Lambda Legal
making the case for equality

National Coalition for LGBT Health

April 6, 2009

BY ELECTRONIC MAIL

Acting Secretary Charles E. Johnson and Staff
Office of Public Health and Science
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 716G
Washington, DC 20201
Attn: Rescission Proposal Comments

Email: proposedrescission@hhs.gov

Re: Rescission Proposal – RIN 0991-AB49
Department of Health and Human Services –Proposed Rule

Dear Secretary Johnson and Health and Human Services Department Staff:

These comments are submitted in support of the proposal by the Department of Health and Human Services ("Department") to rescind the December 19, 2008 final rule entitled "Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law" (the "Rule" or the "regulations").[1] The undersigned consist of thirty-eight organizations dedicated to serving the interests of people living with HIV and/or lesbian, gay, bisexual and transgender ("LGBT") people, including ensuring that they have access to needed and desired health care services. We strongly support rescission of the Rule, as it is unnecessary, potentially very harmful, and confusing.

The National Coalition for LGBT Health ("the Coalition") and Lambda Legal present these comments on behalf of their organizations, the members of the Coalition, and the national, regional, state and community-based organizations joining these comments, which include HIV service organizations, advocacy groups working to reduce discrimination and improve cultural competency with patients who are LGBT or living with HIV, and institutional medical providers and health care

[1] The Rescission Proposal was published at 74 Fed. Reg. 10207-10211 (Mar. 10, 2009). The Final Rule was published at 73 Fed. Reg. 78072-78101 (Dec. 19, 2008) and codified at 45 C.F.R. pt. 88.

Lambda Legal Defense and Education Fund
120 Wall Street, Suite 1500
New York, NY 10005-3094
t. 212-809-8585 f. 212-809-0055
www.lambdalegal.org

National Coalition for LGBT Health
1325 Massachusetts Ave., NW, Ste. 705
Washington, DC 20005
t. 202-558-6828 f. 202-393-2241
www.lgbthealth.net

professionals dedicated to the same goals. Information about the signatories can be found on their respective websites.

Each of us believes strongly that religious liberty is a core American value. At the same time, we are convinced that current law already provides a sensible, effective framework for protecting the religious concerns of workers without sacrificing improperly the health care needs of patients, the professional needs of medical institutions, or the scientific needs of health researchers. In contrast, the Rule seems to invite unwarranted confusion about the law, with increases in religiously motivated, harmful refusals of needed care and impairment of important medical research studies as the inevitable results.

As explained in the comments set forth below, the Rule should be rescinded for all of the following reasons:

- it is unnecessary, because federal law already sensibly forbids religious discrimination against health care workers;
- it is likely to invite harmful conduct that conflicts with existing laws and ethical standards;
- it is likely to reduce health care access and quality of care for LGBT patients and people with HIV;
- it threatens public health research;
- instead of increasing workforce diversity, it threatens diversity by seeming to invite religiously motivated discrimination against those not yet protected under federal law; and
- it fosters confusion rather than clarity.[2]

I. THE RULE IS UNNECESSARY, BECAUSE FEDERAL LAW ALREADY SENSIBLY FORBIDS RELIGIOUS DISCRIMINATION AGAINST HEALTH CARE WORKERS.

The federal employment nondiscrimination law, Title VII, requires employers to provide reasonable accommodation of the religious needs of their employees.[3] Considering disputes in many contexts, courts have interpreted this statute to require employers to adjust and accommodate except when the accommodation sought would impose undue burdens on the employing institution.[4]

This duty applies in health care contexts and has been tested and clarified over the years, including in cases addressing the extent of health care workers' rights to hold jobs in medical fields despite

---

[2] In addition to these problems, the Rule is likely to have adverse impacts on the availability of medically appropriate reproductive health care services, which are being addressed in comments by organizations with leading expertise related to such services.

[3] 42 U.S.C. § 2000e-2(a)(1).

[4] *See, e.g., Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 78 (1977) (evaluating employer's duty to reasonably accommodate religious needs of employees); *Sturgill v. United Parcel Serv., Inc.*, 512 F.3d 1024 (8th Cir. 2008) (same); *Chalmers v. Tulon Co. of Richmond*, 101 F.3d 1012, 1021 (4th Cir. 1996) (noting it would be unreasonable to require employer to accommodate employee's religious need to write critical letters to co-workers pressing sectarian views, which would subject company to religious harassment complaints, if not lawsuits, by targeted employees).

religious or moral objections to some job responsibilities.[5] Thus, when an employee objects to providing appropriate medical treatment, the institutional provider must be able to provide the care through other employees without unreasonable extra costs.[6] But when the objection is to treating certain patients in a respectful, medically appropriate way, accommodation of that objection generally is not possible.[7] Thus, settled law recognizes that "reasonable" accommodation of employees does not include allowing anti-LGBT evangelizing while providing publicly funded medical services or refusing care to patients of whom one disapproves for religious reasons.[8]

The Rule therefore is not needed. Worse, it seems to conflict with Title VII's well-established, sensible framework for accommodating employee religious beliefs without thwarting health care institutions' and researchers' essential functioning. By offering confusing authority that some are likely to take as allowing otherwise, the Rule invites harmful conflict and re-litigation of issues as to which health care providers now have clarity.

