A Medically Underserved Population

Although research on the healthcare disparities that the LGBT population experiences is not yet as robust as that described above, the research that has been done indicates that similar patterns and processes are at work. That is, LGBT people suffer from similar disparities in access to and use of health services as those shown to affect racial and ethnic minorities.[10] And the disparities exhibit themselves in similar ways: compared to their heterosexual counterparts, LGBT people, particularly lesbians, have less access to health insurance; make fewer visits to doctors; are more guarded about the disclosure of medically relevant information (including sexual orientation itself); and exhibit more distrust toward healthcare professionals, including the fear of discrimination based on sexual orientation.[11]

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provision prohibiting those facilities from excluding individuals on grounds of race, color, national origin, or any other ground unrelated to need in the delivery of healthcare services. (See 42 U.S.C. § 291 et seq.; 42 C.F.R. § 124.603(a), (d). See also Cal. Health & Safety Code § 1317 [provision of emergency services and care cannot be based upon a patient's race, ethnicity, national origin, or certain other personal characteristics unless doing so is medically significant to the provision of appropriate care to the patient].)

[10] Laura Dean et al., *Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns* (2000) 4[3] J. Gay & Lesbian Med. Assoc. 101, 111 (hereafter Dean); Healthy People LGBT Companion, *supra*.

[11] Council on Scientific Affairs, Am. Med. Assoc., *Health Care Needs of Gay Men and Lesbians in the U.S.* (May 1996) 275 J. Am. Med. Assoc. 1354 (hereafter AMA, *Health Care Needs*); Julia E. Heck et al., *Health Care Access Among Individuals Involved in Same-Sex Relationships* (June 2006) 96[6] Am. J. of Pub. Health 1111; Susan D. Cochran et al., *Cancer-Related Risk Indicators and Preventive Screening Behaviors Among Lesbians and Bisexual Women* (2001) 91[4] Amer. J. Pub. Health 591

The healthcare disparities that LGBT people face are themselves similar to those of racial and ethnic minorities. For example, several studies have suggested the following findings regarding the lesbian population: (1) lesbians have overall poorer health than the general population; (2) morbidity is greater among lesbians than among heterosexual women; (3) lesbians use the health care system less often than heterosexual women, and only after they have more severe symptoms; and (4) many lesbians use complementary (or "alternative") health care providers to obtain more holistic and less discriminatory care. (See, e.g., Koh, *supra*, at 379-383.) And despite higher risk for some diseases, lesbians and bisexual woman are less likely to have routine screening procedures:

> Several investigators have hypothesized that lesbians are at higher risk for breast cancer than are heterosexual women due to higher risk factors such as obesity, alcohol consumption, nulliparity, and lower rates of breast cancer screening. While definitive studies in this area have yet to be completed, data on prevalence of each of the risk factors confirms the plausibility of this hypothesis. Lesbians also receive less frequent gynecological care than do heterosexual women and therefore might be at greater risk for mortality and morbidity from gynecological cancers. Both of these risks are likely compounded by the difficulties many lesbians experience in communicating with or receiving standard clinical care from physicians and health care systems. (Dean, *supra*, at p. 111, citations omitted.)[12]

(hereafter Cochran); Audrey S. Koh, *Use of Preventative Health Behaviors by Lesbian, Bisexual, and Heterosexual Women: Questionnaire Survey* (June 2000) 172 Western J. of Med. 379 (hereafter Koh).

[12] See also Cochran, *supra*, at p. 596.

As with racial and ethnic minorities, limits on personal financial resources have been found to play a role in healthcare disparities affecting lesbians, as they have a slightly lower socioeconomic status on average than their heterosexual counterparts despite generally higher educational levels. (Koh, *supra*, at p. 10.) Many lesbians are self-employed, work in lower-paying jobs, or work part-time without health benefits. (*Ibid.*) And as for LGBT people generally, a lack of adequate insurance can create a significant barrier to adequate health care for lesbians in particular:

> Since insurance coverage is the primary gateway to health care in this country, lesbians are at a distinct disadvantage relative to married heterosexual women because of the common prohibition against spousal benefits for unmarried partners. Among respondents to one survey [the National Lesbian Health Care Survey (NLHCS)], 16% stated that they did not receive health care because it was unaffordable. In the [Michigan Lesbian Health Survey (MLHS)], 12.3% of the lesbian sample reported that they did not have health insurance, compared to a state rate of 9.7% of Michigan women in general.
>
> Although most middle-aged lesbians surveyed in the NLHCS reported good excellent health, 27% reported that they lacked health insurance. Analysis indicated that lack of insurance may be more prevalent among lesbians with particularly serious health conditions. Lesbians without insurance were significantly more likely to report heart disease, to have Pap tests less often or never, to smoke, to have eating disorders (either overeating or undereating), and to be victims of physical or sexual abuse or anti-gay violence. (Committee on Lesbian Health Research Priorities, Institute of Medicine, Lesbian Health: Current Assessment and Directions for the Future (1999) pp. 41-42 <http://bob/nap.edu/html/leshealth/>, citations omitted (hereafter IOM Lesbian Health Report).)

A major study published by Columbia University's School of Public Health and the Gay and Lesbian Medical Association corroborated these findings, concluding that subgroups of lesbians were at particularly high risk of negative health consequences due to a lack of health insurance. (Dean, *supra*, at p. 10 ["Uninsured respondents are also more likely to have experienced physical and/or sexual abuse .... Certain physical health conditions were also more prominent, including ulcers and other intestinal disorders, substance abuse, and eating disorders"].)

