Faith-Based Health Care And the LGBT Community

Opportunities and Barriers for Equitable Care

TANENBAUM
COMBATING RELIGIOUS PREJUDICE

TANENBAUM 55 Broad Street, 17th Floor New York, NY 10004 212.967.7707 | Tanenbaum.org

TANENBAUM | Center for Interreligious Understanding

Tanenbaum combats religious prejudice, hatred and violence—and works to create a more peaceful world where differences are respected. As a secular, non-sectarian nonprofit, Tanenbaum promotes mutual respect with practical programs that bridge religious difference and combat prejudice in schools, workplaces, health care settings, and areas of armed conflict.

ACKNOWLEDGEMENTS

Tanenbaum thanks E&L Carpenter Foundation for their generous support this paper and all associated efforts and events. We would also like to thank the authors and researchers who contributed to the creation of this paper including, Amy Wilson Stronks, Lynn Stoller, Julia Stronks, Eliza Blanchard, Maria McQuade, Kayana Marx, and Katie Singer. Additionally, we would like to thank everyone who had a hand in reviewing, editing, and giving feedback on this paper including Tanenbaum CEO, Joyce Dubensky and Deputy CEO, Rev. Mark Fowler, Adam Jarrett from Holy Name Medical Center, Alex Di Rocco from Northwell Health, Andrew Bland from The Joint Commission, Anthony Fortenberry from Callen-Lorde Community Health Center, Caroline Dorsen from NYU Rory College of Nursing, Christine Rodriguez from UCONN School of Nursing, Father Charles Bouchard from the Catholic Health Association, Gregory Johnson from EmblemHealth, Judith Jacobson from Columbia University Mailman School of Public Health, Kevin Flynn from St. Joseph's Hospital, Covenant Health, Kimberleigh Joy Smith from Callen-Lorde Community Health Center, Lisa Smith from Catholic Health Association, Mordechai Levovitz from Jewish Queer Youth, Marie Alford-Harkey from the Religious Institute, Sarah Bender from NYC Health + Hospitals, Stephen Ott from New York-Presbyterian, Tari Hanneman from Human Rights Campaign, Rabbi D'vorah Rose from Sutter Health, the dedicated attorneys from Epstein, Becker & Green, and valued Tanenbaum supporter, Meryl Benaim. Finally, and most importantly, we would like to thank all those anonymous participants who sacrificed their time and shared their experiences, allowing us to write this educational tool with the collective hope of creating more inclusive environments for patients of all backgrounds and identities.

To learn more about Tanenbaum's work please visit Tanenbaum.org.

Faith-Based Health Care and the LGBT Community: Opportunities and Barriers for Equitable Care

Amy Wilson-Stronks, MPP, CPHQ, Wilson-Stronks, LLC, Former Board member Gay and Lesbian Medical Association (GLMA)

Lynn Stoller, MA, Assistant Director, Health Care Program, Tanenbaum Center for Interreligious Understanding (former)

Julia K. Stronks, JD, PhD, Professor of Political Science, Whitworth University, Spokane WA

Eliza Blanchard, BA, Assistant Director, Workplace & Health Care Programs, Tanenbaum Center for Interreligious Understanding (former)

Maria McQuade, MA, Program Associate, Health Care Program, Tanenbaum Center for Interreligious Understanding

With special thanks to: Kayana Marx and Katie Singer

Edited by:
Joyce Dubensky, JD, Chief Executive Officer, Tanenbaum Center for Interreligious Understanding

Introduction

This paper is the result of a desire to understand the contemporary state of lesbian, gay, bisexual, and transgender "LGBT" [1] health care and LGBT equity in faith-based health care institutions.

Specifically, this paper demonstrates ways in which faith-based health care institutions, given their missions, are positioned to address the needs of the LGBT community. It also explores real and anticipated tensions between the policies and practices necessary to promote health equity and inclusion for LGBT patients and families, and the mission and values of many faith-based health care institutions.

Faith-based health care institutions, while dealing with the same challenges as their secular counterparts, often face additional mandates due to their faith affiliations. Though studies and related court cases examining the delivery of health care to LGBT patients in faith-based institutions is limited, recent lawsuits at the state and federal levels reveal the potential for conflict when LGBT people access public or consumer services in various settings.[1,2,3] Given this reality and the dearth of health care focused data and research, we were curious to explore the dynamic of patient care and LGBT equality at faith-based health care institutions.

In sum, our qualitative research indicates that while lesbian, gay, and bisexual (LGB)[4] patients experience particular risk factors and often face bias and discrimination in both faith-based and secular health care institutions, their medical care, personal treatment, and experiences of bias tend to be comparable (with the exception of certain specific types of care, which we will later expand upon). Notwithstanding these findings, our research also suggests that LGBT patients often expect that they will not receive the same quality of care in faith-based hospitals. This can result in such patients avoiding or postponing care, especially when the caregiving entity is faith-based.

In contrast to the experiences of cisgender[5] patients, transgender patients are both more likely to experience discrimination in faith-based health care institutions and are less likely to receive quality care. This is largely because faith-based hospitals may not provide transgender patients with care involving hormone therapy or gender affirming surgeries and procedures[6], when compared to secular health care institutions.[7]

In addition to exploring the opportunities for and barriers to comprehensive care for LGBT patients in faith-based health care institutions, our paper offers recommendations for faith-based health care institutions to address the negative anticipatory perceptions that LGBT patients often hold, and to create more inclusive environments that better provide LGBT patients with quality and more comprehensive care. Our recommendations are designed to identify an equitable balance of two powerful values and perspectives: promoting health equity when caring for LGBT patients, and upholding sectarian institutions' missions and values.

Methodology

As noted, literature and research investigating the intersection of LGBT equality and the health care provided by faith-based institutions is limited. As a result, we relied heavily on the perspectives and insights from key informant interviews and our own professional experiences addressing LGBT health care in faith-based health care institutions. We also used and considered national and state legislative trends and court rulings to inform our perspectives in this analysis.

Using a convenience sampling approach, we identified the majority of our informants (10) from the network of one of the authors (AWS), and those who participated in our initial interview sample identified two additional interviewees for a total of 12 subjects. The majority of our interview subjects expressed support for LGBT equality in terms of their personal perspectives. We recognize that this limits our ability to present a fully valid and comprehensive understanding of the issue. However, we experienced challenges identifying and then recruiting individuals from faith-based health care institutions, who may have (but might not have) expressed greater hesitation or reticence toward LGBT health equity.

We selected our interview subjects to represent several key demographics. In light of the small sample, we deliberately attempted to include people with diverse characteristics and backgrounds including: gender (male, female, transgender, gender queer); sexual orientation (straight/heterosexual, gay, lesbian); race (White, Asian, Hispanic); profession (student, medical librarian, lawyer, health care administrator, chaplain, psychiatrist, policy researcher, health care mission leader); religion (Buddhist, Catholic, Agnostic, Methodist, Christian, Christian/Church of Christ, Unaffiliated, Lutheran, Episcopalian); and geographic region (East, Southeast, Midwest, Mid-Atlantic, North East, Pacific regions).

Interviews were conducted by AWS and LS between January 2015 and March 2016 via telephone. All interviews were recorded with permission and transcribed verbatim. Subjects were instructed that the recording could be turned off at any time. Prior to the interview each subject was emailed a project description that detailed the purpose of the interview and description of the project. Specifically, it was explained that the interview was designed to explore the experiences and perspectives of 1. LGBT patients/families seeking/receiving healthcare from faith-based healthcare institutions; 2. Healthcare professionals providing care to LGBT patients/families in faith-based healthcare institutions; and 3. healthcare executives and leadership who are reconciling/aligning the institution's faith tradition and mission with the delivery of quality care to LGBT people. Further, interviews were aimed at identifying recommendations and possibilities for improving LGBT equality in health access and health care at faith-based healthcare institutions and learn of success stories and practice examples that can be shared. At the beginning of each interview we provided a detailed overview of the project, explaining that its purpose is to understand faith-based health care organizations, the care provided for, and the treatment of LGBT patients in these facilities as described above. Additionally, as part of the consent process prior to commencing the interviews, the research team informed each interview subject that their information would be kept confidential

and that participants would not be identified in the final project report(s). Interview transcripts and recordings were de-identified and coded with numerical/alphabetical codes.

All authors read all of the transcripts to become familiar with the data. AWS and LS conducted the detailed analysis through multiple readings of the transcripts using grounded theory (Strauss and Corbin 1998) to identify themes and categories of responses to discussion questions. Key words, phrases, and concepts were highlighted to distinguish major ideas. We used constant comparison, content and thematic analysis to identify and code frequently expressed ideas to support the systematic discovery of theory from the data.[8, 9] There were no a priori codes; all themes emerged through the process of transcript analysis. We then compared the independently identified themes to verify and clarify themes until we achieved consensus on the final coding scheme and shared with the full authorship to clear any disagreements. Following this, AWS and LS independently coded all 12 interviews using the coding scheme. Test-retest checks were conducted throughout to assess coding reliability. In addition, codes were compared for all interviews; discrepancies were resolved by discussion and involvement of the full authorship. Data was managed using the QSR NVIVO 2.0 software. (QSR International, Melbourne, Australia) We used the method of constant comparison to refine these codes and to discern subcategories and determine the interrelationships, if any, among the various codes. We report the results below by describing the most frequently ascertained themes.

Perspectives relayed by our interviewees fall into four inter-related and inclusive contextual categories:

1. Experiences of organizations, communities, or groups

2. Experiences of individuals

3. Perspectives related to LGBT status or addressing LGBT issues

4. Perspectives related to institutional or personal faith affiliation and reconciling faith affiliation with LGBT issues

Interview subjects' responses to the interview questions were often informed by more than one contextual category, depending on the question. For example, some responses reflected experiences or perspectives of an individual, whereas other responses represented the experience or perspective of an organization. This is not surprising given that several of our interview subjects have multiple relevant identities that shape their perspectives and experience. For example, some interviewees who identified as LGBT and received health care at a faith-based health care institution in the past may also have worked for a faith-based health care institution. Interviewees who represented faith-based health care institutions clarified when their response was representative of their personal opinion and not of their organization. All attempts were made to clarify the relevant perspective(s) without infringing on confidentiality.

Although our literature review yielded little information on the intersection of LGBT equality and the health care provided by faith-based institutions, we were able to supplement our search with a number of publications, news articles, reported court cases, and blog posts. These resources provided context for LGBT health and health care and faith-based hospitals, including the issues they face, the policies they implement, and the impact they have on the provision of health care in the United States. Additionally, we reviewed nationally recognized studies and resources on LGBT health and health care from organizations such as the Institute of Medicine, The Joint Commission, The Fenway Center, and the Centers for Medicaid and Medicare Services.