II. THE RULE IS LIKELY TO INVITE HARMFUL CONDUCT THAT CONFLICTS WITH EXISTING LAWS AND ETHICAL STANDARDS.

A. The Rule May Seem Mistakenly to Allow Conduct That Would Violate State and/or Federal Antidiscrimination Laws and Related Ethical Standards.

The laws of many states prohibit discrimination in employment and in public accommodations based on sexual orientation or gender identity.[9] People living with HIV are protected from discrimination under federal and state laws that prohibit disability discrimination in the provision of public accommodations, including the provision of health care. The broad language of the Rule may

---

[5] *See, e.g., Morrissette-Brown v. Mobile Infirmary Med. Ctr.*, 506 F.3d 1317 (11th Cir. 2007) (finding that employer reasonably accommodated employee's religious beliefs which prevented employee from working Friday afternoons and evenings); *Brener v. Diagnostic Ctr. Hosp.*, 671 F.2d 141, 145-46 (5th Cir. 1982) (finding it reasonable to require employee to arrange swaps to avoid working on Sabbath and to fire employee for refusing to work after failing to arrange swap).

[6] *See, e.g.*, *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 226 (3d Cir. 2000) (rejecting discrimination claim of nurse who refused transfer to different position which posed negligible likelihood of need to assist with procedures to which the nurse objected on religious grounds).

[7] *See, e.g., Knight v. Conn. Dep't of Pub. Health*, 275 F.3d 156, 168 (2d Cir. 2001) (affirming summary judgment for state employer which did not permit visiting nurse to engage in anti-gay proselytizing to home-bound AIDS patient); *Bruff v. North Miss. Health Servs., Inc.*, 244 F.3d 495, 501 (5th Cir. 2001) (finding in favor of employer where counselor refused on religious grounds to counsel those in gay or non-marital relationships); *accord Bodett v. Coxcom, Inc.*, 366 F.3d 736 (9th Cir. 2004) (finding that religious supervisor was not entitled to harass lesbian subordinate based on sexual orientation); *Peterson v. Hewlett-Packard Co.*, 358 F.3d 599 (9th Cir. 2004) (finding that employee was not entitled to post anti-gay biblical messages intended to distress gay co-workers).

[8] *See, e.g.*, *Knight*, 275 F.3d at 168; *Bruff,* 244 F.3d at 501.

[9] *See, e.g.,* California (Cal. Gov't Code §§ 12940, *et seq.*; Cal. Civ. Code § 51); Massachusetts (Mass. Gen. Laws ch. 151B, § 4; Mass. Gen. Laws ch. 272, § 98); New Jersey (N.J. Stat. Ann. §§ 10:5-12(a), 10:5-12(f); New York (N.Y. Exec Law §§ 296(1)(a), 296(2)(a)); Oregon (Or. Rev. Stat. §§ 174.100(6), 659A.006, 659A.030, 659A.403), Washington (Wash. Rev. Code §§ 49.60.180, 49.60.215).

be incorrectly interpreted as providing an excuse to discriminate in the provision of health care, in violation of those laws.

Federal protection against discrimination in the provision of health care services on the basis of disability is provided by both the Rehabilitation Act of 1973[10] and the Americans with Disabilities Act of 1990 ("the ADA").[11] Under these laws, health care providers cannot refuse to provide medical care to an individual because he or she has HIV.[12] The statutes enumerate some defenses to such discrimination, but religious beliefs or convictions are *not* among those. Title III of the ADA specifically exempts religious organizations, providing that its provisions "shall not apply . . . to religious organizations or entities controlled by religious organizations, including places of worship."[13] Neither the ADA nor the Rehabilitation Act, however, excuse discrimination in health care or other professional services against a disabled person that is based on a provider's religious beliefs or moral convictions.

Similarly, the provisions of the Church Amendments[14] cannot reasonably be read as allowing disability discrimination prohibited by either the ADA or the Rehabilitation Act. Yet, the regulations nowhere acknowledge the applicability of these antidiscrimination laws. Especially in light of the Rule's broad definitions and the Department's stated intention that the regulations be interpreted broadly, there is a serious risk that the regulations may be read incorrectly as allowing individuals or institutions to refuse medical care to individuals in a discriminatory fashion based on health care workers' religious beliefs or moral convictions about certain patients. Such beliefs cannot be a valid basis for engaging in conduct that violates federal laws prohibiting disability discrimination.[15] But it is patients, clinics and other institutional providers of medical services that will pay the price for the confusion invited by the regulations.

In the context of medical services delivery, there should be absolutely no confusion about the impermissibility of discrimination, whether based on disability, sexual orientation or gender identity. National medical ethics standards promulgated by the American Medical Association ("AMA") have been clear for years. As just one example, AMA Policy E-10.05 states that, while "it may be ethically permissible for physicians to decline a potential patient when . . . [a] specific *treatment* sought by an

---

[10] The Rehabilitation Act prohibits entities that receive federal financial support from discriminating in the provision of services based on disability. 29 U.S.C. § 794.

[11] Title II of the ADA provides in pertinent part that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity." 42 U.S.C. § 12132. Title III of the ADA prohibits discrimination based on disability by places of public accommodations. 42 U.S.C. §§ 12182, 12183.

