

Understanding the Impact of Same-Sex Relationship Recognition on the LGBT Healthcare Experience

Matthew Stiff, Human Rights Campaign, Washington DC, Robert Falk, Human Rights Campaign, Washington, DC
Vanessa Benavides, Tenet Healthcare Corporation, Dallas, TX

Introduction

When 39 year-old Lisa Pond collapsed with a brain aneurysm during her Florida family vacation, emergency personnel rushed her to Miami's Jackson Memorial Hospital. Janice Langbehn, Pond's lesbian partner of 18 years and mother to their four adopted children, arrived at Jackson Memorial and attempted to visit Lisa. Jackson Memorial personnel denied visitation access to Lisa. When Lisa's biological sister arrived eight hours later, Jackson Memorial administrators finally permitted Janice to see her partner. Lisa Pond died shortly thereafter. Lambda Legal Defense and Education Fund filed suit on behalf of Janice against Jackson Memorial. The case has received significant national attention, generating negative press coverage for Jackson Memorial and mobilizing a coalition of lesbian, gay, bisexual and transgender (LGBT) advocacy groups in opposition to the hospital's actions.¹

The national patchwork of same-sex relationship recognition law poses unique challenges for healthcare providers. The confusing patchwork remains in a state of flux, dominated by hotly contested and increasingly frequent legislative enactments, judicial decisions, and voter-initiated ballot measures. The interaction of same-sex relationship recognition with healthcare law impacts the LGBT patient's basic healthcare experience, influencing everything from visitation access to medical decision-making rights. Providers must sift through the patchwork and establish functional administrative policies to deal with these contingencies that affect a significant segment of the American demographic.

According to U.S. Census data, approximately 8.8 million lesbian, gay and bisexual adults live in America.² Within this population there are an estimated 777,000 same-sex couples. About one in five same-sex couples are collectively raising at least 270,300 minor children. While estimates vary, the LGBT community commands some \$745 billion in buying power.³ Market research demonstrates that the LGBT community displays a strong tendency to patronize businesses based on the organization's sensitivity to LGBT civil rights issues.⁴

This article frames the problems accompanying the LGBT healthcare experience, detailing the interaction between same-sex relationship recognition and various areas of state healthcare law. A given state's treatment of same-sex relationships triggers many legal consequences, some of which bear on the LGBT patient's basic experience. Reflecting common concerns cited by the LGBT civil rights community, this article

examines the areas of hospital visitation, surrogate medical decision making, and parental consent for the treatment of minor children. The discussion also considers The Joint Commission's recently released proposed hospital requirements, which bear on the provision of culturally competent care. The article concludes by highlighting resources and offering simple solutions that are designed to improve the LGBT patient experience.

The Interaction Between Same-Sex Relationship Recognition and State Healthcare Law

Relationship recognition refers to a state's legal treatment of a committed relationship between two individuals. Every state permits a man and woman to legally formalize their relationship through the institution of civil marriage. Civil marriage carries with it hundreds of rights and responsibilities.⁵ These rights and responsibilities touch on many issues, from tax treatment and inheritance law to parental status and healthcare rights.

The national landscape of same-sex relationship recognition reflects a limited offering of civil marriage's rights and responsibilities to same-sex couples. As of early June 2009, 13 states and Washington, DC offer some form of state-level same-sex relationship recognition. Six of these states recognize same-sex civil marriage.⁶ Five more states and Washington, DC recognize civil unions or domestic partnerships.⁷ Two states offer same-sex couples limited rights and benefits.⁸ In contrast, 37 states offer no form of state-level same-sex relationship recognition. The federal Defense of Marriage Act also denies same-sex couples all federal benefits flowing from marriage, regardless of whether the couple's home state offers same-sex relationship recognition.

Why should providers grapple with the legal implications of same-sex relationship recognition? The answer is simple: a given state's stance on relationship recognition dramatically impacts the basic healthcare experience of LGBT patients and families.

Visitation Rights. The availability of same-sex relationship recognition often influences the content and interpretation of a provider's visitation policies. Establishing visitation policy is a prerogative of the provider, stemming from their rights as a property owner. Visitation policies balance the interests of improving patient care through visitor access against maintaining the operational integrity of the institution. In order to limit the presence of extraneous persons, many providers

structure their visitation policies around the concept of “family.” Providers often look to state law in delineating the definition of “family.” For this reason, providers located in states lacking same-sex relationship recognition could be more likely to utilize definitions of “family” that fail to anticipate LGBT families.