But the LGBT population faces additional barriers to healthcare access that their heterosexual counterparts – including those who are racial and ethnic minorities – do not. Most of these additional barriers grow out of institutionalized (and, in most places, legal) discrimination, including:

- Systemic bias in favor of heterosexuals in our legal system, such as regulations allowing one member of a married, heterosexual couple to retain jointly owned property without jeopardizing the other's right to Medicaid coverage or continued payment of social security benefits to the other spouse (Dean, *supra*, at pp. 104-06);

- Pressure on women to use birth control as a condition of receiving free or low cost health services at community clinics, although lesbians do not need birth control to avoid unwanted pregnancy, and many experience the denial of that biological fact as a negation of an essential part of their personal identities (*ibid.*);

- Denial of basic recognition routinely granted to partners in committed, different-sex relationships in hospitals and clinics, such as the opportunity to visit one's partner in intensive care, to participate in critical medical decisions, and to have one's decisionmaking role respected in the face of insensitive and even hostile blood relatives (*ibid.*);

- Fear of revealing one's sexual orientation or gender identity to one's employer or co-workers by accessing care through a company benefit plan where the confidentiality of the medical records may not be secure (*ibid.*).

Moreover, "[t]hese and other trends will increase LGBT individuals' fears of breaches in confidentiality and consequent stigmatization." (*Id.* at p. 104.)

As seen with racial and ethnic groups, the alienation of LGBT people from health care providers can be partly attributed to experiences of bias and discrimination. Despite increasing acceptance in recent years, LGBT populations still face stigma and disapproval from large numbers of Americans. (Dean, *supra*, at p. 102.) Both negative attitudes toward LGBT people, and the majoritarian belief system that "denies, denigrates, and stigmatizes any nonheterosexual form of behavior," contribute to the "inadequate assessment, treatment, and prevention of [LGBT] health problems." (*Id.* at pp. 102, 103.) These social conditions impact LGBT health in various ways:

> The areas affected can be conceptualized as ranging from the direct impact of stigmatization and prejudice (e.g., exposure to violence, stress, poor access to care) to failure adequately to address special needs of LGBT populations (e.g., gay-specific sexually transmitted disease, fertility challenges, genital reassignment surgery). (*Id.* at p. 103.)

And from a public health standpoint, anti-gay bias is exhibited in the allocation of scarce resources to research and public health work on issues of concern to the LGBT population. (*Id.* at p. 103.)

Because these negative attitudes prevalent in the general population are also found among health care professionals, LGBT individuals are also subject to discrimination and bias in medical contexts. (*Id.*) Research documents negative encounters including inappropriate interventions,

hostility from providers, and violation of confidentiality. (E.g., Cochran, *supra*, at 596.) When surveyed, LGBT physicians themselves confirm the challenges that members of the LGBT community face in obtaining health services:

> Most respondents (67%) reported knowing gay patients who received substandard care or were denied care because of their sexual orientation. A majority (52%) reported observing colleagues providing reduced care or denying care to patients based on their sexual orientation. And most respondents (88%) reported hearing colleagues make disparaging remarks about gay patients. ... These reports lend credence to the ambivalence many lesbians and gays feel toward their health providers. (Gary L. Stein & Karen A. Bonuck, *Physician-Patient Relationships Among the Lesbian and Gay Community* (2001) 5[3] J. Gay & Lesbian Med. Assoc. 87, 88 (hereafter Stein).)[13]

Similarly, in a survey of medical students, 52% agreed that openly homosexual candidates for residency programs are likely to be discriminated against; in a separate survey of physicians and medical students, 59% of respondents reported having had suffered discrimination, harassment, or ostracism within the medical profession because of their sexual orientation. (Healthy People LGBT Companion, *supra*, at pp. 63-64.) Most disturbing for the future care of gay and lesbian patients, 25% of second-year medical students in a 1999 study believed that homosexuality was "immoral and dangerous to the institution of the family." (*Id.* at p. 63.)

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[13] See also AMA, *Health Care Needs*, *supra*, at 1355 [quoting a practitioner who stated that "other OB/GYNs here don't do Pap smears on a lot of their openly lesbian patients" and noting a 1994 study in which 45% of gynecologists surveyed had "observed substandard or denied care" given to homosexual patients].

Spoken or unspoken, gay and lesbian patients perceive these discriminatory messages from their healthcare providers. In a non-random survey of LGBT patients, of the 30% of survey participants who had not disclosed their sexual orientation to their provider, 47% were concerned about a bad reaction or poor treatment and 85% were concerned about negative results if the information were included in their medical records, such as disclosures to employers, insurers, or family members.[14] (Stein, *supra*, at pp. 91, 92.) The survey analysts also noted that "even among this relatively well-educated, high income, and well-connected group of lesbians and gays, almost 20% of the sample avoided or delayed obtaining necessary medical care for reasons due to their sexual orientation." (*Id.* at p. 92.) Those who are brave enough to disclose their sexual orientation, as Real Party did, too often find that their fears are realized: "In a survey of 558 lesbians and bisexual women who disclosed their sexual orientation to their physicians, examples of negative responses from physicians were given; eg, 'All [my] doctors have become nervous' and 'He got up, left the room and had a nurse finish the questioning.'" (AMA, *Health Care Needs*, *supra*, at p. 1355.)

In sum, as seen with racial and ethnic populations, the research on LGBT health disparities demonstrates that anti-gay bias and discrimination, and resulting LGBT distrust of medical professionals, contribute to such disparities in important ways.

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[14] The percentage of patients who concealed their sexual orientation is even higher in some studies – sometimes as high as 67% to 72%. (See AMA, *Health Care Needs*, *supra*, at p. 1355.)