[12] *See, e.g.*, *Abbott v. Bragdon*, 163 F.3d 87 (1st Cir. 1998) (upholding grant of summary judgment to patient with HIV on her ADA claim against dentist who refused to treat her in the dentist's office); *Sharrow v. Bailey*, 910 F. Supp. 187 (M.D. Pa. 1995) (finding that person living with HIV stated claim against physician under Rehabilitation Act and against hospital under Rehabilitation Act and ADA where physician allegedly refused to perform surgery without protective suits for him and his surgical team).

[13] 42 U.S.C. § 12187.

[14] 42 U.S.C. § 300a-7.

[15] *See, e.g.*, *Employment Div. Dep't of Human Res. of Or. v. Smith,* 494 U.S. 872, 879 (1990) (reiterating that "the right of free exercise does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes).'") (internal citations omitted).

individual is incompatible with the physician's personal, religious, or moral beliefs," the right to decline on religious grounds is subject to the primary duty not to discriminate against *patients*: "Physicians cannot refuse to care for patients based on race, gender, sexual orientation or any other criteria that would constitute invidious discrimination."[16]

But despite those standards, and the longevity of some of the laws protecting against discrimination on the basis of sexual orientation or gender identity,[17] confusion about whether religious believers may ignore civil rights laws that protect others already is a problem.[18] The Rule threatens to make this situation worse.

Recently, the California Supreme Court unanimously rejected the notion that religious motives can justify otherwise improper discrimination against patients, while at the same time emphasizing that health care workers have considerable freedom to avoid conflict between their beliefs and their legal obligation to avoid discriminating. They may refrain from involving themselves in areas of medical practice in which the standard of care requires them to provide or refer for care of which they disapprove.[19] Or, they may provide care up to the limit of their religious objection and then refer, as long as every patient who receives the treatment in question receives it from a nondiscriminatory provider.[20] Thus, as with federal courts construing Title VII, state courts are interpreting state civil rights laws to provide a reasonable framework for affording as much religious freedom as possible without denying any health care to patients and thus defeating the very health care delivery mission for which hospitals, clinics and other such institutions exist.

Sensible limits indeed are essential. Individuals with sincere religious objections to core job functions must not be led to believe they may take and demand payment for jobs they are unwilling to perform. A few examples make the point:

- Could a hospital be required to hire and retain as a surgeon someone who, as a devout Jehovah's Witness, deplores blood transfusion?

---

[16] AMA Policy E-10.05 (adopted June 2000 and most recently updated June 2007) (emphasis added), *available at* http://www.ama-assn.org/ama1/pub/upload/mm/42/glbt_policy0905.pdf (last visited April 6, 2009); *see also* AMA Policy 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.").

[17] *See, e.g., Stoumen v. Reilly*, 37 Cal. 2d 713, 716 (1951).

[18] *See, e.g.*, *North Coast Women's Med. Group, Inc. v. Superior Court (Benitez)*, 44 Cal. 4th 1145 (Cal. 2008) (rejecting physicians' religious freedom affirmative defense to state civil rights claim based on refusal of treatment to lesbian patient); *Swanner v. Anchorage Equal Rights Comm'n*, 874 P.2d 274 (Alaska 1994) (rejecting religious freedom affirmative defense to state fair housing law); *Stepp v. Review Bd. of Ind. Employment Sec. Div.*, 521 N.E.2d 350, 352 (Ind. 1988) (rejecting lab technician's religious discrimination claim after firing due to technician's refusal to perform tests on specimens with HIV warning because technician believed "AIDS is God's plague on man and performing the tests would go against God's will"); *State v. Sports & Health Club*, 370 N.W.2d 844, 853 (Minn. 1985) (rejecting claim for religious belief exemption from state Human Rights Act).

[19] *North Coast Women's Care Med. Group, Inc.*, 44 Cal. 4th at 1159.

[20] *Id.*

- May a devout Catholic who condemns all forms of medically assisted reproduction insist on employment at an infertility clinic?

- May health care workers who subscribe to religious tenets forbidding close physical interaction between persons of different sexes who are not married to each other be exempted from rules requiring equal treatment of all patients regardless of sex?[21]

- May an emergency medical technician refuse to provide life-saving treatment to an injured person based on a religious objection to gender reassignment?[22]

- Is an individual whose religious teachings cause him to believe he has a moral obligation to proselytize against same-sex sexual relations entitled to engage in such proselytizing while working in a health care clinic treating people, including gay men, living with HIV?

- Is license to refuse patients based on religion granted to those who believe they must shun "infidels" of other religious faiths, notwithstanding federal and state laws and medical ethics rules against religious discrimination?

The answer to all these questions is "no," and the answer must be the same for those who object on religious grounds to treating equally LGBT or HIV positive patients and feel a sincere religious imperative to violate ethics rules and laws to the contrary.[23] The regulations thus are profoundly ill-conceived in their seeming elevation of the beliefs of individual health care and research worker beliefs over what may be core job responsibilities. No one is compelled to pursue his or her livelihood in a specialized area of medicine or research. If one voluntarily seeks particular employment and compensation, Title VII guarantees fair protection and accommodation. But in our secular, religiously pluralistic society, employers' missions must not be so subordinated to employees' individual religious needs that business cannot proceed with reasonable efficiency and results, or must bear unreasonable costs for extra staffing.