The Selection of Default Surrogate Medical Decision Makers.

Same-sex relationship recognition law impacts the provider’s ability to designate same-sex partners as default surrogates. Pursuant to surrogate-selection law, providers designate a default surrogate when an incapacitated patient lacks an advance healthcare directive. These statutes favor surrogates who are familiar with the incapacitated patient’s wishes and thereby protect the patient’s decisional autonomy. These laws also protect providers against liability stemming from the surrogate’s treatment decisions.

Providers select the surrogate according to a statutorily prioritized list of individuals. These prioritized lists reflect the presumption that individuals related to the incapacitated patient through blood or marriage are the best equipped to serve as surrogates. Spouses often head these priority lists, and various classes of biological family members follow in descending order of priority (e.g. adult siblings, grandparents, etc.).

In states that offer same-sex relationship recognition, same-sex couples that legally formalize their relationship can be designated as surrogates. The statutory priority lists in these states typically include domestic partners at the same level as spouse.⁹ In a second group of states, the priority lists include a “close friend” category of potential surrogates.¹⁰ However, this “close friend” category occupies the list’s lowest level of priority and so it remains unlikely that a provider could designate a same-sex significant other as a “close friend” surrogate because family members’ wishes would take priority. In a third and final group of states, providers can only designate surrogates that are related to the incapacitated patient through blood or marriage.¹¹ For this reason, same-sex significant others in these states cannot be designated as surrogates.

Advance Healthcare Directives. Same-sex relationship recognition should not impact a provider’s interpretation of advance healthcare directives. The law regulating these directives is relatively standardized across state lines, and statutes as written are neutrally applicable on their face to same-sex couples. Any adult can *ex ante* designate another adult to serve as their surrogate medical decision maker, so long as the proper drafting formalities are observed and the designated individual is not an employee of the hospital. Because these laws (which are often modeled on power of attorney statutes) are written in gender-neutral terms, the sexual orientation of the interested parties should not factor into a provider’s interpretation of an advance healthcare directive.

However, providers may misunderstand state law and decline to honor the valid advance healthcare directives of

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same-sex couples.¹² It appears these missteps are partially attributable to providers’ mistaken belief that their state’s lack of same-sex relationship recognition requires such an outcome. Because default surrogate-selection law often does not encompass same-sex relationships, declining to honor the valid directives of same-sex couples generates uniquely harsh consequences.

Parental Consent for Treatment of Minor Children. Both same-sex relationship recognition and general family law principles impact the medical decision-making rights of same-sex parents. Because the law regards minor children as incapable of making important decisions, providers must secure the informed consent of a minor’s legal parent before initiating a course of medical treatment. While this rule anticipates parents with clear biological ties to their children, confusion arises in the case of same-sex parents. Providers must ensure that the proper parent supplies informed consent and thus tread carefully in acting pursuant to the consent of same-sex parents (who may lack biological ties to their children).

Same-sex parents lacking a biological relationship with their children face limited options in establishing that legal connection. These limitations largely mirror the patchwork restrictions on same-sex relationship recognition. In some states, non-biological same-sex parents can create the legal connection with their minor child through either joint adoption or second parent adoption (i.e. step-parent adoption). Currently, ten states and the District of Columbia allow same-sex couples to petition for joint adoption.¹³ A comparable number of states have sanctioned the grant of second parent adoptions to same-sex couples.¹⁴

Joint Commission Proposed Requirements on Culturally Competent Care

At least one influential hospital accreditation association is currently addressing deficiencies in the LGBT patient experience. In August 2008, The Joint Commission began the process of amending its hospital accreditation standards to better facilitate culturally competent care within hospitals. This process generated the recently released *Proposed Requirements to Advance Effective Communication, Cultural Compe-*

Analysis

tence, and Patient Centered Care for the Hospital Accreditation Program. These proposed requirements entail 21 additions or modifications to elements of performance contained within six separate accreditation chapters.