B. Recognizing A New Right Of Doctors To Withhold Treatment From Certain Patients Based On The Doctors' Personal Beliefs About Those Patients Would Strongly *Discourage* Open And Honest Doctor-Patient Communications And *Worsen* Healthcare

Although bias and discrimination already contribute to the well-documented healthcare disparities LGBT people experience, Petitioners seek to make the communication of such bias an "open and candid" part of the medical encounter. In essence, Petitioners suggest that a doctor's communication of his or her group-based dislike or disapproval of a patient to that patient will encourage communications between doctor and patient and somehow result in better health care. Exactly the opposite is true. It defies logic to argue that patients benefit by being told their physicians think they are inferior or insufficient in some way to deserve appropriate medical treatment. It also defies common precepts of medical care.

1. Open and Honest Communication From Patient to Doctor is Necessary to Facilitate Quality Healthcare

Providers depend on receiving complete and accurate information from patients to provide competent healthcare, so communication from the patient to the doctor is the most critical aspect of the doctor-patient relationship. When the environment fosters trust and openness, free communication facilitates constructing an accurate medical and social history, assessing the patient's belief about health and illness, establishing an empathic connection with the patient, reaching agreement with the patient on treatment decisions, and prescribing a course of action. (IOM Racial/Ethnic Disparities Report, *supra*, at p. 141.) But when a patient guards against disclosure of medically relevant information, misunderstandings of the patient's concerns, misdiagnosis, or unnecessary

testing may result, as well as poor patient compliance, inappropriate follow-up, and poor patient satisfaction. (See *ibid.*)

The law recognizes the importance of patients' communications to doctors by protecting them from unauthorized disclosure. (*See* Cal. Evid. Code §§ 990-1007.) In California, the doctor-patient privilege is "venerable" (*Green v. Superior Court* (1963) 220 Cal.App.2d 121, 125 [33 Cal.Rptr. 604], citing Stats.1851, ch. 1, sec. 398, p. 114), and its purpose is "to encourage free disclosure of facts by the patient to the doctor which otherwise might be withheld and which may aid the doctor in diagnosis and treatment." (*Ibid.* See also *Division of Med. Quality, Board of Med. Quality Assurance v. Gherardini* (1979) 93 Cal.App.3d 669, 679 [156 Cal.Rptr. 55] [purpose is "to encourage the patient's full disclosure to the physician of all information necessary for effective diagnosis and treatment"].) Understanding that "matters disclosed to the physician arise in most sensitive areas often difficult to reveal even to the doctor" (*Division of Med. Quality*, *supra*, 93 Cal.App.3d at p. 679), the policy of this State, as expressed by statute, is to facilitate such disclosure, not hinder it. (*See* 31 Cal.Jur.3d (2002) Evidence, § 518 ["The obvious objective of the physician-patient privilege is to foster open communication between patients and their health care providers. Without assurances that their revelations would be safe from public exposure, persons in need of care would often be discouraged from the open and complete disclosure of private information which is essential to effective treatment"].)

Moreover, communication has been found to be as significant as the lack of insurance in predicting use of health services. Evidence of this

phenomenon is found in studies regarding the impact of language barriers on medical care: health care providers surveyed in four major metropolitan areas identified language difficulties as a major barrier to immigrants' access to health care and a serious threat to quality medical care. These providers expressed concern that they could not get information to make good diagnoses and that patients might not understand prescribed treatment. (Ku & Freilich, Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston (Feb. 2001) at pp. ii-iii. See also IOM Racial/Ethnic Disparities Report, *supra*, at p. 141 ["having a language-concordant physician was associated with better patient self-reported physical functioning, psychological well-being, health perceptions, and lower pain"].) On the other hand, while Latino children generally have much less access to medical care than do white children, that gap becomes negligible when their parents' English-speaking skills are comparable to those of whites. (See R. Weinick & N. Krauss, *Racial and Ethnic Differences in Children's Access to Care* (Nov. 2000) 90 Am. J. Public Health 1771.)

The IOM Racial/Ethnic Disparities Report corroborates the importance of communication in the medical setting:

> Many healthcare providers are acutely aware of the impact of language barriers and other cultural differences and how these factors affect their healthcare practice. In a recent survey of physicians who participate in the "Healthy Families" programs, L.A. Care (the local health authority of Los Angeles County) found that 71% of providers believe that language and culture are important in the delivery of care to patients. Slightly over half (51%) believe that their patients did not adhere to medical treatments as a result of cultural or linguistic barriers. (IOM

> Racial/Ethnic Disparities Report, *supra*, at p. 90, citing Cho & Solis, L.A. Care Health Plan, Healthy Families Culture & Linguistic Resources Survey: A Physician Perspective on their Diverse Member Population (Jan. 2001).)[15]

Not surprisingly, the importance of communication holds true for gay and lesbian patients. Indeed, "[g]ood physician-patient communication is essential to addressing the health care needs of lesbians and gays, especially in discussing health issues related to sexuality, sexual orientation, mental health, health care planning and advance directives, and family relationships." (Stein, *supra*, at p. 92.) And to be effective, the communication must include the patient's sexual orientation. (Dean, *supra*, at p. 108 ["Disclosure of sexual orientation in the health care setting is crucial to the provision of appropriate, sensitive, and individualized care"].) Providers who don't know their patients' sexual orientation may fail to diagnose, treat, and recommend appropriate preventative measures for their patients. (*Ibid.*)

The American Medical Association ("AMA") recognizes the particular importance of respectfully, effective communication in treating LGBT patients:

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[15] In one survey of health care providers: (1) 94% said communication is a top priority in delivering quality care, citing language barriers as a major obstacle to delivering that care; (2) 73% said a patient's understanding of treatment advice and of their disease is the most compromised aspect of care due to language barriers; (3) 72% said language barriers increase the risk of complications; (4) 71% said language issues make it harder for patients to explain symptoms and concerns. (Wirthlin Worldwide, Robert Wood Johnson Foundation (Dec. 2, 2001) Hablamos Juntos: We Speak Together.)