B. <u>The Rule Seems to Excuse Professionally Improper Failures to Obtain Informed Consent and to Avoid Patient Abandonment.</u>

Section 88.2 of the Rule very broadly defines "assist in the performance" to include, *inter alia*, "counseling" and "referral." By then allowing any individual to refuse to "assist in the performance" of any "lawful health service," "health service program," or "research activity" (*see* Section 88.4(d)), the regulations appear to permit health care providers to withhold basic information and counseling from their patients, in violation of the providers' legal and ethical obligations to obtain informed

---

[21] *See Bollenbach v. Bd. of Educ.*, 659 F. Supp. 1450, 1473 (S.D.N.Y. 1987) (finding Title VII violated by employer's assignment of bus drivers to routes based on gender rather than seniority in order to avoid assigning female bus drivers to routes serving Hasidic male students; students' religious objections to riding buses driven by women did not provide legitimate non-discriminatory reason for not permitting females to drive those routes).

[22] *See The Transgender Studies Reader* (Susan Stryker & Stephen Whittle eds., 2006).

[23] *See Wilson v. U.S. West Communications*, 58 F.3d 1337, 1342 (8th Cir. 1995) (finding in favor of employer who required employee to cover graphic anti-abortion button while at work; "Title VII does not require an employer to allow an employee to impose [his or her] religious views on others").

consent and avoid patient abandonment. To meet their legal and ethical obligations to obtain informed consent from their patients, health care providers must inform patients of *all* of their treatment options. To allow a health care provider to refuse to inform a patient of options that the provider considers "objectionable" runs counter to those obligations. Similarly, for a health care provider to refuse to provide a patient with referrals for health care services that the patient needs but the provider considers "objectionable" is contrary to the provider's legal and ethical obligations to the patient, including the obligation to avoid patient abandonment.

For example, in the context of a patient who has just learned that he or she has HIV, the Rule appears to sanction a physician's religiously or morally based refusal to provide medically accurate counseling regarding the ways in which HIV is and is not transmitted and options for engaging in sexual relations so as to minimize the risk of transmitting the virus. Similarly, the Rule might be interpreted as allowing a hospital worker to refuse to treat a substance-abusing gay youth who has attempted suicide if the health care employee objects on religious or moral grounds to the youth's sexual orientation, suicide attempt and/or substance abuse. Every individual has a right not to be forced into an occupation the duties of which offend her or his personal religious or moral convictions. Individuals do not, however, have the right to pursue, accept and demand compensation for particular employment, while refusing to perform important duties of the job according to applicable professional standards. As discussed above, Title VII provides a clear, time-tested framework for balancing the interests in this area. The Rule offers a very problematic "fix" to a situation that is not broken.

III. THE RULE IS LIKELY TO REDUCE HEALTH CARE ACCESS AND QUALITY OF CARE FOR LGBT PATIENTS AND THOSE WITH HIV.

The Rule also purports to "take an active role in promoting open communication within the health care field, and between providers and patients, fostering a more inclusive, tolerant environment in the health care industry than may currently exist."[24] But instead of fostering such an environment, the Rule is likely to foster the opposite when it comes to LGBT people and those living with HIV. Contrary to national medical ethics standards and the civil rights laws of many states, the Rule improperly may be seen as allowing any "health service program" and research program that receives funds from the Department to refuse treatment of or participation by LGBT people or people living with HIV, or to allow anti-gay religious proselytizing or other religiously motivated harassment.

Such conduct already is a problem.[25] The notion that care of LGBT patients or patients with HIV would be enhanced if health care workers are freer to communicate anti-gay religious views to those

---

[24] 73 Fed. Reg. at 78074.

[25] *See generally* Brad Sears & Deborah Ho, *HIV Discrimination in Health Care Services in Los Angeles County: The Results of Three Testing Studies* 1-2, Williams Institute, Dec. 1, 2006, *available at* http://www.law.ucla.edu/williamsinstitute/ publications/Discrimination%20in%20Health%20Care%20LA%20County.pdf (reporting that studies conducted from 2003 to 2005 found that 55% of obstetricians, 46% of skilled nursing facilities, and 26% of plastic and cosmetic surgeons in Los Angeles County refused to treat patients living with HIV); Ronald A. Brooks et al., *Preventing HIV Among Latino and African American Gay and Bisexual Men in a Context of HIV-Related*

patients stands the Hippocratic Oath on its head. The AMA long has recognized the medical challenge posed by the fact that patients often are reluctant to disclose a minority sexual orientation or gender identity to their health care providers. The AMA therefore emphasizes the importance of care providers' "nonjudgmental recognition of sexual orientation" to their "ability to render optimal patient care in health as well as in illness."[26] Open communication by the *patient* is essential to quality health care and must be encouraged.[27] "[I]ncidences of discrimination – real and perceived – mar the relationship between consumers and their health care professionals, plans, and institutions. … An environment of mutual respect is essential to maintain a quality health care system. Consumers must not be discriminated against in the delivery of health care services … as required by law based on … sexual orientation…."[28]

Communication of religiously inspired bias against LGBT people and people living with HIV by health care workers to patients impairs the communication that is most essential – from patient to provider – so appropriate care can be provided. In health care settings, expression of anti-LGBT sentiments or stigmatizing views about people with HIV not only shuts down patient communication, it drives away LGBT patients and patients with HIV, with negative personal and public health consequences. Given widespread anti-LGBT bias, LGBT people already are understandably less likely to reveal their sexual orientation or gender identity to their health care providers, and therefore give an incomplete medical history. The Rule poses the risk of making an already challenging public health situation worse.