Current Environment of LGBT Equality

Within the last decade, advancements have been made toward LGBT equality in the U.S. While the general public often measured this trend through the status of marriage equality, the health care community has begun, in recent years, to pay attention to health disparities facing the LGBT community.[10] This focus correlates with an increasing emphasis on improving patient safety, increasing the quality of care, and creating more patient-centered systems, where all patients

have equal access to and receive safe, timely health care services. In this effort, hospitals and health care organizations have increasingly dedicated resources to "advance cultural competence, improve communication, and provide equitable and more patient-centered care to several diverse patient populations."[11]

This growing identification and understanding of discrimination and disparate treatment is challenging previous conceptions of what it means for LGBT people to be truly equal in the health care system, as well as in the eyes of American law and contemporary society. At national and local levels, health equity efforts are expanding. Due to recent studies indicating that LGBT people have less access to adequate health care and are more likely to suffer from certain conditions and diseases, including cancer, HIV/AIDS, and depression, there is increasing recognition that members of sexual orientation and gender identity minority groups are demographics that experience significant health disparities.[12]

According to a study sponsored by the Kaiser Family Foundation, lesbian, gay, and bisexual adults are less likely to have a usual place to go for medical care as compared to heterosexual adults. Another study found that 48% of transgender adults postponed or went without care when they were sick because they could not afford it.[13] Therefore, the goal for LGBT health and health care initiatives, in both secular and sectarian settings, is to create environments in which LGBT people feel safe, and providers are aware of the potential risk factors as well as the resources and best practices for providing LGBT patients with effective care.[14]

It is difficult to discern the exact number of LGBT-identifying people in the United States. This is due to a number of factors, including the heterogeneity of LGBT groups; the incomplete overlap between identity, behavior, and desire; the lack of research about LGBT people; and the reluctance of some individuals to disclose LGBT identities when that identity is stigmatized within society.[15] Current estimates, taken from a Gallup poll conducted in 2016, report the LGBT population to be approximately 10 million people, or 4.1% of the U.S. population.[16] This is a significant increase from polls conducted in 2012, which indicated that only 3.5% of the population identified as LGBT.

Current theories suggest that this increase is driven by an increasing number of Millennials (people born between 1980 and 1998) who are openly identifying as LGBT. The open number of Millennials increased from 5.8% in 2012, to 7.3% in 2016. Sharp increases were also noted among women (4.4%), Asians (4.9%), and Hispanics (5.4%).[17]

LGBT populations face a number of obstacles that prevent them from attaining health equity. This includes their frequent reluctance to disclose sexual or gender identity when receiving medical care for fear of discrimination and decreased quality of care; lack of provider knowledge regarding LGBT health issues and needs; and compounded discrimination and barriers to appropriate and quality health care for LGBT persons who belong to other historically disadvantaged and vulnerable populations.[18] Our interview subjects reported similar obstacles.

Stigma associated with LGBT identity begins at a young age, and the resulting discrimination experienced by LGBT populations has a measurable and adverse effect on health, resulting in health disparities, negative health outcomes, and impaired physical and mental health.[19, 20] The Family Acceptance Project reports that “adverse, punitive, and traumatic reactions from parents and caregivers in response to their children’s LGBT identity” is related to higher rates of substance abuse and poor mental health when compared to heterosexual populations.[21]

The U.S. Transgender Survey conducted in 2015 reported even greater obstacles and discrimination facing transgender communities.[22] This survey collected information from 27,715 transgender respondents from all 50 states; it found that 33% of respondents, who had seen a provider in the past year, had at least one negative experience with a doctor or other health care provider related to being transgender. Specifically, these experiences include verbal harassment from health care providers and/or other staff, refusal of treatment, or that they had to teach the health care provider about transgender people and appropriate patient care. Twenty-three percent of respondents reported that at some point during the past year, they needed health care but did not seek it due to fear of being disrespected or mistreated as a result of their trans-identity. This number is even higher among transgender people who also belong to other marginalized and vulnerable populations.[23]

Given the above, it is not surprising that LGBT people often delay and/or avoid seeking health care, which contributes to higher rates of psychological distress (39%) and lower self-reported health scores (22% said their health was “fair” or “poor”). To improve the care experience for LGBT people

and support health improvements, many health care organizations are making efforts to provide better patient-centered care by creating LGBT culturally competent environments.

Some faith-based health care organizations are involved in this growing effort to enhance LGBT quality care. This is particularly important given the increasing number of hospitals and hospital systems that have religious affiliations and are influenced by religious doctrine (over 20% since 2001).[24, 25] Of that 20%, almost 70% of religiously affiliated hospitals are Catholic, meaning one in six hospital beds in the United States is now affiliated with the Catholic Church.[26] This demonstrates the importance of addressing the LGBT experience in our health care system, and the necessity of faith-based hospitals participating in LGBT health equity initiatives. Without the support of these faith-based hospitals, LGBT patients will not have equitable access to quality care and treatment.

It is noteworthy that, over the past decade, the health care landscape has begun experiencing a dramatic increase in hospital consolidations. "It's harder than ever before for independent health care organizations to thrive without alliances," noted PeaceHealth spokesperson Tim Strickland.[27] The consulting firm Booz Allen Hamilton predicts that a fifth of the nation's 5,000 hospitals could merge over the next few years.[28] As a practical matter, this means that many previously independent health care organizations that did not have a faith affiliation will be merging, and sometimes it will be with faith-based health care institutions.

These trends suggest that conversations between faith-based groups and LGBT groups will be particularly important. For one thing, the issues involving LGBT health care differ from the issues affecting other minority groups; this is because LGBT patients sometimes encounter individuals or institutions that refuse to provide certain services based on their religious beliefs and their understanding of religious freedom.[29] Given this, individual employees and administrators of faith-based health care institutions are often unsure of their rights and obligations to patients under the law. The result is that many institutions hesitate to address this topic in a robust way, even though that may be needed to ensure equitable care.

As noted, the number of Catholic hospitals and health care systems has significantly increased in recent decades. Ten of the 25 largest hospital systems in our country are now Catholic.[30] Given that all Catholic hospitals are required to adhere to the Ethical and Religious Directives for Catholic Health Care Service, groups like the ACLU have expressed concern that the increase in Catholic health care institutions may restrict LGBT patients' ability to access certain reproductive health and gender affirming services.[31] Specific restrictions relevant to the LGBT community could include in vitro fertilization, hormone treatments, and gender affirmation surgeries.[32]

This concern, regarding greater restrictions applied to health care services, also applies to Catholic mergers with non-Catholic, Christian hospitals and health systems who may abide by more inclusive practices and policies. For example, in 2013, St. Joseph Health System in California, a Roman Catholic system, merged with Hoag Memorial Hospital Presbyterian creating the Covenant Health Network. Prior to the merger, health care providers at Hoag were told by

the Administration that their practices and services would not be affected by the merger and that, "Hoag and St. Joseph Health will retain their individual identities and faith affiliations — Presbyterian and Catholic, respectively." However, after the merger, the Hoag Administration promptly ended patient access to elective abortion services. The merger was widely viewed as a success however as the Hoag Administration was allowed to continue performing sterilizations, offering contraceptive consultations, and other reproductive services that "are not typically found inside Catholic hospitals." Although this is a just a brief synopsis of the merger and does not fully capture the complexities, it has been reported that providers at Hoag were "blindsided" by the changes and notably upset by the "abortion ban." [33]

Finally, it is important to keep in mind that business considerations can and do impact the health care industry and the quality and equality of care. For one thing, health care institutions are businesses. Our data, taken from Tanenbaum's "Survey of American Workers," shows that American employees who work at companies with processes in place to handle complaints and key policies that address discrimination report higher job satisfaction.[34] Data and exposure can move companies to address such issues, including with the LGBT population. Take, for example, the Corporate Equality Index (CEI) established by the Human Rights Campaign. By creating a competitive assessment of businesses and the extent to which they were "LGBT Friendly," the CEI established a data-driven endorsement mechanism for companies seeking to gain a market edge by establishing themselves as "LGBT Friendly." To remain competitive, others had to follow, and the Index influenced companies to adopt practices of non-discrimination and LGBT inclusion. [35]

Another relevant business consideration is patient satisfaction, which correlates to providing inclusive environments and quality care for patients of all backgrounds, gender identities, and sexual orientations. Not only does patient satisfaction influence return rates and reputations, but also it is increasingly being tied to reimbursement for institutional care.[36] Because LGBT persons are among patient populations reporting on their overall satisfaction, how they are treated and the care they receive can have an impact on revenues. As such, ensuring that they feel respected and are satisfied with the care they receive is an important priority for sectarian and secular institutions.

Further, Human Rights Campaign is promoting a Healthcare Equality Index (HEI) as the health care equivalent of the Corporate Equality Index and a targeted tool for advancing LGBT health care equality. The HEI evaluates hospitals and establishes whether they should be designated Leaders in LGBT Healthcare Equality. Originally, HRC used what they identified as the "Core Four" criteria for LGBT patient-centered care which included patient non-discrimination: a visitation policy that includes same-sex spouses and partners, employment non-discrimination, and staff training on LGBT patient-centered care that includes five senior hospital administrators. [37] In the 2016 survey however, which was released in 2017, HRC expanded their scoring criteria from the "Core Four" to five separate scoring categories in which facilities can score up to 100 points to qualify as a "LGBTQ Healthcare Equality Leader." These categories include: Non-Discrimination & Staff Training, worth up to 40 points; Patient Services and Support, worth 30 points; Employee

Benefits and Policies, worth 20 points; Patient and Community Engagement, up to 10 points; and Responsible Citizenship, in which 25 can be dedicated if the facility has engaged in activities which would undermine LGBTQ equality and patient care.[38]

In 2018, 418 hospitals, or 67% of the 626 that participated in the HEI, were designated Leaders. Forty-seven of the 626 participating hospitals identified themselves as religiously affiliated (the HEI did not offer a definition for religiously affiliated hospitals). Several faith-based hospitals were designated Leaders through the HEI, including several facilities from a faith-based health system located in Kansas and Missouri, called St. Luke's, and one hospital, St. Mary's Medical Center in California, which is part of the faith-based Dignity Health system.[39] The presence of faith-based health care institutions on the HEI demonstrates that with the intentional implementation of LGBT-conscious policies and practices, religion and LGBT health equity are finding ways to co-exist.

What is a Faith-based Health Care Institution?

Although we reference faith-based health care institutions throughout this paper, the reality is that the term has no consistent or legal definition. For purposes of this paper, we sought to apply a definition of faith-based health care institutions that would not be exclusive to a single religious tradition and would be relevant for exploring faith affiliation in the context of health care.