> Our AMA: (1) believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness. In the case of the homosexual patient this is especially true, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between physician and the homosexual patient effective progress can be made in treating the medical needs of this particular segment of the population; (2) is committed to taking a leadership role in: (a) educating physicians on the current state of research in and knowledge of homosexuality and the need to take an adequate sexual history; [and] (b) educating physicians to recognize the physical and psychological needs of their homosexual patients; .... (AMA Policy H-160.991, Health Care Needs of the Homosexual Population <http://www.ama-assn.org/ama/pub/category/14754.html#6> [as of April 1, 2007].)

Moreover, providers who are culturally competent with respect to LGBT concerns are much more likely to understand the deleterious effects expressions of anti-gay bias have on healthcare delivery (such as deterring these persons from seeking necessary medical care). (See, e.g., Cochran, *supra*, at p. 596; U.S. Dep't of Health and Human Services, Office on Women's Health, Lesbian Health Fact Sheet (Nov. 2, 2000), at p. 3 <http://www.womenshealth.gov/owh/pub/factsheets/lesbian1.pdf> [as of April 1, 2007].) Culturally competent providers also are more likely to know the range of health problems commonly experienced by LGBT patients and thus what information to elicit or verify; to avoid making erroneous assumptions when gathering health information from them; and to involve the partners of these patients in discussions about their health

care in ways that facilitate information flow and increase favorable outcomes. (IOM Lesbian Health Report, *supra*, at pp. 42-43, citation omitted.) At least one well-respected study has concluded that health risks and health-seeking behaviors strongly correlate with comfortableness and ease of communication with the provider. (*Ibid.*)

Unfortunately, in addition to the difficulties in health care access discussed above, LGBT individuals also "face significant obstacles in communication with health care providers." (Dean, *supra*, at p. 107.) The most significant hurdle arises from individual providers' negative attitudes about LGBT people: "many lesbians and gay men report that their doctors are not sensitive to or knowledgeable about their particular health risks and needs, and do not disclose pertinent information about treatments or prevention." (*Ibid.*) Moreover, even among providers who assumed that LGBT people were among their patients, most saw no reason to address this in a direct way. (*Ibid.*) Barriers to communication also exist at the system level: in hospitals, visitation and medical decision-making policies often exclude partners of LGBT patients, and the Centers for Disease Control requires LGBT-targeted public health or educational material to undergo "community review" but does not require that review panels include gay men, lesbians, or knowledgeable experts. (*Id.* at p. 108.)

To conclude, the studies to date make clear that negative attitudes and treatment by providers discourage lesbians and gay men from seeking and participating fully in their health care, and that incidents of discrimination – such as reluctance or refusal to treat, negative comments during treatment, or rough handling during examinations – do occur with

disturbing frequency. Just as with other vulnerable patient populations, there can be no question that disrespectful or exceptionally awkward communication impedes healthcare delivery and leads to poor quality of care, whether the barriers are due to language, cultural misunderstanding, or personal biases on the part of the medical professional.

2. Communication of Doctors' Biases Would Further Discourage Communication From Patients Who Fear Negative Reaction

While exempting physicians from nondiscrimination laws might encourage physicians to be more honest about ***their*** personal needs – including their discriminatory views about patients about whom they disapprove for religious reasons – doing so undoubtedly would strongly discourage patients from speaking openly about their sexual orientation or any other medically relevant information that may induce the physician to terminate or impose limits on the treatment relationship.

Again, even without Petitioners' claimed right to express religious views and personal biases to their patients, medical researchers and practitioners have concluded that many lesbian and gay patients are already reluctant to reveal their sexual orientation. In fact, one researcher noted that "it seemed to be easier for these respondents to disclose to their parents (often reported as the most stressful event in the coming out process) than to health care providers." (Michele J. Eliason & Robert Schope, *Does "Don't Ask Don't Tell" Apply to Health Care? Lesbian, Gay and Bisexual People's Disclosure to Health Care Providers* (Dec. 2001) 5[4] J. Gay & Lesbian Med. Ass'n 125, 132 (herafter Eliason).) Physicians more freely expressing their views concerning why gay patients should not be treated as

others – cloaked with the legal authority to refuse treatment for patients on the basis of sexual orientation or similar personal characteristics – would exacerbate this challenge, further undermining the open and honest communication that Petitioners purport to desire. As a doctor at Harvard Medical School wrote in a first-person commentary, "Finding help is not easy. It is hard to trust other people, even professionals, when one anticipates disapproval." (Jennifer E. Potter, *Do Ask, Do Tell* (Sept. 2002) 137[5] Annals of Internal Med. 341, 341.) Given that the position advocated by Petitioners encourages open communication by the physician and inevitably ***discourages*** open communication by the patient, their argument begs the question: Which of these is more important?

In the medical community, the answer is settled unequivocally in favor of the patient. That the communication of bias by a doctor to a patient would worsen already-present healthcare disparities is hardly debatable. According to the Institute of Medicine, "[p]rejudice is the least subtle of the mechanisms likely involved in clinical disparities, and does not require a sophisticated understanding of doctor-patient interaction to see how it might work." (IOM Racial/Ethnic Disparities Report, *supra*, at p. 161.) How it does work is this:

> Because of negative attitudes prevalent in the U.S. public as well as among physicians and other medical staff, LGBT individuals are subject to discrimination and bias in medical encounters. Moreover, they are likely to receive substandard care, or remain silent about important health issue they fear may lead to stigmatization. Bias from health care professionals – and perception of such bias – have been identified as personal and cultural barriers to care, leading to reduction in help-seeking and quality of care. In addition, stereotyping and lack of education may lead

> health care providers to ignore known special preventive care and treatment needs of LGBT people (e.g., provision of pap smears to lesbians ...) Medical forms and the format of medical intake and history are often insensitive to the experience of LGBT patients, [and thus are] likely to discourage disclosure of sexual orientation and behavior. (Dean, *supra*, at p. 6, citations omitted.)