Transgender patients are vulnerable to bias in health care settings in unique ways. Many transgender people seek access to medical treatments for the purpose of gender transition, including hormone therapy and sex reassignment surgery. Such treatments alleviate the profound gender-related distress that many transgender people experience prior to transition and are critical to their health and well-being. It is important for people undergoing gender transition to understand their full range of treatment options based on a thorough and individualized assessment. Religiously or morally based refusals to provide transition-related information and treatment shut doors in the face of a population whose well-being is dependent upon access to unbiased care, which too often puts lives at risk.

Stigma, Discrimination and Homophobia: Perspectives of Providers, 19 AIDS Patient Care & STDs 737, 738 (2005) (referencing 2003 report of American Civil Liberties Union survey finding that HIV stigma has resulted in denials of medical treatment, privacy violations, and refused admittance to nursing homes); Kate A. O'Hanlan, *Do We Really Mean Preventive Medicine For All?*, 12 Am. J. Prev. Med. 411, 414 (1996) ("In a survey of nearly one thousand Southern California physicians, one third of physicians in primary care specialties were found to have significantly homophobic attitudes."); *see also generally* Ilan H. Meyer, *Why Lesbian, Gay, Bisexual and Transgender Public Health?*, 91 Am. J. Pub. Health 856, 857 (June 2001); Council on Scientific Affairs, American Medical Association, *Health Care Needs of Gay Men and Lesbians in the United States*, 275 J.A.M.A. 1354, 1359 (1996)).

[26] AMA Policy H-160.991. *See also* Jennifer E. Potter, "Do Ask, Do Tell," 137 Annals of Internal Med. 341, 341 (Sept. 3, 2002) (stressing that "Finding help is not easy. It is hard to trust other people, even professionals, when one anticipates disapproval.").

[27] *See* AMA Policy H-160.991.

[28] Advisory Committee on Consumer Protection and Quality in the Health Care Industry, Report to the President of the United States, *Consumer Bill of Rights and Responsibilities* (Nov. 1997), *available at* http://www.hcqualitycommission.gov/cborr/chap5.html.

In addition to refusals of transition-related treatment, there is a long and shameful history in this country of transgender individuals being denied life-saving and basic care by medical personnel who disapprove of or disdain gender variant people. The Rule seems likely to exacerbate this problem by appearing to offer legal protection for such unconscionable acts.

People living with HIV also reasonably fear bias and stigma in health care settings.[29] Restrictions on health care services related to family planning and procreation are especially problematic, due to moral judgments that people with HIV should not have children or be parents. Health care providers cannot ethically express medically unwarranted personal sentiments of this kind, much less act on them, whether or not they are religiously-based.

The vagueness of many pertinent, "defined" terms increases these risks for LGBT patients and patients living with HIV and their families. The lack of clarity in the definition of "assist in the performance" is especially problematic. The Rule provides for broad interpretation of the regulations,[30] which would seem to invite some individuals to block LGBT people and their families from receiving services at any stage, including in emergency situations when no other doctor or health care professional is available. The use of the term "any activity" in this definition and the failure to define "procedure" as used in relation to "assist in the performance," if interpreted "broadly," might lead some individuals to view the regulations as allowing them to avoid touching or providing any care at all to a gay or transgender person or one living with HIV.

In addition, the very broad definitions for a "health care entity" and "health service program" may lead to LGBT people and people living with HIV being denied health coverage from private and public insurers and health plans, treatment at emergency rooms, and help from individual doctors in many serious situations and situations in which the patient lacks convenient, affordable alternatives. Under these broad definitions and the language of Section 88.4(d), LGBT people, those living with HIV, and their children and other family members may be excluded from the majority of public health entry points and services available in the United States, whether or not actually justified legally. While courts later may well rule that the rejections were improper, patients will suffer inexcusably in the meantime.

IV. THE RULE THREATENS PUBLIC HEALTH RESEARCH.

The Rule may have significant stifling and distorting effects on medical research. Because the regulations apply to all funds provided through the Department, the problems could affect not only quantitative research, such as large-scale surveys by the Centers for Disease Control and Prevention (CDC), but also qualitative research, such as studies funded under the Substance Abuse and Mental Health Services Administration (SAMHSA).

For example, the National Center for Health Statistics (NCHS) under the CDC is responsible for the Youth Risk Behavior Surveillance System, which asks questions of American young people about their risky behaviors. If a researcher or survey administrator morally objects to the drinking of alcohol, for example, do the regulations allow that person to refuse to ask questions related to

---

[29] *See*, *e.g.*, Sears and Ho, *supra* note 25; Brooks et al., *supra* note 25.
[30] *See* 45 C.F.R. § 88.1.

alcohol consumption? If so, NCHS apparently would need to hire an additional person and have two persons ask questions of each respondent in order to get all questions asked. But what if a research employee does not voice his or her religious objections to job duties until later, so those responsible for managing the research cannot provide additional staff in a timely manner or at all? In situations in which budget constraints and/or lack of information prevent addition of extra staff without religious objections to job duties, certain questions will not be asked and survey results are likely to be rendered incomplete and/or inaccurate. The Youth Risk Behavior Survey is conducted in the majority of states and the District of Columbia. What if several of those jurisdictions have administrative and/or research staff who refuse to participate? A lack of comparable data would result, leaving federal and state governments unable to track accurately the risky behavior of American youth and to judge the effectiveness of interventions to reduce such behavior and improve the health of this population.