We are therefore defining the scope of faith-based health care institutions as institutions or organizations established to provide health care services that are intertwined with a religious affiliation in all of the following ways:

1. The institution was founded by or originated from a religious group.
2. Decision-making policies are guided by a faith tradition/doctrine. This includes what services are and are not provided and how health care professionals within the institution are expected to make decisions.
3. Certain leadership and/or board member positions are affiliated with a faith tradition, and those individuals are representing a faith tradition for the purposes of guiding institutional operations in a manner consistent with faith teachings.
4. The mission, vision and values of the institution outline a connection to a faith tradition.

Some hospitals would satisfy some, but not all, of the above criteria. For example, on the East Coast, hospitals that comprised North Shore Long Island Jewish Medical Center, now part of Northwell Health, were originally established by the Jewish community, but are no longer guided by this faith tradition. These institutions would not meet our definition of a faith-based health care institution.

Our definition, utilized to distinguish between secular and faith-based health care institutions, is applied with the intention of identifying patient experiences that are unique to faith-based health care institutions. For our purposes, we are also including all types of health care related services under the term "institution," not only hospital settings.

Faith-based health care institutions are widespread and, in some areas, they are the only health care resource available.[40] Thus, if we are to improve LGBT health care nationwide, faith-based health care institutions will be necessary actors in this effort. Today, as in the past, faith-based health care institutions are an important source of care for many disenfranchised populations. In part, this is because most are founded with a mission to care for the poor, vulnerable, and those who are considered "at risk" demographics.[41] Given this framework, these entities, when prepared in advance, can help improve the overall health of the LGBT population in the United States, while staying true to their core mission.

Mission as Moral Compass: Motivations for and Obstacles to Change

Our research suggests that many faith-based health care institutions have begun to consider how their core missions relate to LGBT patient care. Many have taken steps to create and communicate a welcoming environment to their LGBT patients.[42] Similarly, the importance of aligning a faith-based institution's organizational mission with LGBT friendly policies, practices, and positions was echoed in each of the interviews we conducted with four individuals in leadership positions at three separate hospital systems. In fact, they referenced their institutional missions as one of the primary motivators in addressing and driving change in policy and practice related to caring for LGBT patient populations to create more inclusive and welcoming environments.

Two interviewees shared their perspective on this dynamic as follows:

"The Joint Commission has the 'big stick' but I would like to believe that we do this because of the basic tenets of our faith that come from a place of: we are all one family and made in the image and likeness of God and therefore owe a reverence – and I use that word intentionally as opposed to just the word respect – toward anyone that comes to us for care."

"I truly believe for us it's a mission. People at [my institution] are very serious about demonstrating God's care and anything that makes people feel marginalized is something that this organization doesn't want to be identified with."

In addition, in an article recently published by the Catholic Health Association of the United States (CHAUSA), John Wallenhorst, Senior Vice President of Mission and Ethics stated, "As part of the Catholic Health Ministry, we honor the dignity of every person, and we are committed to the common good. We strive always to act in a way that is consistent with our identity and to serve all persons with care and compassion." [43]

While advances in law, policy, and accreditation standards are referenced as important motivators and guides for institutional change, the representatives we interviewed from faith-based hospitals noted their missions as their primary motivation for making changes to avoid marginalization and enhance growth when it came to fair and equal treatment for LGBT patients. To that end, several interviewees stressed the importance of referencing and leveraging their faith-based institutional mission and vision, when encouraging their leadership to support and drive changes in institutional policy and practice.

One interviewee, working in a leadership role within a faith-based health care institution, shared the following statement regarding institutional identity and LGBT equality:

"I think the overarching driver is the value that we put on respect and compassion and that we believe this is an important part of our organizational identity and needs to be translated in very practical ways. We need to be particularly attentive to show respect for people that may not typically receive the respect that they deserve, that may be marginalized."

Despite the many challenges and obstacles that LGBT individuals face when accessing health care, the data collected from our interviews suggests there is hesitancy about characterizing LGBT patients as "vulnerable" or "underserved", and using that framework as justification for providing needed services.

For example, one interviewee noted:

"In our mission statement we talk about vulnerable persons and while I don't want to define LGBT persons too broadly as vulnerable, I want to recognize that societally there are still problems and we want to make sure they receive the respect they need when coming to our institutions."

Yet, as we mentioned previously, framing the LGBT community as "vulnerable" or "underserved" discounts the resiliency of this population and can also be interpreted by patients and their families as a disparagement.

Interestingly, even though all the interviewees recognized that the LGBT community, as a whole, is at risk of receiving lower quality care and having worse health outcomes than their heterosexual, cisgender counterparts, many still noted reasons for caution with this approach.

Messaging and Mission: A (Sometimes) Delicate Balance

Any shift or change in an institution's policy, practice, or culture depends upon the commitment of its leadership. In terms of creating a welcoming environment for LGBT people, faith-based health care leaders face the additional challenge of navigating and managing the expectations of hospital and community-based leadership, as well as hospital staff, patients, families, and faith community

members. People from these various groups may be reluctant to accept new policies or practices that they see as conflicting with their religious beliefs and practices.

Four of the five leaders we interviewed relied upon careful messaging and education to help navigate this tension. Messaging included outward, public communiqués as well as internal institutional messages. In both instances, this messaging was intended to reach two audiences: first, to help faith providers understand the need to care compassionately for LGBT people; and, secondly, to communicate to the LGBT community that the institution will provide them with quality and respectful care.

Interviewees working at faith-based health care institutions referenced a number of activities they participated in to create inclusive and welcoming environments for their LGBT patient populations. Those steps included creating more LGBT friendly visitation and decision-making policies, and generally adopting gender conscious language that aligned with Joint Commission standards. All interviewees seemed to agree that implementing policies around visitation and non-discrimination (and educating staff around these policies) were squarely in line with their faith-based institutional mission. They experienced little pushback on implementing LGBT inclusive policies that stemmed from a faith perspective.

“I wouldn’t say there was any particular difficulty…there was no overt opposition or interior opposition…for HR and Mission, my experience was that it wasn’t even a question.”

Among our interviewees, the responsibility of navigating the religious values of the organization with LGBT inclusion efforts is frequently referenced as a “dance,” “balance,” or “walking a fine line.” This choice of language acknowledges that the effort to reconcile faith tradition and organizational mission is not always a seamless one. However, it is something that some health care leaders are increasingly willing to engage in, in a continuous and meaningful way. One interviewee noted, “We do have to be thoughtful of those folks that may be offended so we need to be discrete while still being authentically ourselves.”

The necessity for “discretion” and “balance” was particularly evident when participants were asked about how people in their institutions might respond to diversity initiatives. These initiatives could include simple things like displaying ally or safe space stickers, hanging inclusive posters, such as a picture of a same-sex family, in public spaces where they would be viewed by incoming patients. There was a wide variety of responses to this question. One respondent noted:

“I think some people would have a hard time with it but at the end of the day, I think they would be ok with it. I think they’d do it…There would be some discussion though about are we promoting a lifestyle that our faith doesn’t necessarily promote…It would be a tough decision.”

Another shared:

“It’s not a battle I’d push right now because there are other issues. I’m not saying we wouldn’t do it. But it would be more ‘out’ about how far we’re willing to challenge church doctrine.”

Ultimately, all interviewees speaking from a health care leadership perspective emphasized the importance of taking the time to go through the exercise of aligning institutional mission with LGBT equity initiatives in a very methodical and intentional way. While this was often described as a slow process, there was agreement, as articulated by one respondent that, "for a faith-based health care organization, alignment with organizational mission and values is definitely a way to go. It definitely was for us and would likely be true for the larger Catholic health care community."

Love the Sinner

Several interviewees referenced "love the sinner, hate the sin" in connection with messaging and reconciling personal or institutional values with caring for LGBT patient populations. One interviewee described this concept as "a faithful response" to the potential tensions and intersection of faith and LGBT identity, noting that,

"If religious institutions are founded with the goal of providing care to underserved populations or as a way of providing a service for people in need, I think focusing on that would be a good way to get people on board."

In other words, faith-based health care institutions may see a conflict between the aspect of their mission that promotes care for the vulnerable and underserved populations, which may include LGBT patients, and the aspect of their mission that may consider same-sex relationships or gender affirmation surgeries and treatments to be a sin. Several interviewees noted that the framework of "love the sinner, hate the sin" may help those providing health care services to reconcile this tension by allowing the institutions to provide high-quality, compassionate health care to LGBT patients, even when the institution's faith tradition still considers living as a sexual being with an LGBT identity to be a "sin."

As one of our interviewees observed, "[C]ertain faiths would use the term 'hate the sin, not the sinner.' I don't necessarily agree with that term, but I see what people mean is that you see people as people and you may not agree with what they do, but you prioritize their personhood. I think in that space, care gets provided. However, I can't speak to whether the quality of care is as strong because if you create a space for not agreeing with someone's life then you bring in unconscious biases. It shapes the way you might counsel or listen to them."

Juxtaposed to the foregoing, another interviewee, an LGBT advocate shared a different perspective on the "love the sinner, hate the sin" approach, as follows:

"We [in our LGBT program] try to make the patient feel like they have control over their own health care so a charity model of 'oh we're helping this poor person' could be demeaning [for LGBT people]."

This question is worth considering. Can this internal framework enable conflicted faith providers and institutions to provide not only equitable but also unbiased care for LGBT patients? Alternatively, because this framework still views a person with a lesbian, gay, bisexual, or transgender identity as "sinful," might this framing contribute to unintended, but deep-seated, bias that negatively influences the quality of the health care or the personal treatment provided? Research conducted regarding implicit bias, and the nature of unconscious bias itself, suggests that this is possible, even when a provider is well intentioned.[44] Further, the patient and/or their families may also negatively perceive this construction of LGBT identities and its use as a justification of patient care, if they become aware of it.

Notwithstanding these issues, interviewees generally expressed agreement that while "love the sinner, hate the sin" may not be an ideal way to advance LGBT equity in health care settings, it may be the most effective internal messaging strategy in some circumstances. Or, as one of our interviewees noted:

"[I]t may not [be] the best but maybe it's a good start if that's what you need to get the institution on board from just a totally pragmatic perspective."

Challenges to Consider

While some faith-based institutions have found support for equal treatment of the LGBT community from within their faith traditions, challenges still exist which can complicate their situations. From our qualitative research, we identified three key issues that are particularly challenging for faith-based institutions. They include:

LGBT perceptions that they are not welcome at faith-based health care institutions.

Care for trans-people, especially as it relates to gender affirming treatments and procedures.

Confusion about appropriate conduct given conflicting state, federal, and constitutional jurisprudence, and hospital policies.