But gathering accurate information about sexual behavior history is an essential component of good medical care. And if a physician is uncomfortable eliciting this information, or if the patient is uncomfortable providing it, the physician will not be able to provide appropriate, sensitive and individualized health care to these patients. (Dean, *supra*, at p. 13; IOM Lesbian Health Report, *supra*, at p. 43.)

AMA policies make clear that it is open communication by the ***patient*** – not by the doctor – that is essential to quality health care and thus must be encouraged. (See, e.g., AMA Policy H-160.991, <http://www.ama-assn.org/ama1/pub/upload/mm/42/glbt_policy0905.pdf> [as of April 1, 2007].) The President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry agrees and has observed that "incidences of discrimination – real and perceived – mar the relationship between consumers and their health care professionals, plans, and institutions."[16] In contrast, disclosure of a patient's sexual orientation allows physicians to "focus [their] inquiries, personalize professional

[16] President's Adv. Comm'n on Consumer Prot. & Quality in the Health Care Industry, Consumer Bill of Rights and Responsibilities <http://www.hcqualitycommission.gov/cborr/chap5.html> [as of April 1, 2007].

advice and assistance, and generate an overall higher quality of care."[17] Similarly, studies of cancer in lesbian and bisexual women have concluded that "[d]eveloping 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." (Cochran, *supra*, at p. 596.) As other researchers succinctly explained, "[t]o give the best possible health care, physicians, nurses, and other health care providers need to have relevant, accurate information about their patient's needs." (Eliason, *supra*, at p. 125.)

Again, provider prejudice or bias results not just in diminished care, by influencing physicians' diagnostic and treatment decisions,[18] but also in diminished patient response[19] and avoidance of care.[20] Because many

[17] Lambda Legal, Disclosing Your Sexual Orientation or Gender Identity to Healthcare Providers: The Effect of New HIPAA Regulations (June 18, 2003) <http://www.lambdalegal.org/our-work/publications/facts-backgrounds/page.jsp?itemID=31989549> [as of April 1, 2007].

[18] IOM Racial/Ethnic Disparities Report, *supra*, at pp. 162-66.

[19] IOM Racial/Ethnic Disparities Report, *supra*, at pp. 174-75 ("[The] higher rate of refusal of recommended treatments may reflect patients' experiences of discrimination in other sectors or mistrust of authority. Some mistrust and refusal, however, might be a 'rational' reaction to explicit discrimination, aversion, or disregard displayed by the provider. If minority patients perceive that their provider has a lower regard for them, they will be less likely to comply with treatment recommendations."). See also Dean, *supra*, at p. 108 ("Failure to establish rapport and communication between physicians and patients is associated with decreased levels of adherence to physician advice and treatment plans, and decreased rates of satisfaction. Additionally, clinicians unaware of their patients' sexual orientation may fail to accurately diagnose, treat, or recommend appropriate preventive measures for a range of conditions"), citation omitted.

providers are hostile to LGBT patients, it should come as no surprise that many of these patients are in fact afraid to be open with their providers, despite the adverse impact of secrecy on the relevance and quality of the care they receive. Studies have confirmed that a sizeable majority of lesbians (53-72%) do not disclose their sexual orientation when they seek medical care. (IOM Lesbian Health Report, *supra*, at p. 45.) Sixty percent of the women in one study and 27% of respondents in another reported encounters with health care workers who assumed they were heterosexual, but 61% of women in the first study felt they could not reveal their sexual orientation, and a lower proportion stated that they would not be comfortable revealing it. (*Ibid.*) As one researcher concluded, "[h]omophobic attitudes and discrimination against lesbians have been documented in a range of healthcare personnel, including physicians, medical students, and nurses. People who have experienced discrimination may be discouraged from seeking health care." (Koh, *supra*, at p. 379, citations omitted.)

To a large extent, effective communication depends on trust between patient and provider. Yet the public's trust in the health profession – and particularly the trust of members of underserved populations – will be harmed if more patients learn that their doctors harbor class-based prejudice or bias, or are free to reject or segregate patients based on medically irrelevant characteristics such as race or sexual orientation. (E.g., IOM

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[20] Dean, *supra*, at p. 108 ("The lesbians who disclosed their sexual orientation were more likely to seek health and preventive care, to have a Pap test, to be non-smokers, and to report comfort in communication with providers. By contrast, difficulty communicating with the primary care provider was associated with delay in seeking health care.").

Racial/Ethnic Disparities Report, *supra*, at p. 36.) "[T]he healthcare provider, rather than the patient, is the more powerful actor in clinical encounters." (*Id.* at p. 12.) And it is for these reasons that the solid consensus among medical professionals is against invidious discrimination, recognizing that it impedes doctor-patient rapport and degrades the quality of health care. Accordingly, the Community Health Amici underscore that policies calling for nonjudgmental recognition of sexual orientation diversity are exactly right as a matter of health-care policy and that these policies are supported by California's civil rights law, while Petitioners' position turns sound practice upside down.