While the proposed requirements endeavor to improve culturally competent care for numerous populations, three changes relate specifically to sexual orientation and gender identity issues:

- >> The proposed requirements include additions to the Leadership chapter.¹⁵ These additions are designed to help hospitals plan their services through a better understanding of their patient populations. The proposed requirements direct hospitals to utilize available demographic data to determine the needs of served populations. The relevant element of performance lists sexual orientation and gender identity or expression as two demographic characteristics for potential evaluation.
- >> The proposed requirements amend the Record of Care, Treatment, and Services chapter to ensure that the patient's medical record captures additional demographic information needed to provide care.¹⁶ This additional demographic information includes sexual orientation and gender identity or expression.
- >> Most importantly, the proposed requirements include additions to the Rights and Responsibilities of the Individual chapter.¹⁷ These additions require hospitals to provide patients with care and treatment free from discrimination. The non-discrimination is based on several enumerated statuses, including sexual orientation and gender identity or expression.

The proposed requirements are undergoing a six-week Summer 2009 Field Review process. The Joint Commission is collaborating with the National Health Law Program to create an implementation guide to accompany the ultimate standards. This implementation guide will "prepare Joint Commission surveyors and accredited hospitals for the release of the new standards addressing culturally competent patient-centered care." The 18 month-long project is scheduled to conclude in January 2010.

Provider Resources and Suggested Solutions

Given the interaction between same-sex relationship recognition and the foregoing areas of state healthcare law, significant anxiety accompanies LGBT families in the healthcare setting. These families worry that providers will decline to extend visitation access to their loved ones, fail to honor same-sex partner advance healthcare planning, and disallow same-sex parents from making healthcare decisions for their minor children.

These concerns are amplified by the LGBT community's longstanding tension with some in the medical profession. Practitioners considered homosexuality to be a mental illness until the early 1970s. LGBT patients express conflicting reservations about revealing their sexual orientation to healthcare providers. This atmosphere predisposes LGBT individuals to avoid seeking care and withholding valuable diagnostic information from providers.

The following resources and suggested measures supply providers with a point of departure for evaluating the quality of the LGBT healthcare experience in their facilities.

Healthcare Equality Index. The Healthcare Equality Index (HEI) offers a measuring stick to gauge a provider's LGBT patient care. The HEI is a joint project of the Human Rights Campaign Foundation and the Gay and Lesbian Medical Association (GLMA).¹⁸ HRC is the nation's largest lesbian, gay, bisexual, and transgender civil rights organization and GLMA is the nation's largest organization for LGBT medical professionals.

The HEI annually surveys providers on healthcare industry policies and practices related to the treatment of LGBT families in the healthcare setting. The goals of the HEI are to benchmark healthcare facilities on identified best practices and policies with respect to equal treatment of LGBT individuals and families. The HEI then shares and recognizes these best practices with healthcare industry leaders.

Pursuant to their participation in the HEI, providers submit confidentially their hospital visitation and medical decision-making policies. An HEI companion administrative guide, entitled *Breaking Down Barriers: An Administrator's Guide to State Law & Best Policy Practice for LGBT Healthcare Access*, reviews these submitted policies and benchmarks best hospital practices for LGBT families.

Patient and Employment Non-Discrimination Statements. Written statements that express a provider's commitment to non-discrimination on the basis of sexual orientation and gender identity improve the LGBT patient experience. These statements signal that everyone involved with the institution—both employees and patients—are valued by the provider and treated with respect. While changes to non-discrimination policy carry real consequences and must be carefully considered, the positive experiences of Fortune 500 corporations that have adopted these policies should ease provider fears.¹⁹

Among HEI participant-providers, sexual orientation status is commonly included within non-discrimination statements. Nearly 73% of HEI participants protect against patient discrimination and 98% protect against employment discrimination on the basis of sexual orientation.²⁰ In contrast, the inclusion of gender identity protections remains decidedly less common. Only 7% of HEI participants protect against patient discrimination and 63% protect against employment

discrimination on the basis of gender identity. Because of this disparity, adopting both sexual orientation and gender identity non-discrimination protections signals a strong commitment to improving the LGBT patient experience.

Administrative Policy Updates. A provider's administrative policies typically reflect state law. Because same-sex relationship recognition law remains dynamic, changes in this area could require updates to policy. For example, the Nevada state legislature recently enacted domestic partnership legislation. Providers operating within the state of Nevada should update their default surrogate-selection policies to reflect the fact that domestic partners can be designated as default surrogates.