LGBT Apprehension and Faith-Based Health Care Institutions

Several of our interviewees reported that LGBT patients and families were reluctant and apprehensive about accessing care at health care organizations that identify as "faith-based." Indeed, interviewees reported that they had, or knew someone who had, specifically avoided seeking care at faith-based institutions because they anticipated being treated poorly, both medically and emotionally.

One interviewee stated:

“My friends who are LGBT would not go to faith-based hospitals if they had the option.”

Another noted:

“Totally anecdotal, but my sense is there is an extra reluctance or fear that there is discrimination at faith-based health care institutions.”

Two of our transgender interviewees stated that they would avoid going to a faith-based hospital if possible, noting:

“I personally would not want to go to a Catholic hospital. Maybe that’s my own bias but my preference would be not to.”

Another respondent stated:

“I’ve always managed to avoid [receiving care from a faith-based health care institution]. I think I’ve always tried to consciously avoid that as much as possible.”

Our interviewees offered a range of potential reasons for LGBT individuals’ apprehension and avoidance of faith-based health care institutions. Some referenced avoidance as a political or moral stance, explaining they did not wish to support an institution that they believed represented values that were not in line with their own. Others cited examples of discrimination, such as refusal to treat a person due to their sexual orientation or gender identity.

Several interviewees referenced the widely publicized case of a Michigan pediatrician who declined to treat the infant daughter of a lesbian couple, citing her religious beliefs as her reason for declining to provide care for their child.[45] Another story frequently referenced was the case of a Missouri man who was removed from his life partner’s bedside. In that situation, the man and the patient had a civil union, yet the patient had a different health care proxy for visitation. When the patient’s family members objected to the visits by his partner, hospital staff called the police. The man was then arrested and escorted out of the hospital.[46]

Notably, the examples given of negative experiences were not all personal. It appears that stories and events known to the public, as well as societal experiences like being “shamed” by a member or members of a faith community after disclosing their LGBT identity, are influencing the LGBT community’s concerns about faith-based health institutions. According to a recent PEW survey, between 73% and 84% of LGBT adults describe the Muslim, Mormon, Catholic, and Evangelical faiths as unfriendly toward people who are LGBT. Among LGBT adults, about three in ten (29%) say that they have been made to feel unwelcome in a place of worship.[47] Many LGBT identifying individuals have been ostracized by their families as a direct result of the family’s faith. A recent study by the Family Acceptance Project found that high religious involvement in families was strongly associated with low acceptance of LGBT children.[48] These experiences often impact LGBT individuals’ perceptions of faith traditions and faith-affiliated services, including health care.

Interviews with leaders of faith-based health care organizations show that they are aware that LGBT people and their families can be reluctant about seeking care at their institutions (as compared to seeking care at a secular institution). One leader shared a personal experience. A patient who was scheduled for elective surgery contacted her in advance of the procedure. The patient wanted to ensure that his partner would be treated respectfully and would be allowed all appropriate access, including equal visitation and participation in care decisions. The leader noted that,

"So, he, knowing that we were Catholic, called and wanted to know, 'How will this play out for me and how will I be received?'"

In this case, the institution had policies and practices in place mandating that LGBT patients and families are treated with dignity and respect, and the leader was able to reassure the patient that his loved one would be welcome to visit and fully participate as the partner of the patient. Our interviewee, the institution's leader, commented that this experience really helped her understand the apprehension that many LGBT people experience when they receive care at faith-based institutions.

When asked to compare the care provided to LGBT versus non-LGBT people, one faith-based health care leader we interviewed responded:

"I do think it's different [care provided to LGBT people at faith-based health care institutions] just by virtue of people asking the question 'Am I going to be welcome there?' From the perspective of care, I would like to believe that it is not different. But, in terms of what are the anticipations and anxieties, that may be different. And I also think that there are some cases, and there have been some cases in my experiences, where the care has been different and not from the standards that I would hope or expect."

The same interviewee further noted that most of the issues they encounter with LGBT identifying patients and faith-based institutions involve visitation rights.

"A patient identifies a significant other and that person is designated as the person who should be able to visit as a spouse [but] something happens, usually on overnight time... a complaint generally comes to the 24-hour patient advocate line. Sometimes it's resolved with one conversation, sometimes several conversations and education, and in one instance, corrective action on the part of the colleague. We always go to education first, but sometimes you need more."

Other interviewees explained how the faith affiliation of individuals providing care in faith-based institutions could also generate concerns among LGBT patients and families.

"[LGBT people] fear the [individual] provider will be Christian and not see them as human or as less than human and not take as good care of them. The fear of being proselytized to is also there, and I've seen it happen at my hospital."

Another interviewee noted how LGBT patients and their families are, in many cases, confronted

with negative or discriminatory attitudes and biases (conscious or unconscious) from health care providers. However, this is not an experience that cisgender or heterosexual patients and families face in relation to their sexual orientation or gender identity.

“It’s funny, I’m thinking about an incident a while back around artificial insemination for a lesbian couple and staff being pretty freaked about it. Granted it was a while back and everything got solved to the patient’s satisfaction, but that’s not something that a straight couple has to even worry about it. Is the treatment different? Ultimately no, but the attitudes are. At the end of the day, we’re going to do the right thing, but you shouldn’t have to see a rejection of people that are caring for you on their faces. In terms of the treatment, were you treated with this medication, yeah, they’re going to get the same treatment, but a straight couple doesn’t have to deal with certain issues.”

It is important for providers to recognize that, compared to heterosexual or cisgender patients, LGBT identifying patients have likely had very different experiences or, at least, different concerns when visiting health care institutions. As a result, the words and actions of the providers may be experienced and interpreted differently than intended. Their impact may even vary depending on the demographic(s) with which the patient identifies. For example, one interviewee recalled an experience when a friend, who identified as a transgender man, went to a faith-based clinic because he was experiencing pelvic pain and bleeding.

“He was in a lot of pain and nervous. The provider said to him, ‘We can’t see you.’ His assumption was that the provider was denying care because of his identity, while in fact it was because this walk-in clinic cannot provide pap smears. If the provider had clarified things, it might have gone a lot better. Providers should be aware that, if a trans-person is coming to see you, chances are they have a lot of anxiety. You can’t lead with, ‘We can’t see you.’ Your patient is coming in with all this other stuff that you don’t necessarily know about.”

Ultimately, the challenge appears to be that in many cases, people in the LGBT community do not know if, and when, they will be treated differently because of their sexual orientation or gender identity. And, if, and when, their friends, families, or partners will be treated differently or discriminated against by a provider or an institution. Such unpredictability can cause anxiety and fear when accessing care. This apprehension can be further triggered or exacerbated when an institution or health care provider is expressly linked with a faith tradition.

One interviewee specifically observed that, in comparison to other marginalized identities associated health inequalities (race, gender, ethnicity, language), a person who identifies as LGBT may feel additional vulnerability (due to their LGBT identity). This is because of their unprotected legal status on a federal level, the lack of protection and non-discrimination laws in some states, and because of the theological or cultural roots of LGBT discrimination.

“I do think it’s important to recognize that sexual orientation and gender identity are particularly targeted on an ideological level in a way that other identifiers are not. There’s no teaching in Catholicism that says women are bad per se. For sexual orientation and gender identity, there are specific theological statements related to the unacceptability of LGBT people in a way that

merits a discussion [by] faith-based institutions. I think anybody could run afoul of a faith-based institution's teachings and could suffer accordingly. But I think that the specific ideology related to gender identity and sexual orientation could make things worse for LGBT people [rather] than other groups that are not specifically identified. Most people that go to faith-based health care institutions may be targeted for what they do, while LGBT people are being targeted for who they are. You wouldn't ask a woman to check her identity at the door but LGBT people, there's no way to disassociate."

Regardless of the reason — personal experience, a news story, or an experience conveyed through word of mouth — our interviews suggest that LGBT individuals are more likely to distrust faith-based health care institutions compared to secular institutions. In contrast, among our interviewees, there was general agreement that, with the significant exception of transgender care and reproductive health services (where there are current issues that we cannot sufficiently cover in this paper), the quality of care provided to LGBT patients and their families at faith-based health care institutions is likely no better and no worse than the care provided at secular institutions.[49] In general, it appears that, as one interviewee said, "a lot of the fear is just around a perception but it isn't necessarily in practice."

Navigating Transgender Health

While many interviewees focused on perception and anxiety barriers among LGB patients and families about accessing care at faith-based hospitals, they highlighted potential and actual barriers to accessing care when it comes to the issue of transgender health. Among representatives of health care institutions and interviewees who identified as transgender or allied with the transgender community, there was widespread agreement that this particular community uniquely faces discrimination, most overtly in the form of being denied certain types of needed medical care.

Several interviewees expressly described faith-based health care institutions as unwilling or ill equipped to provide competent and comprehensive care to transgender patients. As one participant explained:

"I don't think any of the institutions where I've been able to get competent trans health care have ever been faith-based. I've never heard of it and my assumption is that it's just not possible. Well, let's say that it is possible but it's just not happening."

Another interviewee shared a story about seeking health care:

"I was actually at a support group meeting and someone cracked a joke about, 'Well you wouldn't go to a Catholic hospital to get health care' and everyone laughed so the understanding was that you obviously wouldn't do that and that anecdote shows how people may generally feel. And I'm

on all these different listservs etc. with people trying to find a doctor and I've never heard 'oh, go to [a faith-based hospital] ….' That just never happens."

Indeed, all our interviewees who worked for faith-based hospitals indicated that transgender health care was an issue for their institutions. This was reflected in hospitals' unwillingness to address issues related to transgender patient care, or ignorance about how to create and implement policies and practices to improve it.

One interviewee noted that gender identity was expressly included in his hospital's non-discrimination policy and, therefore, "on a philosophical level, we want to express sensitivity but on a practical level…there are some potential ethical dilemmas. Not at all in terms of respect or sensitivity and no restrictions in terms of care for transgender patients unrelated to transition[ing] or more tangentially related, but we don't know, quite frankly, where to think about providing services, including hormone replacement and [gender] reassignment and so that's a dilemma."

In particular, Catholic health care institutions face this dilemma. The Ethical and Religious Directives for Catholic Health Care Services that all Catholic health care institutions must follow do not explicitly address gender affirming care and procedures, but do forbid sterilization of all patients, whether transgender or cisgender.[50] According to the 2018 edition of the Ethical and Religious Directives issued by the United States Conference of Catholic Bishops:

"Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available." [51]

As some gender affirming surgeries induce permanent sterility in the patient, they may be considered impermissible by the Directives and, as a result, impermissible in Catholic health care facilities. This becomes more complicated, however, when a transgender patient wants a gender affirming surgery that does not result in sterilization, such as breast surgery.