3. Enforcing Discrimination Policies Promotes Good Health Care

While discrimination exacerbates healthcare disparities for minority populations, enforcement of non-discrimination policies promotes quality healthcare. Recognizing this principle, the applicable ethical practice standards of the medical profession do not condone a doctor's refusal to treat a patient based on personal characteristics that are medically irrelevant and protected by a generally applicable civil rights law, whatever the motivation for the refusal.[21]

[21] AMA Opinion E-9.12 ["physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, or any other basis that would constitute invidious discrimination"]; AMA Opinion E-10.05 ["physicians cannot refuse to care for patients based on race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination"]; AMA Policy H-65.976 (nondiscriminatory policy for health care needs of homosexual population); AMA Policy H-65.983 (non-discrimination policy); AMA Policy H-65.990 (civil rights restoration); AMA Policy H-65.992 (continued support of human rights and freedom); AMA Policy D-65.996 (nondiscriminatory

These policies against discrimination stem not just from a general recognition of the principle of equality, but also from a belief that discrimination – whatever the rationale – degrades health care. As described above, numerous studies, researchers, and healthcare practitioners have concluded in recent years that lesbians and gay men continue to face widespread discrimination and that it worsens their health care. For example, the American College of Obstetricians and Gynecologists ("ACOG") addressed this issue in a 2005 report. (Amer. College of Obstetricians & Gynecologists, *Primary Care of Lesbians and Bisexual Women in Obstetric and Gynecologic Practice* in Special Issues in Women's Health (2005) p. 61 (hereafter ACOG).) ACOG explained that lesbian and bisexual women "may perceive negative attitudes on the part of their caregivers, causing them to hesitate in obtaining routine health maintenance visits. ... [L]esbians reported experiencing ostracism, rough treatment, derogatory comments, or having their life-partners excluded from discussions by their medical practitioners." (ACOG, *supra*, at pp. 62-63.) Accordingly, ACOG concluded that "[p]ractitioners have the responsibility to provide quality care to all women regardless of their sexual orientation." (*Id.* at p. 61.) That discussion and recommendation has, of course, direct relevance to the factual background of this case.

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policy for health care needs of the homosexual population) <http://www.ama-assn.org/ama/pub/category/14754.html> [as of April 1, 2007]. See also Brief of Amicus Curiae submitted in this case by the Gay and Lesbian Medical Association, et al., providing recognized standards of medical practice by numerous medical associations that uniformly prohibit discrimination based on protected characteristics, including sexual orientation.

Similarly, in an introductory editor's letter to the American Journal of Public Health's first issue ever dedicated exclusively to the health concerns of the LGBT community, the guest editor explained that "[d]espite the many differences that separate them, [this community] share[s] remarkably similar experiences related to discrimination, rejection, and violence across cultures and locales." (Ilan H. Meyer, *Why Lesbian, Gay, Bisexual, and Transgender Public Health?* (June 2001) 91[6] Am. J. Pub. Health. 856, 856 (hereafter Meyer).) In the healthcare area, "[s]tigma and discrimination affects the health of [the community] in many ways," including poor clinical care and inadequate attention to specific healthcare concerns. (Meyer, *supra*, at p. 857.) The AMA agrees that these attitudes have real and adverse effects on patients and their health, stressing that a physician's failure to recognize a patient's homosexuality and "the patient's reluctance to report his or her sexual orientation can lead to failure to screen, diagnose, or treat important medical problems." (AMA, *Health Care Needs*, *supra*, at p. 1359.)

In contrast, when medical practitioners are dissuaded from expressing discriminatory attitudes and taking discriminatory actions toward lesbians and gay men, healthcare is better. One researcher writes, "provision of adequate care requires that care providers be sensitive to the needs of these populations. Insensitive or hostile care may lead to inappropriate interventions, fail to effect change, and add to alienation and mistrust of the authority of public health recommendations." (Meyer, *supra*, at p. 857.) Indeed, healthcare professionals have described optimum care as "culturally competent" care, or care that is not just non-

discriminatory but also non-judgmental and sensitive to patients' particular communities and behaviors.[22]

One of the largest healthcare providers in California, Kaiser Permanente, expects "cultural competence" from its physicians and staff. Kaiser has developed a Provider's Handbook on Culturally Competent Care for the Lesbian, Gay, Bisexual and Transgendered Population (the "Kaiser Provider's Handbook") to help them meet that expectation. In it, Kaiser explains that "[t]he term 'culturally competent care' describes health care that is sensitive to the health beliefs and behaviors, epidemiology and treatment efficacy of different population groups ... [S]tudies are now indicating that sexual orientation and gender identity are as important as age or race in understanding health care utilization patterns and cost of care." (Kaiser Provider's Handbook, at p. 1.) Moreover – and significantly for this case – Kaiser does not consider a health care practitioner's personal beliefs to provide an excuse for failing to provide culturally competent care. Instead, the Kaiser Provider's Handbook instructs: "Provider's personal religious or moral beliefs can be separate from the dynamics of their

[22] One commonly accepted definition of "cultural competence" is set forth in the U.S. Dept. of Health and Human Services' Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report (March 2001) at p. 28: "Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communication, actions, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual or an organization within the context of the cultural belief, behaviors, and needs presented by consumers and their communities."

relationship with [LGBT] patients. Assess how your biases impact the way you communicate with the patient ..."[23] (*Id.* at p. 16.)

The proven ill effects of discrimination on healthcare quality explain, at least in part, why the governing bodies of the healthcare professions now speak emphatically with one voice against discriminatory treatment of patients on the basis of sexual orientation, regardless of the purported justification. As discussed further below, firm legal precedent dovetails with these public health policies.