Similarly, what if employees object to taking or processing samples obtained from research subjects believed to be LGBT and/or to have HIV, or object to providing care to those subjects, where access to medical care often is an incentive to participating in research studies?[31] Needless to say, public health research will suffer if those responsible for managing studies cannot insist that their employees perform the core functions of their jobs.

V. INSTEAD OF INCREASING WORKFORCE DIVERSITY, THE RULE THREATENS DIVERSITY BY SEEMING TO INVITE RELIGIOUSLY MOTIVATED DISCRIMINATION AGAINST THOSE NOT YET PROTECTED UNDER FEDERAL LAW.

The Department stated that "an underlying assumption of this regulation is that the health care industry, including entities receiving Department funds, will benefit from more diverse and inclusive workforces by informing health care workers of their rights and fostering an environment in which individuals from many different faiths and philosophical backgrounds are encouraged to participate."[32] The undersigned heartily agree that diversity in the workforce is a laudable goal. But the Rule focuses only on diversity of "religious, cultural and/or ethnic groups," while ignoring the LGBT community. As discussed above, existing federal law *already* forbids discrimination based on religion or ethnicity in both employment and in public accommodations, thus protecting health care and research workers, as well as patients and research subjects, against discrimination on those grounds. And yet there is no federal law that explicitly prohibits discrimination based on sexual orientation or gender identity. In other words, the "playing field" already is unequal, and these regulations risk making an unjust situation worse by seeming to invite even more religiously motivated discrimination against LGBT people.[33]

The Rule is likely to *reduce* workplace diversity, to the detriment of those LGBT employees who already suffer religiously motivated co-worker harassment and who may be most attuned to patients who suffer the same social marginalization and related health disparities.

---

[31] *See, e.g.*, *Stepp*, 521 N.E.2d at 352 (rejecting employee's religious discrimination claim after firing due to employee's religiously motivated refusal to test specimens with HIV warning).
[32] 73 Fed. Reg. at 78093.
[33] *See, e.g., Bodett,* 366 F.3d at 736; *Peterson*, 358 F.3d at 599; *Chalmers*, 101 F.3d at 1021.

VI. THE RULE FOSTERS CONFUSION RATHER THAN CLARITY.

The Department purported to bring clarity through the adoption of the Rule. In its "Introduction" to the published Rule, the Department stated that the Rule "clarifies the scope of protections to applicable members of the Department's workforce, as well as health care entities and members of the workforces of entities receiving Department funds."[34] In fact, however, the Rule will have the opposite effect if it is not rescinded: fostering confusion and uncertainty among those involved with providing, obtaining, and funding health services, health service programs, and research activities – to the substantial detriment of patients and public health research quality.

A. Confusion Due To the Scope of the Rule and Its Definitions

The confusion starts with the scope of the Rule, which sets forth provisions variously applicable to three very different statutes: the Church Amendments, Public Health Service Act Section 245,[35] and the Weldon Amendment.[36] Although these three laws all contain provisions providing legal sanction to some limited persons and/or institutions for religious refusals on some limited bases to engage in some activities, they differ in important ways. By codifying one set of regulations to establish legal requirements that apply under such differing laws, confusion is sown. That confusion is compounded by the call for "broad" interpretation of the Rule.[37] And the confusion is increased still further by the lack of definitions for some terms and the use of broad, vague definitions for other terms, which in some cases combine terms that have separate meanings in the three governing statutes.

First, the laws differ as to whether religiously-based refusals are allowed by individuals, by institutions, or by both. Section 245 of the Public Health Service Act prohibits discrimination against "health care entit[ies]."[38] The Weldon Amendment prohibits discrimination against "institutional or individual health care entit[ies]."[39] Different provisions of the Church Amendments prohibit: requirements imposed on individuals;[40] requirements imposed on entities;[41] discrimination against physicians or other health care personnel;[42] and discrimination against applicants for training or study.[43] Yet, the Rule needlessly and impractically addresses these divergent matters in one set of regulations.

---

[34] 73 Fed. Reg. at 78074.
[35] 42 U.S.C. § 238n.
[36] Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, § 508(d), 121 Stat. 1844, 2209.
[37] *See* 45 C.F.R. § 88.1.
[38] 42 U.S.C. § 238n. The statute defines "health care entity" as "includ[ing] an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions." *Id.*, § 238n(c)(2).
[39] Pub. L. No. 110-161, § 508(d), 121 Stat. at 2209. The statute defines "health care entity" as "includ[ing] an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." *Id.*
[40] 42 U.S.C. §§ 300a-7(b)(1), 300a-7(d).
[41] *Id.*, § 300a-7(b)(2).
[42] *Id.* §§ 300a-7(c)(1), 300a-7(c)(2).
[43] *Id.*, § 300a-7(e).

Second, the laws differ in terms of whether they relate to abortion, abortion and sterilization, or more broadly to health services, health service programs or research activity. The restrictions of Section 245 of the Public Health Service Act apply only in certain specified contexts related to abortion. The Weldon Amendment applies only in other specified contexts related to abortion. The Church Amendments apply only in still other specified contexts related to abortion and sterilization, with the exception of two provisions which apply in specified contexts related more broadly to "health service or research activity" or "health service program[s] or research activity."[44] Yet, again, the Rule blends these differing contexts and confusingly creates one set of definitions for all of them.