This reality gained some visibility recently. A case at MedStar Georgetown University Hospital in Washington D.C. made its way into the media when a transgender patient scheduled for breast implant surgery was informed that the hospital no longer did breast surgery on transgender patients. The hospital said that the decision was because "a high-quality gender transition service is best delivered in the context of an integrated program rather than in a fragmented manner." Transgender advocacy organizations, human rights organizations, and comprehensive transgender care health care organizations differed with the proffered rationale and there was speculation about the hospital's motivation, particularly if the decision was due to its Catholic affiliation.[52]

For Catholic hospitals, the Ethical and Religious Directives outline restrictions and ethical positions on health care issues, including end-of-life care and reproductive health. However, as

stated by more than one of our interviewees, the stance of the church on topics surrounding gender identity is ambiguous. As a result, faith-based institutions and providers are left to individually interpret the Directives and determine what constitutes acceptable and appropriate care in their system. This disproportionately affects care for transgender patients, who often need treatments and procedures, such as surgeries and hormone replacement therapy, for gender affirmation.

One interviewee summarized the situation succinctly:

"I'd say that it's the biggest challenge right now. Because there's no solution."

Faith and Legal Obligations: Complications and Legal Complexities

In addition to the challenges already noted, legal considerations involving freedom to practice one's religion and prohibitions against discrimination further complicate issues involving LGBT persons and faith-based health care institutions.

This often leads to confusion regarding health care providers' and institutions' legal rights and obligations, which in turn can create conflicts and obstacles to LGBT individuals' receipt of health care. While understanding the law is key, it is also necessary to seek balance so that LGBT patients, and all patients, receive equitable and quality care, while also respecting religious conscience. This is easier to achieve when institutions anticipate and prepare for possible conflicts between religious beliefs and the provision of care to LGBT patients. Additionally, such preparation is just good business and can reduce litigation.

From the perspective of the health care provider, there is a range of possible legal concerns. First, to what extent do the U.S. Constitution and any other laws (federal, state, local) allow an individual or institutional provider to decline services because of religious beliefs? Second, to what extent must a health care institution accommodate an employee who has a religious objection to providing certain types of care? And third, what are their legal responsibilities to the LGBT patient?

With respect to religion, the First Amendment of the U.S. Constitution protects religious freedom and prohibits government interference and the establishment of a state religion.[53] The Fourteenth Amendment expands on this by prohibiting discrimination, specifically in relation to certain demographics, including religious affiliation. Essentially, this mandate requires equal protection and application of the law. The right to practice one's religion without fear of governmental intervention and discrimination is further guaranteed in the Civil Rights Act. Implemented in 1964, Title VII of the Civil Rights Act created the Equal Employment Opportunity Commission (EEOC), which protects employees from discrimination because of their sex, race, color, national origin, and religion.[54]

Although the protections of Title VII do not explicitly cover sexual orientation or gender identity, the EEOC has taken the position that "sex" encompasses sexual orientation and gender identity

since as early as 2012. The U.S. Supreme Court has also notably expanded the protections of Title VII to protect against gender stereotypes and same-sex sexual harassment in landmark cases such as Price Waterhouse v. Hopkins and Oncale v. Sundower. At the time of publication, the Supreme Court has agreed to hear a set of closely watched cases that hinge on whether gay and transgender workers are protected from discrimination under Title VII of the Civil Rights Act. The Court's decision is expected to have a great impact on the future of LGBT employment rights.

While the Obama Administration's Justice Department took the litigation position that the language of Title VII includes discrimination claims based on an individual's transgender identity, including transgender status, the Trump Administration has since reversed this policy, by amending federal data collection methods to exclude information on sexual orientation and gender identity (SOGI).[55] In May 2019, the Trump Administration also announced a final "conscience rule" which further expands healthcare workers' ability to deny a patient's medical care if it is not in line with their personal beliefs.[56] The rule, however, may be challenged in court; many groups oppose the new rule, arguing the provisions are overly broad and could imperil care for LGBT patients and their children, and for patients seeking reproductive health care.

Depending on how these complex situations are approached and addressed, the scales may be tipped favoring one of these constitutionally protected rights over the other. On the state level, we have seen laws implemented that prioritize one or the other of these Constitutional mandates (i.e., freedom of belief or equal protection). For example, lately we have seen a proliferation of state Religious Freedom Restoration Acts (RFRAs) that hold faith-based institutions and individuals exempt from charges of discrimination if their actions are motivated by their faith. Simultaneously, other states have passed non-discrimination legislation designed to protect the LGBT community in housing, employment, family law, and health care. Some states have shaped these laws with exemptions for the religious community and some have not.[57]

The United States affirms two core rights and freedoms that are relevant to this discussion—to be able to practice one's faith, and to be equally protected under the law. Sometimes, these mandates can complement each other, but other times, they conflict.[58] Consider a secular health care institution that provides certain services, like gender affirmation surgeries. The institution may have employees who object to providing these services due to religious reasons. Generally speaking, these employees are protected, and the institution is required to accommodate them (provided the accommodation does not cause the institution undue hardship). The question for the institution is how to respond to the needs of the patient in such circumstances. This question is even more challenging when the institution is faith-based. Yet, proactively seeking a resolution dedicated to providing equitable care, while also protecting an institution's and its employees' religious beliefs to the greatest extent possible, is the better practice in either institution.

Considering the mission of many faith-based hospitals is to provide care for those considered "underserved", this situation offers an opportunity for faith-based hospitals to rise to the occasion and fill this gap in care.

Demonstrating the Challenge: A Tale of Two States

Legal conflicts in two different states illuminate the difficult legal environment in which institutions operate.

In September 2014, a Michigan pediatrician refused to treat a newborn baby girl because the baby's parents are a same-sex female couple. Though the doctor had originally accepted the baby as a new patient, when she realized the parents were a same-sex couple, she reversed her decision, explaining that as a Christian she could not in good conscience take the baby as her patient. She explained to the parents that her conclusion was based on her understanding and practice of Christianity and her belief that homosexuality is a sin. She therefore decided, after praying and looking for guidance from her faith, that she should not be the baby's doctor. The baby's parents only learned of the physician's decision when they arrived for the appointment and were informed that another physician would be taking care of them. Although the family was referred to a new doctor in the practice, the parents decided to find another pediatrician (and practice) to care for their daughter.[59]

When this story hit the news, many people were outraged (indeed, as noted above, it is one of the reasons cited for anticipatory angst about using faith-based hospitals). The doctor's decision to decline to provide care triggered debates regarding state and federal anti-discrimination laws versus protections guaranteeing religious freedom. People started asking a number of questions - whether health care providers should be allowed to reject patients solely for religious reasons, thereby refusing to provide treatment; whether LGBT patients should have legal protection from this sort of discrimination based on their identity; and whether these decisions are best made by an individual health care provider, a health care institution, or the government. The debates have not yielded a consensus and states continue to take different approaches in answering such questions.[60]

In Michigan in 2009, a graduate student was expelled from a counseling program at Eastern Michigan University after she asked her superiors to refer a gay client to another counselor in the program. She issued this request because she felt that as a Christian, homosexuality is a sin and she did not want to affirm that "lifestyle" in any way. Due to her expulsion, the student then sued the University, claiming that she had been the victim of discrimination based on her religious beliefs.[61]

At first, the case was dismissed by the federal court, but then the U.S. Court of Appeals for the Sixth Circuit requested that the lower court rehear the case.[62] It was eventually settled out of court in 2012, but while the case was winding its way through the courts, the Michigan State Legislature became involved.[63] The legislature responded to the issue by creating religious freedom legislation, colloquially referred to as the "Julea Ward" Bill, named after the EMU graduate student.[64] As of this writing, Michigan state law now protects professionals in the counseling field from being sued when they refuse based on their religious beliefs to treat people.[65] Other states have followed suit.

Currently, fourteen states have some version of a law that exempts people with religious beliefs from having to adhere to anti-discrimination laws. Four states have religious exemptions for medical professionals who decline patients based on their LGBT identity.[66] These laws have yet to be examined by the U.S. Supreme Court.

California, for example, has a state civil rights statute that prohibits for-profit companies from discriminating against clients or patients based on sexual orientation. The statute does not authorize exemptions for religiously affiliated companies.[67] Thus, when a for-profit Christian fertility clinic declined to serve same-sex patients more than 10 years ago, a lesbian couple brought a lawsuit under the California law. After years of litigation, the couple prevailed, and the California State Supreme Court ruled against the Christian clinic. The decision was not appealed, but it is likely that the U.S. Supreme Court will one day take a similar case that determines whether state statutes designed to preclude the exercise of religious objections to providing health care are constitutional.[68]

Religious Accommodation vs. Equal Care

Institutions trying to serve patients and obey the law often find the law complex, nuanced, and not always intuitive. During his tenure as President, Barack Obama used his federal executive authority to ensure equal protection and care for LGBT people in instances where the provision of care conflicted with the religious beliefs of individuals or institutions. Many lower courts have followed this example. It is noteworthy that many of these protections are dependent on the Administration in power, as they were issued by Executive Order and can be rolled back. Indeed, the current Administration has made its own adjustments.

On January 18, 2018, the U.S. Department of Health and Human Services announced the formation of a new division within the HHS Office for Civil Rights called the Conscience and Religious Freedom Division. This new division is charged with enforcing existing federal laws that are currently designed to protect patients and providers of all religious backgrounds from religious discrimination in HHS-funded facilities. However, there has been controversy around this effort. While protection for religious freedom is critical, there are also concerns about whether religious freedom will be prioritized without fully protecting the provision of care to those otherwise denied it. For example, the AMA objected to a proposed notice of rulemaking designed to provide enhanced protections for conscience objections and the right for medical professionals to refuse to provide care. The AMA was troubled that the proposed rule could result in greater discrimination against vulnerable patients, and therefore urged that it be withdrawn.[69]

Given the critical but competing legal interests and the various ways that the laws are in play federally, at the state and local levels, through Executive Orders, via rulemaking and in the courts, one thing is clear. A lack of total clarity is likely to continue evading the health care and LGBT community, while litigation on this topic will likely persist for the foreseeable future.

So what are health care providers to do? We would suggest assessing missions and key goals, and then identifying likely challenges and planning how to address them.

One approach for accomplishing these ends, especially in the current legal environment, is to identify and anticipate situations where conflicts could arise and educate employees and the broader community about how and why decisions are made at the institution. When it comes to providing care for LGBT patients, this will involve educating and accommodating staff with transparency and consistency.

But first, there are steps that institutions can take to prepare themselves for this work.