4. Neither The Law Nor Good Medical Practice Permits Referrals To Avoid Non-Discrimination Laws

Petitioners urge this Court to adopt a rule that doctors with a religious objection to providing treatment to a particular patient may refer that patient elsewhere. Accepting this argument would be to condone and approve a policy of segregation in healthcare, a policy that has been rejected in American jurisprudence for well over 50 years. (See *Brown v. Board of Education* (1954) 347 U.S. 483 [74 S.Ct. 686, 98 L.Ed. 873].) This position contravenes both the law and, as the Community Health Amici have explained, good medical practice.[24]

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[23] In an amicus brief in support of Real Party filed in this case on March 29, 2007, Kaiser Foundation Health Plan, Inc., The Permanente Medical Group, Inc. and the Southern California Permanente Medical Group explain in greater detail the institution's policies against sexual orientation discrimination, including discrimination motivated by sincere religious belief.

[24] Indeed, to permit referrals stemming from a discriminatory refusal to treat a patient, based on an assumption that some other doctor can provide equivalent care, would approve a form of "separate but equal" medical

As discussed fully in Real Party's briefs, the legal framework set out by the U.S. and California supreme courts does not permit a religious adherent to avoid a neutral law of general applicability by simply referring someone who is not to their liking elsewhere. The cases do not permit a restaurant owner to refer an African-American to a nearby restaurant or an apartment owner to refer an unmarried woman to a nearby apartment. The California Supreme Court specifically addressed this idea in *Smith v. Fair Employment and Housing Commission* (1996) 12 Cal.4th 1143, 1175 [913 P.2d 909, 51 Cal.Rptr.2d at 700], explaining that "[t]o say that the prospective tenants may rent elsewhere is to deny them the full choice of available housing accommodations enjoyed by others in the rental market. To say they may rent elsewhere is also to deny them the right to be treated equally by commercial enterprises." (*Id.* at p. 1175.) Here, the well-settled law does not permit the Petitioners to refer Real Party to another doctor because she is lesbian. The California Supreme Court has explicitly held that nondiscrimination statutes do more than just help everyone have equal access to desirable goods and services; they also protect each person's "legal and dignity interests in freedom from discrimination based on personal characteristics." (*Smith*, 12 Cal.4th at p. 1170. See also *Heart of Atlanta Motel v. United States* (1964) 379 U.S. 241, 250 [85 S.Ct. 348, 13 L.Ed.2d 258] [when those engaged in commerce turn away members of disfavored groups, it inflicts dignitary harm on humiliated individuals and also harms society generally]. Cf. *Rolon v. Kulwitzky* (1984) 153 Cal.App.3d 289 [200 Cal.Rptr. 217] [for Unruh Civil Rights Act purposes,

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practice that both the law and society have come to understand is fatally flawed in concept as well as inevitably deficient in execution.

"equal services" in restaurant means seating lesbian couple in one of desirable booths offered to "couples," not just offering meal at tables used for singles and groups].) In sum, legal precedent makes it clear that discriminatory referrals by physicians do not satisfy physicians' duty under the civil rights laws to treat all patients and prospective patients equally.

Moreover, the Community Health Amici believe that the end-run around anti-discrimination laws that Petitioners seek undoubtedly would result in worse health care for some of the most needy members of society. Particularly in indigent or rural areas, patients with frowned-upon personal characteristics (e.g., particular races, ethnicities, religions, and LGBT people, among others) are most likely to be sent elsewhere for their medical needs. Given the cost of health care and limits of many people's provider options, being sent away will mean that some will never have their needs addressed at all and other will have them addressed much later; in some circumstances, it will mean serious health problems being untreated entirely or being treated very belatedly, with severe adverse health consequences. Even apart from the unacceptable dignitary harm of being told "we don't treat your kind here," referrals do not, and cannot, justify an exemption for physicians (or anyone else) from laws of nondiscrimination. If physicians do not have the right to discriminate directly (and they do not), then they should not be permitted to accomplish discrimination by other means by suggesting or requiring that disfavored patients go elsewhere for treatment that physicians offer to favored groups of patients with the same medical need.

C. Any Exception To The Unruh Civil Rights Act For Religiously Motivated Discrimination Would Swallow The Rule

The Community Health Amici have submitted this Brief because of a common concern that the position advocated by Petitioners is not just troubling and wrong but potentially disastrous. A decision in Petitioners' favor would set a precedent that could lead to the evisceration of civil rights laws – a matter of grave concern to all the Community Health Amici, given their missions and areas of expertise, and to all Californians.

A religious exception to the Unruh Civil Rights Act presumably would apply similarly to discrimination against any group protected by the Act. The Community Health Amici do not believe that there is a principled or effective way to distinguish sexual orientation from other protected personal characteristics, such as race or gender, particularly not in the context of civil rights statutes such as the Unruh Civil Rights Act. There is a firm state policy against discrimination on the grounds covered by the Act. (*Winchell v. English* (1976) 62 Cal.App.3d 125, 128 [133 Cal.Rptr. 20] ["Statutes such as the Act are declaratory of the state's public policy against racial discrimination .... 'Discrimination on the basis of race or color is contrary to the public policy of the United States and of this state.'"], quoting *Burks v. Poppy Constr. Co.* (1962) 57 Cal.2d 463, 471.) And the statute does not rank or distinguish among the covered personal characteristics in any way that could allow religiously motivated discrimination on some prohibited grounds while maintaining solid protection against discrimination on other prohibited grounds. Accepting the doctors' arguments would foster discrimination not just against LGBT people but also against other vulnerable groups based on protected personal

characteristics. Neither the law nor public policy should countenance such a result.