Visitation policies present a possible opportunity for revision. Every provider—even those operating in states without same-sex relationship recognition—can amend their visitation policies to embrace non-traditional family structures. As evidenced in the policies submitted by HEI participants, many prestigious providers utilize a definition of “family” as the baseline determinant for identifying the permitted class of visitors. The LGBT patient experience can be improved by utilizing an explicitly LGBT-inclusive definition of “family” for visitation policy purposes. The aforementioned HEI companion guide illustrates an inclusive definition of “family.” The definition is designed to guide staff members and to anticipate potentially troubling situations like the Jackson Memorial case.

Staff Training. The LGBT patient experience can be improved through specifically structured staff training sessions that address the above issues. For example, providers can offer training modules to staff regarding the special case of advance healthcare directives and same-sex couples. These modules can detail the unique consequences that attend the failure to recognize directives between same-sex couples. Staff training in these areas is critical because organizations that commit themselves to improving the LGBT patient experience necessarily transmit that commitment through the demeanor of their staff.

Educational Materials and Inclusive Forms. Because the consequences of disparate treatment can be grave, advocacy organizations like HRC and Lambda Legal prepare packets of legal information that educate LGBT individuals on the importance of advance healthcare planning. Even though this resource exists, thousands of LGBT individuals go without advanced healthcare directives. They either do not take advantage of the resource or they simply do not know it is available. As a consequence, they are ill-prepared for the potential impact on them and their families. Providers could play a pivotal role in mitigating the impact by distributing basic advanced healthcare directive packets to patients who openly identify as LGBT.

Inclusive forms also improve the LGBT patient experience. These forms signal that the provider welcomes members of the LGBT community and remains aware of disparate treatment issues. Patient-history forms can be amended to expand relationship status identification beyond traditional heterosexual categories. Amended forms can also allow for flexibility in gender identification through the inclusion of a transgender option.

Conclusion

The current interaction between same-sex relationship recognition and state healthcare law significantly impacts the LGBT patient's healthcare experience. These impacts distort the patient's perception of their provider and exacerbate a historically problematic relationship between the LGBT community and healthcare professionals. Efforts are underway to move from a tense relationship to a norm of understanding, as hospital accreditation organizations are addressing these issues. Providers should utilize available resources to get out in front of the issue and ultimately improve the LGBT patient-care experience in their facilities. In heeding the lessons of Jackson Memorial, a provider's attention to these issues could prevent such tragedies from occurring and ultimately avoid the inevitable accompanying litigation. **■**

Matthew Stiff is a McCleary Law Fellow at the Human Rights Campaign. He graduated summa cum laude from The Ohio State University and obtained his juris doctor from New York University School of Law.

Robert Falk is the general counsel for the Human Rights Campaign and Human Rights Campaign Foundation. He previously served as general counsel of the Whitman-Walker Clinic, acting general counsel at D.C. General Hospital, and has 15 years of healthcare practice experience in prominent national law firms.

Vanessa Benavides is Senior Counsel in the Regulatory Group of the legal department at Tenet Healthcare Corporation in Dallas, TX. She is also a member of AHLA's Advisory Council on Diversity.

The authors recognize Ellen Kahn, Tom Sullivan, and Alison Delpercio for their pioneering work on the HEI.

Endnotes

- 1 Tara Parker-Pope, *Kept from a Dying Partner's Bedside*, N.Y. TIMES, May 19, 2009, at D5.
- 2 For a comprehensive analysis of LGBT demographic data, see Gary J. Gates, *Same Sex Couples and the Gay, Lesbian, Bisexual Population: New Estimates from the American Community Survey*, The Williams Institute, Oct. 2006, available at www.law.ucla.edu/williamsinstitute/publications/SameSexCouplesandGLBpopACS.pdf.
- 3 See Robert Witeck & Wesley Combs, *Business Inside Out: Capturing Millions of Brand Loyal Gay Consumers*, at 59, Kaplan Publishing (2006).
- 4 *Id.* at 73-80.
- 5 The Government Accountability Office (GAO) identified 1,138 federal statutory provisions involving marital status as of December 31, 2003. Although