Institutions can begin by clarifying the principles that will undergird their policies. For example, by delineating between caring for all patients (which is likely part of a faith-based institution's mission) and declining to do some procedures, an institution can follow its faith mandates and not discriminate against a person based on their identity.

Adhering to this practice clarifies that health care providers will not provide certain services, like in vitro fertilization, to anyone. As such, if they then refused to provide the service to LGBT patients, providers would not be discriminating against them based on their identity. There is a real distinction between refusing to provide a service at all, to any and all patients, and refusing to provide a service because of the patient's status or identity.

In general, there is less legal and professional support for denying a service to a patient based on their identity or status, than there is for denying the service to everyone. The American Medical Association states that a physician can ethically decline to enter into a doctor-patient relationship with a patient if the "specific treatment" requested conflicts with the physician's religious, personal, or moral beliefs. The physician may not however, refuse to provide treatment to a patient "because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination." [70, 71]

Second, leadership must carefully assess their justifications for which procedures will be deemed not in line with the mission of the institution. Then, they must educate everyone as to their rationale. If an institution has a mission-related objection to gender affirming surgeries, for example, the law is likely going to accommodate that. However, it has to be clear that the objection is really mission related. If an institution provides cosmetic breast surgery to cisgender men and women, it would be harder to argue that breast surgery for the transgender population should be excluded for mission-related reasons. Though we have not identified legal rulings on this issue as of this writing, we anticipate that courts are likely to uphold consistently applied and carefully delineated policies and procedures based on core values and the institution's mission.

Third, clarify the process for employees to raise faith-based objections to providing certain services. It is prudent to require employees to give advance notice of procedures that violate their religious beliefs. The institution should then explain that accommodations will be attempted, and should

consider clarifying that, in an emergency, employees may need to step in. Here, too, education and training can be helpful. Employees may not know, for example, that people in the LGBT community face challenges around access to health care. Helping employees understand the issues at stake can go a long way toward encouraging equitable health care to underserved populations.

Health care institutions that face these types of challenges should focus on managing health care providers' behavior or conduct at work, not their beliefs. That is to say, trainings and educational materials should focus on how providers are expected to behave toward their patients in the health care setting, instead of trying to change their minds or taking a position on the validity of their beliefs. In fact, health care institutions should have a code of conduct that specifies how providers and other staff are expected to treat patients and colleagues (i.e. treat patients and colleagues with respect, focus on the provision of care to patients, and do not create a hostile work environment). These codes and policies could then be referenced if a provider objects to treating LGBT patients.

Policies such as these will help provide a framework for whether a provider's refusal does or does not fall within the health care institution's accepted guidelines of professional conduct. In this way, providers' individual faith-based objections can be honored, while LGBT patients and families can maintain access to high-quality health care.

Institutional Recommendations: Current Practices that Work and Room to Grow

Given that many LGBT individuals feel anxiety and/or reluctance about accessing care at faith-based health care institutions, leaders in these institutions would do well to acknowledge, focus on, and take action to reach out to this community. One interviewee summarized the situation as follows:

"Faith-based institutions need to go over the top to demonstrate that we want [LGBT patients] to come and want [LGBT patients] to come out. Secular hospitals need to do this too but not to as great of an extent, because the barrier isn't there in the same way."

Another interviewee shared a story about a successful community outreach initiative in which a Catholic hospital participated in a local gay pride event, as part of the hospital's outreach plan. The institution's employees handed out merchandise with the hospital's logo. Our interviewee acknowledged that even though this may seem like a minor gesture, the reaction by the LGBT community at the parade was actually positive, indicating that positive change and interactions can begin with even the smallest efforts.

"Instead of asking questions like, 'Why is a Catholic hospital [at the parade]?' People instead tended to say things like, 'I was born at this hospital!'"

The interactions the hospital had with the LGBT community at the parade sent a message that was well received. The LGBT community recognized that the hospital wanted to remove barriers, dismantle negative stereotypes, and make connections with their community members. This outreach strategy conveyed a welcoming message that had a positive impact.

Good marketing is thus a critical part of any strategy for creating an inclusive environment for LGBT patients and families. External marketing, like advertising and participating in gay pride parades, is key for reaching the community and potential patients. Simultaneously, internal marketing is also necessary for reaching internal constituencies who provide care. This can include ensuring that frontline staff are trained to effectively welcome and care for LGBT patients and families; waiting rooms and other patient spaces reflect the diversity of the patient population; intake forms and electronic medical records appropriately capture the wide range of identities and sexual orientations that patients may have; and that all staff are informed of and trained to address LGBT patient challenges and care. This might include a poster displaying a same-sex family, a pride or safe space sticker, a flyer or health pamphlet tailored to LGBT patients, or inclusive signage for bathrooms and patient rooms. Such additions to a hospital's public spaces can convey that this is an environment where LGBT patients and their families can feel safe and properly cared for.

Many of the faith-based hospitals with which we spoke had engaged in some of these internal and external messaging strategies. Yet, they also struggled with how "far" to go, or as one interviewee put it, how "out" they could and should be. In one case, the hospital leadership at a faith-based institution expressed discomfort in posting fliers with same-sex families in patient spaces, despite their interest in engaging and serving the LGBT community. In cases like this, tension points are evident. There is a desire to create a welcoming space but adding a picture of a same-sex couple can challenge the institution's, leaders or other constituents' beliefs. These can be hard decisions. However, when they are not implemented, the ability to dismantle stereotypes of LGBT persons is more limited and it can be harder to create the welcoming environment needed to address anxieties experienced by LGBT patients.

Patients form impressions at the first point of contact. For some, this point of contact may be a telephone call; for other patients, it may be when they step through the front door. This is why creating an inclusive physical environment requires a comprehensive plan with ongoing evaluation. At any point, an LGBT patient's negative experience can influence their impression of the entire institution and possibly trigger deeply held concerns about how they will be treated. For example, if registration forms only allow for identifying marital status as married, single, divorced, or widowed, or only include the binary categories of male or female to identify gender, LGBT people and families may not find themselves represented. This can cause distrust and might prevent the institution from acquiring information necessary to provide patient-centered care.

Tailoring intake admissions and processes to acknowledge and include LGBT patients and families provides a signal to these patients that the institution respects who they are and how they identify. In fact, creating an environment that assumes a wide variety of diversity, including diversity in

sexual orientation and gender identity, is one way to help patients and families of minority identities feel safe in the health care setting. If they feel safe, patients and families will likely feel more comfortable sharing personal information that may be important for their diagnosis, treatment, and care management. Additionally, an environment with visibly and experientially inclusive non-discrimination policies, including staff who are trained to identify and use appropriate gender pronouns, supports the dignity and respect of LGBT patients.

While some LGBT people are religious, others are not. Given that reality, and the concerns that many LGBT patients have with respect to their care and treatment at faith-based institutions, it is worth noting that religious symbols and icons may have an impact. A recent study conducted at the University of Manitoba regarding the experience of LGBT individuals in health care settings noted, "[o]ne particularly interesting thing was that people were disturbed or put off by religious iconography, such as crosses, in hospitals and clinics."[72] As such, it stands to benefit institutions to carefully consider the placement of such symbols, including how they represent the institution's values, and how they may impact the incoming patient population.

Once appropriate placement is settled, it is also important for institutions to establish best practices and policies for navigating tensions that may still emerge, ideally in a way that still respects and upholds their core mission and identity as well as that of the patient raising the issue. For example, if a patient is uncomfortable in their assigned room due to the religious icons, greater comfort and ease can be created if an icon is covered or removed. Without altering an institution's identity, this policy can acknowledge the hospital's identity, beliefs, and values as well as its commitment to welcoming and serving all patients.

Training and Education

The majority of our interviewees stated that non-discrimination policies are key and must be implemented to support and protect LGBT patient care. For policies to be fully institutionalized, however, it is important to train and educate providers, hospital management and staff, and hospital visitors about LGBT patient care and the policies to ensure that all are treated with dignity and respect. Such training should include issues like the unique health risks and challenges experienced by lesbian, gay, bisexual, and/or transgender patients; appropriate behavior and language when interacting with LGBT patients; and clarification of what procedures and practices the hospital will and will not do, thereby promoting full transparency and better patient-centered care.

"There is a need for education of colleagues and a need for education of visitors that come to the hospital."

"… [S]ometimes because nurses and front desk staff are scared and don't know how to appropriately address LGBT patients and families, there's a tension that the patients and families can feel."

To be effective, the policies and institutional values of health care institutions must be understood and implemented broadly and consistently by all hospital staff. Employees must understand what is expected of them, particularly as it relates to interacting with and appropriately caring for LGBT patients and families. This includes how the values of their faith-based health care institution, values so often connected to compassion and dignity, are reflected in institutional policies on non-discrimination, visitation, and advanced directives.

Training hospital staff and care professionals can help ensure institutional values are practiced. It can also help health care providers recognize and respond to the specific challenges that LGBT patients and families may be facing. Trainings can help staff better understand the anxiety some patients feel about anticipated treatment and their concerns about barriers to care as well as health disparities experienced by different demographics. It can also prepare them for how to appropriately behave and provide patients with equitable care. Implementing ongoing practical training and education for all hospital employees is also an important signal for employees that competent and respectful care of LGBT patients and families, as with all patients, is a skill set that is valued and expected by the institution and leadership.

Effective training can have other benefits as well. It can help to operationalize the institutional mission and policies of the hospital or health system, specifically as it relates to health equity for LGBT patients. Such training opens the door for health care providers who experience tension between their religious beliefs and caring for LGBT patients and families to fully express their concerns, while simultaneously clarifying and reinforcing the institution's policies for managing professionalism and conscience.

Keep the Conversation Going: Change Requires Ongoing Dialogue

To be sure, there are real challenges for faith-based health providers when their religious beliefs conflict with their goal of providing quality health care. That is precisely why ongoing trainings and creating an institution that is a continuum of learning is so important.

When hospital leadership creates safe spaces, practices and strategies for improving care for LGBT patient populations, dialogue that is more open is possible. Through increasingly open conversations, tensions can surface and be addressed as well as suggestions for creating and sustaining an inclusive environment for diverse patient populations.

One of our participants, who works at a faith-based hospital in a leadership role, specifically noted the importance of addressing areas of tension "because those are the areas where change is required." Ignoring or avoiding conversations that are deemed too controversial or highly charged only aggravates and entrenches those issues further.

Beyond these internal conversations, several individuals in leadership recognized that there is also value in expanding the community. They recommended creating a network with other faith-based health care institutions where they could share challenges, success stories, resources, better practices and generally engage in open dialogue.