Third, the definitions in the Rule fail to reflect differences among the laws. As the Department acknowledges, the three statutes use different terms and fail to define many of them.[45] At the same time, the Rule uses problematically broad definitions of such crucial terms as "health care entity" and "entity." In addition, the Rule's definitions in some cases combine terms that are intended to have different meanings into one definition. For example, the Church Amendments clearly intend that the terms "individual" and "entity" have separate meanings, such that an "entity" is not an "individual" and vice versa. This is illustrated by various sections in Title 42 of the U.S. Code (all part of the Church Amendments): Sections 300a-7(c)(1), (c)(2), and (e), which impose prohibitions on "entities;" Section 300a-7(d), which prohibits imposition of requirements on "individuals;" and Section 300a-7(b), which prohibits courts, public officials, and other public authorities from imposing some requirements on "individuals" and certain other requirements on "entities." Yet the Rule defines both the terms "entity" and "health care entity" to include "an individual physician or other health care professional" (as well as other specified individuals) and has a separate definition for the term "individual" (defined as a "member of the workforce of an entity/health care entity").[46] By combining separate terms from one statute into the same definition and combining terms from different statutes together as if they are the same, the Rule confuses and mistakenly conflates the very different requirements and prohibitions of the three statutes.

Although the Rule tries to lay out, via the "Applicability" section,[47] a roadmap for separating out those different requirements and prohibitions, the end result is a great lack of clarity and a tremendous risk of misinterpretation and misapplication. And among those most likely to suffer as a result of this confusion are vulnerable patients, overburdened health care providers and underfunded public health researchers.

B. <u>Additional Confusion for Health Care Providers</u>

The regulations do not explain how health care providers, programs and entities should handle complaints of religious or moral discrimination. The regulations do not describe the character of the employee's complaint, nor what to do when an employee's objections clash with a patient's needs or an employer's legal duties and capacities. Small medical offices may only have one receptionist or physician's assistant. If the receptionist has a moral objection to scheduling a patient's appointment

---

44 *Id.*, § 300a-7.
45 *See* 73 Fed. Reg. at 78091.
46 45 C.F.R. § 88.2.
47 *Id.*, § 88.3.

because of the treatment sought or the patient's sexual orientation, gender identity, marital status, family make-up, religion or any other trait covered by civil rights laws and medical ethics, the health care provider may have no staffing alternative and also risk civil rights liability if the employee's discriminatory refusal to assist that patient is allowed. Similarly, if the assistant has a religious objection to individuals living with HIV, how could the provider permit the assistant to refuse to take that patient's medical history or otherwise to interact with and assist that patient?

By combining restrictions from three disparate laws, confusingly conflating terms used in those statutes, broadly defining terms, calling for broad interpretation and implementation of the regulations, and failing to explain how these regulations are to be implemented and reconciled with other laws, the Department has adopted a regulatory scheme that inevitably will confuse and harm those seeking to provide health care as well as those in need of receiving it, many of whom already are terribly vulnerable to discrimination.

C. Additional Confusion for Funded Entities

The Rule is designed to govern not only direct Department grantees, but also sub-grantees of Department grantees and appears to require funded entities that re-grant funds to track their sub-grantees' compliance. While the Department has referred to this as an "incremental cost," it may well in fact be enormous in terms of both employee costs and storage costs. To take just one area of concern, state departments of health often have hundreds if not thousands of sub-grantees. Even if the regulations were clear and easy to understand (which they are not), making sure that each sub-grantee complies and remains in compliance would be an expensive logistical nightmare for states that already face crushing challenges.

D. Additional Confusion Due to Certification Obligations

As noted above, the requirements and prohibitions imposed by the three statutes differ in their content and their application. For example, the Church Amendments' prohibition on discriminating against a physician or other health care personnel due to, *inter alia*, refusing to perform or assist in the performance of a "lawful health service or research activity" applies only to "entit[ies] which receive[] after July 12, 1974, a grant or contract for *biomedical or behavioral research* under any program administered by the Secretary of Health and Human Services."[48] In contrast, its prohibition on *requiring* performance or assisting in performance applies in the context of "any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."[49] In response to comments, the Department revised the language of the proposed "certification" in an attempt to distinguish between the differing obligations imposed on recipients of different types of grants. However, the Department's approach of trying to address differing obligations imposed on different grant recipients in one certification document is very confusing. The proposed Certification for sub-recipients has the same flaw, plus the burdensome and unjustifiable problems noted above with respect to sub-recipients.

---

[48] 42 U.S.C. § 300a-7(c)(2) (emphasis added).
[49] *Id.*, § 300a-7(d).

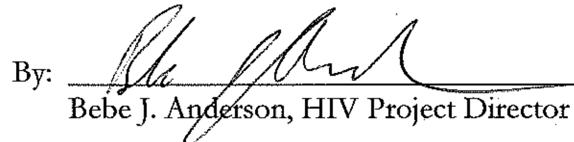
CONCLUSION

For the reasons set forth above, we urge the Department to rescind the Rule. Should the Department decline to rescind the Rule in its entirety and/or contemplate issuance of new regulations addressing this topic, we strongly urge that any modified or newly proposed rule be drafted in accord with the foregoing comments. Finally, if the Department contemplates proposing outreach and/or education to accomplish the objectives of the Final Rule, the undersigned consider it vitally important that any such outreach and/or education fully address prohibitions on discrimination in the health care context, including in particular the discrimination prohibitions referenced in these comments.