Moreover, contrary to Petitioners' argument, the Community Health Amici do not believe that there is a principled or effective way to distinguish the specific infertility, which treatment that Real Party sought and Petitioners declined in this case, from other infertility treatments, or from other medical treatments or even from arenas outside of healthcare. Indeed, that is why a California appellate court in 1964 rejected a challenge to the Unruh Civil Rights Act in which a physician refused to treat an African-American child on the basis of her race. (*Washington v. Blampin*, *supra*, 226 Cal.App.2d 604.) The policy reasons why *Blampin* was correctly decided apply just as firmly today as they did four decades ago. Similarly, in the absence of any statutory basis for distinguishing discrimination against patients from discrimination in other business settings covered by the Unruh Civil Rights Act, the claimed religious exception cannot meaningfully be limited only to medical contexts. These consequences demonstrate why a decision for Petitioners would be so dangerous. Petitioners would allow "sincere" religious beliefs to exempt individuals from all statutes that conflict with their beliefs. Religious beliefs, as long as alleged to be sincere, would immunize their adherents from neutral laws of general applicability and allow any individual to be in essence a walking "law-free" zone as to those particular beliefs. Any action (or non-action), no matter how repugnant to the law or how harmful to others in the community, could be protected, provided it was based in a sincere religious belief. Real Party already has highlighted to this Court a

sampling of behaviors that this new rule could permit. The U.S. Supreme Court too has observed the implications of arguments advanced (unsuccessfully) by those such as Petitioners here: "The rule respondents favor would open the prospect of constitutionally required religious exemptions from civic obligations of almost every conceivable kind ..." (*Smith*, 494 U.S. at 888.) Judges and juries would be left with only one relevant question: Did the individual base his or her unlawful conduct on a sincere religious belief? This would create a dramatic new defense to the application of any civil rights law, or indeed of any law.

The U.S. Supreme Court and the California Supreme Court have consistently and clearly held that Petitioners' desired rule cannot be the law for good reason, else "every citizen [would] become a law unto himself." (*Catholic Charities of Sacramento, Inc. v. Superior Court*, *supra*, 32 Cal.4th 527, 548, quoting *Smith*, 494 U.S. at p. 879.) For third parties who rely on protections offered by our secular legal system, Petitioners' proposal would be less like starting down the proverbial slippery slope and more like a quick fall off a high cliff.

D. The Existing Legal Framework Protects Against Discrimination While Permitting Free Exercise of Religion

The law already has achieved a balanced, proper framework that permits free exercise of religion subject to civil rights statutes and other neutral, generally applicable laws that protect third parties. Real Party has set forth in detail the correct, well-established legal framework for resolution of this dispute. In contrast, Petitioners have ignored it. Indeed, the controlling cases from the U.S. Supreme Court and the California

Supreme Court are not analyzed by Petitioners ***at all***. Instead, Petitioners spend their briefs either on irrelevant issues or on proposals of their own design (that conflict directly with the controlling law).

The Petitioners seek a radically changed relationship between free exercise of religion and neutral laws of general applicability, including civil rights laws. They seek a test in which the touchstone is a religious adherent's "good-faith" belief. However, free exercise of religion and civil rights laws of general applicability ***already*** co-exist, and the courts and health care community already have fashioned a fair and sensible relationship between them. It is not a relationship that permits the sincerity of one's personal beliefs to justify discriminatory treatment of another.

To the contrary, as Real Party has explained, when doctors enter into a commercial medical practice, like any other licensed professional activity, they accept as limits on their conduct laws of nondiscrimination that are generally applicable to the rest of society. In addition to being a rule set forth in well-settled law, it is a proper one. Irrespective of their personal religious or moral views, physicians may not choose to perform (or not to perform) medical treatments for certain patients and not for others based on the patients' protected personal characteristics.

III.
CONCLUSION

Petitioners err in their statements of the law and of good health care principles. On the other hand, Real Party describes both accurately and thoroughly. Accordingly, the Community Health Amici respectfully request that the Court reaffirm existing law and reverse the Court of Appeal.

Dated: April 2, 2007

Respectfully submitted,

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CERTIFICATION OF COMPLIANCE

I hereby certify that the foregoing brief was produced using Microsoft Word, was prepared using a proportionately spaced typeface consisting of 13 points, and that, as determined by this software, the brief, exclusive of the cover pages, application, and tables, contains 9,713 words and is therefore in compliance with Rule 8.204(b) and (c) of the California Rules of Court.

Dated: April 2, 2007

Respectfully submitted,

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PROOF OF SERVICE

I, Martha Kalenderian, declare:

That I am a resident of Los Angeles County, California; that I am over eighteen (18) years of age and not a party to this action; that I am employed in Los Angeles County, California; and that my business address is Winston & Strawn LLP, 333 S. Grand Avenue, 38th Floor, Los Angeles, CA 90071.

On April 2, 2007, I served a copy of the attached document, described as BRIEF IN SUPPORT OF REAL PARTY IN INTEREST BY *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM; ASIAN PACIFIC AIDS INTERVENTION TEAM; ASIAN PACIFIC AMERICAN LEGAL CENTER OF SOUTHERN CALIFORNIA; BIENESTAR HUMAN SERVICES; CALIFORNIA LATINAS FOR REPRODUCTIVE JUSTICE; CALIFORNIA PAN-ETHNIC HEALTH NETWORK; CALIFORNIA WOMEN'S LAW CENTER; COALITION FOR HUMANE IMMIGRANT RIGHTS OF LOS ANGELES; JORDAN RUSTIN COALITION; KHMER GIRLS IN ACTION; LATINO COALITION FOR A HEALTHY CALIFORNIA; MERGER WATCH PROJECT; MEXICAN AMERICAN LEGAL DEFENSE AND EDUCATION FUND and ZUNA INSTITUTE, on the parties of record by placing true copies thereof in sealed envelopes to the office of the persons at the addresses set forth below:

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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on April 2, 2007, at Los Angeles, California.

Martha Kalenderian