Next Steps: Creating a More Equitable Health Care System

Though our interviewees generally believed that the LGBT community avoids faith-based health care, there was a striking conviction that emerged in their comments. As a group, interviewees felt that once LGBT individuals came through the doors of a faith-based health care organization, the majority of challenges they actually faced:

1. Were not specific to the faith-based institutions, but were also experienced by LGBT people at secular institutions; and

2. Were not specific to the LGBT community, such as certain restrictions around reproductive health, family planning services, and gender affirming treatments and surgeries.

Because of the Affordable Care Act, there has been a significant increase in the number of insured LGBT people. Yet, health disparities for lesbian, gay, bisexual, and transgender people still exist, putting those who identify as LGBT at a disadvantage. Creating a system of health care that is responsive to and respectful of the LGBT community is an important way to improve lesbian, gay, bisexual, and transgender health. Moreover, it is a good business decision. At this precarious time in the U.S. health care system, faith-based health care organizations are in a position to leverage their mission and significantly improve LGBT health and health care.

Bibliography

Allen, Samantha. “These Five Court Cases Could Change the Future of LGBT Rights.” The Daily Beast, July 7, 2018.

American Association of University Women (AAUW). “Know Your Rights: Title VII of the Civil Rights Act of 1964.” https://www.aauw.org/what-we-do/legal-resources/know-your-rights-at-work/title-vii/.

Ard, MD, MPH, Kevin L., and Harvey J. Makadon. “Improving the Health Care of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Understanding and Eliminating Health Disparities Improving the Health Care of Lesbian, Gay, Bisexual and Transgender.” National LGBT Health Education Center, The Fenway Institute, Fenway Health, 2012.

“Arlene’s Flowers v. Washington.” ACLU, June 19, 2018. https://www.aclu.org/cases/arlenes-flowers-v-washington.

Brydum, Sunnivie. “The True Meaning of the Word ‘Cisgender’.” The Advocate, July 31, 2015.

Burke, Sheila. “LGBT community braces for impact of new counseling law.” AP News, May 6, 2016.

Cahill, Sean, Tim Wang, and Bishar Jenkins. “Trump Administration continued to advance discriminatory policies and practices against LGBT people and people living with HIV in 2018.” The Fenway Institute (2019).

Cal. Gov. Code, § 12940, subd. (a).

Canestraro, Linda M. “Disparities in Care: LGBT Patients Often are Vulnerable, Marginalized.” Journal of the Catholic Health Association of the United States: Health Progress (July 2015).

Carabez, Phd, RN, Rebecca. Et al. ““Never in all my years…”: Nurses’ Education About LGBT Health.” Journal of Professional Nursing 31, no. 4 (July/August 2015): 323-29.

Center for Disease Control/National Center for Health Statistics. “Healthy People 2010.” November 6, 2015. Accessed November 6, 2015.

Creswell, Julie, and Reed Abelson. “New Laws and Rising Costs Create a Surge of Supersizing Hospitals.” New York Times, August 12, 2013.

Davenport, David. “The 1st Versus The 14th Amendments.” Forbes, October 18, 2017.

Department of Health and Human Services. “Protecting Statutory Conscience Rights in Health Care.” https://www.hhs.gov/sites/default/files/final-conscience-rule.pdf

Equal Employment Opportunity Commission. “Title VII of the Civil Rights Act of 1964.” https://www.eeoc.gov/laws/statutes/titlevii.cfm

Ethical and Religious Directives for Catholic Health Care Services. Washington, D.C.: United States Conference of Catholic Bishops, 2018.

“Family Acceptance of LGBT Adolescents Protects Against Depression, Substance Abuse and Suicidal Behavior.” Family Acceptance Project, December 6, 2010.

“First Amendment: An Overview.” Legal Information Institute, Cornell Law School, June 2017, www.law.cornell.edu/wex/first_amendment.

Gates, Gary J. “In U.S., More Adults Identifying as LGBT.” Gallup, January 11, 2017.

Hahn Chaet, MSB, Danielle. “AMA Code of Medical Ethics’ Opinions Related to Discrimination and Disparities in Health Care.” AMA Journal of Ethics 18, no. 11 (November 2016): 1095-97.

Harrison, Brian F., and Melissa R. Michelson. Listen, We Need to Talk: How to Change Attitudes About LGBT Rights. N.p.: Oxford Scholarship Online, 2017.

"Healthcare Equality Index 2018." Human Rights Campaign Foundation, 2018.

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. (Pg. 149-150)

"Julea Ward, Michigan Counseling Student Expelled for Gay Views, Wins Settlement." Huffington Post: Queer Voices, December 11, 2012.

Hafner, Katie. "As Catholic Hospitals Expand, So Do Limits on Some Procedures." New York Times, August 10, 2018.

"HHS should withdraw proposal on health care conscience rights." American Medical Association (April 6, 2018).

Hiltzik, Michael. "Hoag's underhanded abortion ban." Los Angeles Times, June 21, 2013.

Hosanna-Tabor Evangelical Lutheran Church and School v EEOC, 132 S.Ct. 694 (2012).

Human Rights Campaign. "State Map of Laws and Policies." http://www.hrc.org/state-maps/employment.

Kates, Jennifer, Usha Ranji, Adara Beamesderfer, Alina Salganicoff, and Lindsey Dawson. "Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S." Henry J Kaiser Family Foundation, May 3, 2018.

Kaye, Julia, Brigitte Amiri, and Louise Melling. "Health Care Denied." American Civil Liberties Union, May 2016.

"Manitoba LGBT Women Report Homophobia in Health Care System." CBC News, February 12, 2016.

Martin, Nina. "Catholic Hospitals Grow, and With Them Questions of Care." ProPublica, October 17, 2013.

Miles, M. and A. Huberman (1984). Qualitative data analysis: a sourcebook of new methods. Newbury Park, CA, Sage Publications.

Minemyer, Paige. "Number of Catholic Hospitals in US has grown 22% since 2001." Fierce Healthcare, May 5, 2016.

Movement Advancement Project. "Equality Maps: Religious Exemption Laws." http://www.lgbtmap.org/equality-maps/religious_exemption_laws .

Movement Advancement Project. "Equality Maps: State Non-Discrimination Laws." http://www.lgbtmap.org/equality-maps/non_discrimination_laws.

Office of the Attorney General. "Revised Treatment of Transgender Employment Discrimination Claims Under Title VII of the Civil Rights Act of 1964." https://www.justice.gov/ag/page/file/1006981/download

Oppeneheimer, Mark. "A Counselor's Convictions Put Her Profession on Trial." The New York Times, February 3, 2012.

"Patient satisfaction now factors into Medicare reimbursement." American Nurse Today 7, no. 10 (October 2012).

Patton, M. (1990). Qualitative evaluation and research methods. Newbury Park, Sage Publications.

Pérez-Stable, M.D., Eliseo J. “Director’s Message: Sexual and Gender Minorities Formally Designated as a Health Disparity Population for Research Purposes.” National Institute on Minority Health and Health Disparities. Accessed October 6, 2016.

Phillip, Abby. “Pediatrician refuses to treat baby with lesbian parents and there’s nothing illegal about it.” The Washington Post, February 19, 2015.

Ryan, Caitlin, et al. “Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults. Pediatrics 23 (1) (2009); 346-352

Sands, David. “Julea Ward Bill Passed in Michigan House Allows Religious Counseling Student to Deny Gay Clients.” Huffington Post, June 14, 2012.

Sears, Brad, and Lee Badgett. “Beyond Stereotypes: Poverty in the LGBT Community.” TIDES | Momentum (June 2012).

Sieczkowski, Cavan. “New Details Emerge About Roger Gorley’s Arrest For Refusing To Leave Sick, Gay Partner.” The Huffington Post, April 12, 2013. Updated February 2, 2013.

Stulberg, MD, MA, Debra B., Ryan E. Lawrence, MDiv, Jason Shattuck, MD, and Farr A. Curlin, MD. “Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care.” J Gen Intern Med 25, no. 7 (2010): 725-30.

Sullivan, JM. “An Opportunity for Positive Change.” Health Progress 74, no. 7 (September 1993).

Taylor, Marisa. “A Michigan doctor refuses to treat lesbian couple’s baby, citing religion.” Aljazeera, February 19, 2015.

Taylor, Paul, et al. “A Survey of LGBT Americans.” Pew Research Center, June 13, 2013.

The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and FamilyCentered Care for the Lesbian, Gay, Bisexual, and (LGBT) Community: A Field Guide. Oak Brook, IL, Oct. 2011. LGBTFieldGuide.pdf.

The United States Department of Justice. “Attorney General Holder Directs Department to Include Gender Identity Under Sex Discrimination Employment Claims.” https://www.justice.gov/opa/pr/attorney-general-holder-directs-department-include-gender-identity-under-sex-discrimination.

Thoreson, Ryan. “”All We Want is Equality”: Religious Exemptions and Discrimination Against LGBT People in the United States.” Human Rights Watch (February 19, 2018).

Trull, Armando. “Can MedStar Georgetown Deny Breast Implant to Transgender Woman?” WAMU 88.5 American University, June 22, 2015.

Ethical and Religious Directives for Catholic Health Care Services. Washington, D.C.: United States Conference of Catholic Bishops, 2018.

U.S. Census Bureau, 2010 American Community Survey.

U.S. Department of Health and Human Services, Office of Minority Health. “National Stakeholder Strategy for Achieving Health Equity.” National Partnership for Action to End Health Disparities, April 8, 2011.

Uslova, Georgeanne M., and Vania Leveille. “Worried About the Repeal of Obamacare? So Are We. Here’s Why.” ACLU, February 17, 2017.

van Ryn M, Saha S. “Exploring Unconscious Bias in Disparities Research and Medical Education”. JAMA.2011;306(9):995–996.

“What American Workers Really Think About Religion.” Tanenbaum Center for Interreligious Understanding, 2013.