Analysis

- numbers vary by jurisdiction, state law also generally provides several hundred additional statutory provisions that hinge on marital status. See GAO, *Defense of Marriage Act: Update to Prior Report*, GAO/OGC-04-353R (Washington, D.C.: Jan. 23, 2004).
- 6 As of June 2009, the following states recognize civil marriage for same-sex couples under state law: Massachusetts, Connecticut, Iowa, Vermont (as of September 1, 2009), Maine (as of mid-September 2009), and New Hampshire (as of January 2010).
 - 7 As of June 2009, the following states recognize either domestic partnerships or civil unions: California, Nevada (as of October 2009), New Jersey, Oregon, Washington (as of July 2009), and Washington, D.C.
 - 8 Colorado and Hawaii offer same-sex couples limited rights and benefits through mechanisms like “reciprocal beneficiary agreements.”
 - 9 As of June 2009, this inclusive group of states is as follows: California, Colorado, Connecticut, District of Columbia, Hawaii, Iowa, Maine, Maryland, Massachusetts, New Hampshire, Nevada, New Jersey, New Mexico, Oregon, Vermont, and Washington. For accompanying statutory authority, see Matthew Stiff, *Breaking Down Barriers: An Administrator’s Guide to State Law & Best Policy Practice for LGBT Healthcare Access*, at 13 n.46, Human Rights Campaign Foundation (May 2009), available at www.hrc.org/issues/coming_out/12668.htm.
 - 10 As of June 2009, this “close friend” group of states is as follows: Alaska, Arizona, Delaware, Florida, Idaho, Illinois, Mississippi, New York, North Dakota, Pennsylvania, South Dakota, Tennessee, Utah, West Virginia, Wisconsin, and Wyoming. For accompanying statutory authority, see Matthew Stiff, *supra* note 9, at 13 n.47.
 - 11 As of June 2009, this non-inclusive group of states is as follows: Alabama, Arkansas, Georgia, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, Texas, and Virginia. For accompanying statutory authority, see Matthew Stiff, *supra* note 9, at 13 n.48.
 - 12 These failures have generated litigation in the past. See, e.g., *Flanigan v. University of Maryland Hosp. Sys.*, (Cir. Ct. for Baltimore City, Md. 2002) (hospital ignored durable power of attorney and denied Bill Flanigan access to his domestic partner until after partner had lost consciousness, preventing Flanigan from communicating his partner’s wish to decline life prolonging treatment).
 - 13 As of June 2009, joint adoption is available to qualifying same-sex couples at a statewide level in the following jurisdictions: California, Connecticut, District of Columbia, Illinois, Indiana, Maine, Massachusetts, New Jersey, New York, Oregon, and Vermont. Nevada and New Hampshire have authorized joint adoption in certain jurisdictions, although not at a statewide level.
 - 14 Second parent adoption involves preserving the parental rights of one legal parent while also investing parental rights in a second legally recognized parent. As of June 2009, second parent adoption is available to qualifying same-sex couples at a statewide level in the following jurisdictions: California, Connecticut, District of Columbia, Illinois, Massachusetts, New Jersey, New York, Pennsylvania, and Vermont. Second parent adoption is available to qualifying same-sex couples in select jurisdictions within the following states: Alabama, Alaska, Delaware, Hawaii, Iowa, Louisiana, Maryland, Minnesota, Nevada, New Hampshire, New Mexico, Oregon, Rhode Island, Texas, and Washington.
 - 15 The Joint Commission, *Proposed Requirements to Advance Effective Communication, Cultural Competence, and Patient Centered Care for the Hospital Accreditation Program* (Standard LD.04.03.01, Element of Performance 4) (2009).
 - 16 See The Joint Commission, *supra* note 15 (Standard RC.02.01.01, Element of Performance 4).
 - 17 See The Joint Commission, *supra* note 15 (Standard RI.01.01.01, Element of Performance 11).
 - 18 See Human Rights Campaign Foundation & Gay and Lesbian Medical Association, *Healthcare Equality Index: Creating a National Standard for Equal Treatment of Lesbian, Gay, Bisexual and Transgender Patients and their Families*, May 2007, available at www.hrc.org/issues/hei.asp.
 - 19 The Employment Non-Discrimination Act in its current form would prohibit employment discrimination based on sexual orientation and gender identity. With prospects for passage of the legislation stronger than ever, the window of opportunity could be closing for providers to reap the benefits of affirmatively adopting these non-discrimination policies (rather than implementing the changes out of legal obligation).
 - 20 See Human Rights Campaign Foundation & Gay and Lesbian Medical Association, *supra* note 18, at 9.

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