Respectfully submitted,

NATIONAL COALITION FOR LGBT HEALTH
Rebecca Fox, Executive Director
rebecca@lgbthealth.net

LAMBDA LEGAL
Jennifer C. Pizer, Senior Counsel
jpizer@lambdalegal.org
Bebe J. Anderson, HIV Project Director
banderson@lambdalegal.org
Tara L. Borelli, Staff Attorney
tborelli@lambdalegal.org

By: 
Bebe J. Anderson, HIV Project Director

AIDS ACTION BALTIMORE, INC.
Lynda Dee, President
www.aidsactionbaltimore.org

AIDS ACTION COUNCIL
Ronald Johnson, Deputy Director
www.aidsaction.org

AIDS ACTION COMMITTEE OF MASSACHUSETTS
Rebecca Haag, Executive Director
www.aac.org

AIDS FOUNDATION OF CHICAGO
David Ernesto Munar, Vice President, Policy & Communications
www.aidschicago.org

THE AIDS INSTITUTE
Carl Schmid, Director of Federal Affairs
www.theaidsinstitute.org

AIDS LEGAL REFERRAL PANEL
Bill Hirsh, Executive Director
www.alrp.org

AIDS PROJECT LOS ANGELES
Philip G. Curtis, Director, Government Affairs
www.apla.org

AIDS TREATMENT DATA NETWORK
Ken Fornataro, Executive Director
www.atdn.org

AMFAR, THE FOUNDATION FOR AIDS RESEARCH
Yi-An Ko, Research and Policy Assistant
www.amfar.org

THE ATLANTA LESBIAN HEALTH INITIATIVE
Linda Ellis, Executive Director
www.thehealthinitiative.org

CASCADE AIDS PROJECT
Michael Kaplan, Executive Director
www.cascadeaids.org

THE CENTER FOR HIV LAW & POLICY
Catherine Hanssens, Executive Director
www.hivlawandpolicy.org

CENTERLINK
Terry Stone, Executive Director
www.lgbtcenters.org

EASTERN MAINE AIDS NETWORK
Patricia A. Murphy, Esq., Executive Director
www.easternmaineaidsnetwork.com

FLORIDA KEYS HIV COMMUNITY PLANNING PARTNERSHIP
David Brakebill, Patient Care Co-chair
www.fkhcpp.com

GAY & LESBIAN ADVOCATES & DEFENDERS
Bennett H. Klein, AIDS Law Project Director
www.glad.org

THE GAY & LESBIAN MEDICAL ASSOCIATION
Joel Ginsberg, Executive Director
www.glma.org

GEORGIA EQUALITY
Jeff Graham, Executive Director
www.georgiaequality.org

HIV & AIDS LEGAL SERVICES ALLIANCE
Trip Oldfield, Executive Director
www.halsalegal.org

HIVICTORIOUS, INC.
Bob Bowers, President
www.hivictorious.org

HIV LAW PROJECT
Alison Yager, Esq., Project Manager, Center for Women & HIV Advocacy
www.hivlawproject.org

HOWARD BROWN HEALTH CENTER
Michael C. Cook, President and CEO
www.howardbrown.org

INTERNATIONAL WOMEN'S HEALTH COALITION
Ellen Marshall, U.S. Foreign Policy Consultant
www.iwhc.org

L.A. GAY & LESBIAN CENTER
Lorri L. Jean, Chief Executive Officer
www.lagaycenter.org

LIFELONG AIDS ALLIANCE
Erick Seelbach, Director of Prevention, Education, and Public Policy
www.llaa.org

LOG CABIN REPUBLICANS
Dr. David A Reznik, HIV/AIDS - Healthcare Policy Advisor
http://online.logcabin.org

MAUTNER PROJECT: THE NATIONAL LESBIAN HEALTH ORGANIZATION
Leslie J. Calman, Ph.D., Executive Director
www.mautnerproject.org

NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS
Julie Scofield, Executive Director
www.nastad.org

THE NATIONAL GAY AND LESBIAN TASK FORCE ACTION FUND
Rae Carey, Executive Director
www.ngltf.org

POSITIVE IMPACT, INC.
Michael Baker, Director of Advancement
www.positiveimpact-atl.org

PUBLIC HEALTH - SEATTLE & KING COUNTY
Robert W. Wood, MD, Director, HIV/AIDS Program
www.kingcounty.gov

SAN FRANCISCO AIDS FOUNDATION
Jeff Hall, Legislative Affairs Director
www.sfaf.org

SYLVIA RIVERA LAW PROJECT
Franklin Romeo, Staff Attorney
www.srlp.org

TAPESTRY HEALTH
Leslie Laurie, Chief Executive Officer
www.tapestryhealth.org

TITLE II COMMUNITY AIDS NATIONAL NETWORK (TII CANN)
William E. Arnold , C.E.O. & Vice Chair
www.tiicann.org

THE WOMEN'S COLLECTIVE
Patricia Nalls, Executive Director/Founder
www.womenscollective.org