Endnotes

1 Throughout this paper, we will refer alternatively to LGBT and LGB persons. We recognize that there is greater diversity within the community and that many now reference LGBTQ and LGBTQI when speaking about lesbian, gay, bi-sexual, transgender, queer, intersex persons. For purposes of this paper, our qualitative research was focused on an LGBT framework, and our findings are therefore framed in that context.
2 Allen, Samantha. "These Five Court Cases Could Change the Future of LGBT Rights." The Daily Beast, July 7, 2018.
3 Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission, 584 U.S. __ (2018)
4 "Arlene's Flowers v. Washington." ACLU, June 19, 2018. https://www.aclu.org/cases/arlenes-flowers-v-washington.
5 Throughout this paper, references are made to LGBT people, and on occasion LGB people. This is deliberate and occurs when we are making distinctions about how particular people within the diverse group of individuals called LGBT people are treated.
6 The term cisgender is typically credited to biologist Dana Leland Defosse. Quite simply, the word "cisgender" means the opposite of "transgender". A cisgender person is one who identifies with their biological sex, or the gender they were assigned at birth, whereas a transgender person is one who does not identity with their biological sex or the gender they were assigned at birth. "Cis" and "trans" are both Latin-derived prefixes, "cis" meaning "on this side of" and "trans" meaning "across, beyond, or on the other side of." Brydum, Sunnivie. "The True Meaning of the Word 'Cisgender'." The Advocate, July 31, 2015
7 Gender affirming care refers to services or procedures that transgender individuals can access which will allow them to express their gender in a way that is different from their sex or gender assigned at birth and more in line with their gender identity.
8 Hafner, Katie. "As Catholic Hospitals Expand, So Do Limits on Some Procedures." New York Times, August 10, 2018.
9 Miles, M. and A. Huberman (1984). Qualitative data analysis: a sourcebook of new methods. Newbury Park, CA, Sage Publications.
10 Patton, M. (1990). Qualitative evaluation and research methods. Newbury Park, Sage Publications.
11 Harrison, Brian F., and Melissa R. Michelson. Listen, We Need to Talk: How to Change Attitudes About LGBT Rights. N.p.: Oxford Scholarship Online, 2017.
12 The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and FamilyCentered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide. Oak Brook, IL, Oct. 2011. LGBTFieldGuide.pdf. (Pg. 1)
13 Pérez-Stable, M.D., Eliseo J. "Director's Message: Sexual and Gender Minorities Formally Designated as a Health Disparity Population for Research Purposes." National Institute on Minority Health and Health Disparities. Accessed October 6, 2016.
14 Kates, Jennifer, Usha Ranji, Adara Beamesderfer, Alina Salganicoff, and Lindsey Dawson. "Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S." Henry J Kaiser Family Foundation, May 3, 2018.
15 The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and FamilyCentered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide. Oak Brook, IL, Oct. 2011. LGBTFieldGuide.pdf. (Pg. 2)
16 Ard, MD, MPH, Kevin L., and Harvey J. Makadon. "Improving the Health Care of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Understanding and Eliminating Health Disparities Improving the Health Care of Lesbian, Gay, Bisexual and Transgender." National LGBT Health Education Center, The Fenway Institute, Fenway Health, 2012. (Pg. 2)
17 Gates, Gary J. "In U.S., More Adults Identifying as LGBT." Gallup, January 11, 2017.
18 ibid.
19 U.S. Department of Health and Human Services, Office of Minority Health. "National Stakeholder Strategy for Achieving Health Equity." National Partnership for Action to End Health Disparities, April 8, 2011. (Pg. 14)
20 U.S. Department of Health and Human Services, Office of Minority Health. "National Stakeholder Strategy for Achieving Health Equity." National Partnership for Action to End Health Disparities, April 8, 2011. (Pg. 20)
21 James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. (Pg. 103)
22 Ryan, Caitlin, et al. "Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults. Pediatrics 23 (1) (2009); 346-352
23 James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. (Pg. 93)
24 For example, transgender people with disabilities (42%) were more likely to have had at least one negative health care experience in the past year than respondents who did not identify as having a disability (30%), while Middle Eastern (40%) and American Indian (50%) transgender respondents reported the most negative experiences in health care settings. Notwithstanding this pattern, the Survey also revealed that transgender men (42%) report more negative experiences than transgender women (36%) and non-binary respondents (24%).
25 Minemyer, Paige. "Number of Catholic Hospitals in US has grown 22% since 2001." Fierce Healthcare, May 5, 2016.
26 Stulberg, MD, MA, Debra B., Ryan E. Lawrence, MDiv, Jason Shattuck, MD, and Farr A. Curlin, MD. "Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care." J Gen Intern Med 25, no. 7 (2010): 725-30.
27 Minemyer, Paige. "Number of Catholic Hospitals in US has grown 22% since 2001." Fierce Healthcare, May 5, 2016.
28 Martin, Nina. "Catholic Hospitals Grow, and With Them Questions of Care." ProPublica, October 17, 2013.

29 Creswell, Julie, and Reed Abelson. “New Laws and Rising Costs Create a Surge of Supersizing Hospitals.” New York Times, August 12, 2013.
30 Thoreson, Ryan. “”All We Want is Equality”: Religious Exemptions and Discrimination against LGBT People in the United States.” Human Rights Watch (February 19, 2018).
31 Uttley, MPP, Lois, and Christine Khaikin, JD. “Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report.” MergerWatch, 2016.
32 Kaye, Julia, Brigitte Amiri, and Louise Melling. “Health Care Denied.” American Civil Liberties Union, May 2016.
33 Ethical and Religious Directives for Catholic Health Care Services. Washington, D.C.: United States Conference of Catholic Bishops, 2018.
34 Hiltzik, Michael. “Hoag’s underhanded abortion ban.” Los Angeles Times, June 21, 2013.
35 “What American Workers Really Think About Religion.” Tanenbaum Center for Interreligious Understanding, 2013.
36 “Corporate Equality Index 2018.” Human Rights Campaign Foundation, 2018.
37 “Patient satisfaction now factors into Medicare reimbursement.” American Nurse Today 7, no. 10 (October 2012).
38 “Healthcare Equality Index 2018.” Human Rights Campaign Foundation, 2018.
39 “HEI Scoring Criteria.” Human Rights Campaign, 2019.
40 “Healthcare Equality Index 2018.” Human Rights Campaign Foundation, 2018.
41 Uttley, MPP, Lois, and Christine Khaikin, JD. “Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report.” MergerWatch, 2016.
42 Sullivan, JM. “An Opportunity for Positive Change.” Health Progress 74, no. 7 (September 1993).
43 Canestraro, Linda M. “Disparities in Care: LGBT Patients Often are Vulnerable, Marginalized.” Journal of the Catholic Health Association of the United States: Health Progress (July/August 2015).
44 Canestraro, Linda M. “Disparities in Care: LGBT Patients Often are Vulnerable, Marginalized.” Journal of the Catholic Health Association of the United States: Health Progress (July/August 2015).
44 Canestraro, Linda M. “Disparities in Care: LGBT Patients Often are Vulnerable, Marginalized.” Journal of the Catholic Health Association of the United States: Health Progress (July/August 2015).
46 Phillip, Abby. “Pediatrician refuses to treat baby with lesbian parents and there’s nothing illegal about it.” The Washington Post, February 19, 2015.
47 Sieczkowski, Cavan. “New Details Emerge About Roger Gorley’s Arrest For Refusing To Leave Sick, Gay Partner.” The Huffington Post, April 12, 2013. Updated February 2, 2013.
48 Taylor, Paul, et al. “A Survey of LGBT Americans.” Pew Research Center, June 13, 2013.
49 “Family Acceptance of LGBT Adolescents Protects Against Depression, Substance Abuse and Suicidal Behavior.” Family Acceptance Project, December 6, 2010.
50 Hafner, Katie. “As Catholic Hospitals Expand, So Do Limits on Some Procedures.” New York Times, August 10, 2018.
51 Ethical and Religious Directives for Catholic Health Care Services. Washington, D.C.: United States Conference of Catholic Bishops, 2018.
52 ibid.
53 Trull, Armando. “Can MedStar Georgetown Deny Breast Implant to Transgender Woman?” WAMU 88.5 American University, June 22, 2015.
54 “First Amendment: An Overview.” Legal Information Institute, Cornell Law School, June 2017, www.law.cornell.edu/wex/first_amendment.
55 Equal Employment Opportunity Commission. “Title VII of the Civil Rights Act of 1964.” https://www.eeoc.gov/laws/statutes/titlevii.cfm
56 Office of the Attorney General. “Revised Treatment of Transgender Employment Discrimination Claims Under Title VII of the Civil Rights Act of 1964.” https://www.justice.gov/ag/page/file/1006981/download
57 Department of Health and Human Services. “Protecting Statutory Conscience Rights in Health Care.” https://www.hhs.gov/sites/default/files/final-conscience-rule.pdf
58 Movement Advancement Project. “Equality Maps: Religious Exemption Laws.” http://www.lgbtmap.org/equality-maps/religious_exemption_laws.
59 Davenport, David. “The 1st Versus The 14th Amendments.” Forbes, October 18, 2017.
60 Phillip, Abby. “Pediatrician refuses to treat baby with lesbian parents and there’s nothing illegal about it.” The Washington Post, February 19, 2015.
61 See, Taylor, Marisa. “A Michigan doctor refuses to treat lesbian couple’s baby, citing religion.” Aljazeera, February 19, 2015.
62 Burke, Sheila. “LGBT community braces for impact of new counseling law.” AP News, May 6, 2016.
63 Oppeneheimer, Mark. “A Counselor’s Convictions Put Her Profession on Trial.” The New York Times, February 3, 2012.
64 “Julea Ward, Michigan Counseling Student Expelled for Gay Views, Wins Settlement.” Huffington Post: Queer Voices, December 11, 2012.
65 Sands, David. “Julea Ward Bill Passed in Michigan House Allows Religious Counseling Student to Deny Gay Clients.” Huffington Post, June 14, 2012.
66 ibid.
67 Movement Advancement Project. “Equality Maps: Religious Exemption Laws.” http://www.lgbtmap.org/equality-maps/religious_exemption_laws.
68 Cal. Gov. Code, § 12940, subd. (a).

69 This question of whether states must exempt faith-based institutions from antidiscrimination laws shows up in a wide variety of situations. May a state require Christian florists to serve LGBT customers? May a state require all publically funded hospitals to provide abortion and contraceptive services, even if the hospitals are faith-based? The Supreme Court is highly likely to answer these questions eventually but has thus far taken every opportunity to postpone a clear ruling. While current state and federal law authorizes institutions, in some cases, to refuse to provide abortions, for example, it is not at all clear that they could legally refuse to provide routine or other emergency medical treatments to LGBT patients or same-sex couples. There is a possibility that the Supreme Court justices will side with faith-based institutions for issues related to religiously motivated decisions to decline services but would conclude that principles of equal protection outweigh freedom of religion considerations with respect to the treatment of individuals.

70 "HHS should withdraw proposal on health care conscience rights." American Medical Association (April 6, 2018).

71 Hahn Chaet, MSB, Danielle. "AMA Code of Medical Ethics' Opinions Related to Discrimination and Disparities in Health Care." AMA Journal of Ethics 18, no. 11 (November 2016): 1095-97.

72 Taylor, Marisa. "A Michigan doctor refuses to treat lesbian couple's baby, citing religion." Aljazeera, February 19, 2015.

73 "Manitoba LGBT Women Report Homophobia in Health Care System." CBC News, February 12, 2016.