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BREAKING DOWN BARRIERS: AN ADMINISTRATOR'S GUIDE TO STATE LAW & BEST POLICY PRACTICE FOR LGBT HEALTHCARE ACCESS

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INTRODUCTION AND SUMMARY OF RECOMMENDATIONS

Lesbian, gay, bisexual and transgender ("LGBT") families often face discrimination when attempting to access the American healthcare system. This discrimination sometimes results in the denial of hospital visitation access and in various restrictions on the medical decision-making rights of LGBT families. Because visitation access and medical decision-making can become critical during emergency and end-of-life medical care, this disparate treatment can have tragic consequences for LGBT families.[1]

The problems confronting LGBT families in the American healthcare system are deeply rooted in bias and ignorance. Erasing these inequities requires a coordinated and multi-pronged response on the part of healthcare administrators, medical staff and the LGBT community. To identify policy solutions to these problems, the Human Rights Campaign Foundation ("HRC Foundation") administers the Healthcare Equality Index ("HEI"), an annual survey of healthcare industry policies and practices related to LGBT individuals and their families. The goals of the HEI are 1) to benchmark healthcare facilities on identified best practices and policies with respect to equal treatment of LGBT individuals and families and 2) to share, implement and recognize these best practices with healthcare industry leaders.

Now in its fourth year, the HEI counts some of the world's most prestigious healthcare institutions as survey participants.[2] In 2009, for the first time in the history of the HEI, these

[1] *See, e.g., Langbehn v. Jackson Memorial Hospital*, Case No. 08-21813-CIV-JORDAN/McALILEY (Janice Langbehn and Lisa Pond were about to begin a family cruise with their three children in Miami when Pond suddenly collapsed; Jackson Memorial Hospital informed Langbehn she was in an antigay state and city and denied visitation access to see Pond for almost 8 hours). The case was dismissed in September 2009, but the hospital has implemented an explicitly inclusive visitation policy. The Lambda Legal Defense and Education Fund provides information on this case, available at http://www.lambdalegal.org/our-work/in-court/cases/langbehn-v-jackson-memorial.html.

[2] Among the HEI's many other illustrious participants, the HEI 2008 survey and the HEI 2009 survey collectively feature the nation's ten most prestigious hospitals (as measured by the U.S. News and World Report "Honor Roll" hospital rankings). These institutions are: Johns Hopkins Hospital, the Mayo Clinic, the Ronald Reagan UCLA Medical Center, the Cleveland Clinic, Massachusetts General Hospital, New York-Presbyterian University Hospital of Columbia and Cornell, the University of California San Francisco Medical Center, Brigham and Women's Hospital, Duke University Medical Center and the Hospital of the University of Pennsylvania. Additional "Honor Roll" participants include the University of Michigan Hospitals and Health Centers, Vanderbilt University Medical Center and Stanford Hospital and Clinics. The "Honor Roll" rankings represent the top 0.3% of the 5,453 medical centers rated by U.S. News and World Report, and are available at http://health.usnews.com/articles/health/best-

institutions provided documentation of their administrative policies relating LGBT healthcare access issues. This document summarizes our policy review findings and surveys relevant state medical law. We have benchmarked current practice and identified the best practices possible in the areas of visitation, advance healthcare directives, surrogate medical decision-making and parental consent for the treatment of a minor. Some areas are ripe for updates to hospital policy, while other areas lend themselves to improved staff-training programs; still other areas remain dominated by patchwork state law and are better addressed through further education. Although these areas comprise just a few of the issues requiring attention, each component piece is a valuable addition to the creation of the national standard for the equal treatment of LGBT families in the healthcare setting.[3]

We would like to express deep gratitude for the cooperation of participating hospital administrators and the unprecedented transparency of these institutions' sharing of policy. This collaborative effort provided the initial point of departure for creating the national standard for equal treatment. As each subsequent HEI survey provides more opportunity for collaboration and as state law embraces diverse family structures, the national standard for equal treatment will more fully develop.

Summary of Recommendations

After careful review of submitted hospital policies, conversations with hospital administrators and the HEI Advisory Council, and an in-depth examination of current state law, the HRC Foundation recommends that the following steps be taken by healthcare institutions to ensure the equal treatment of LGBT families in the healthcare setting:

- **Incorporate** an *explicitly* inclusive definition of "family" for visitation policy purposes.
- **Provide** training modules to staff bearing specifically on the importance of advance healthcare directives for LGBT families.
- **Offer** educational information specifically tailored towards LGBT individuals and families on advanced healthcare directives at the point of patient intake.
- **Update** any policies to reflect the most current advances in medical decision-making, relationship recognition, and parenting law for LGBT individuals and families.[4]

hospitals/2008/07/10/best-hospitals-honor-roll.html.

[3] The policy recommendations discussed throughout this document hold relevance for the entire lesbian, gay, bisexual and transgender community. This document's use of the term "same-sex" when describing relationships should not be interpreted as exclusive of transgender couples. A person's sexual orientation is distinct from a person's gender identity and expression. "Sexual orientation" refers to an individual's physical and/or emotional attraction to the same and/or opposite sex. "Heterosexual," "bisexual" and "homosexual" are all sexual orientations. The term "gender identity," distinct from the term "sexual orientation," refers to a person's innate and deeply felt psychological identification as male or female. This identification may or may not correspond to the person's body or assigned sex at birth (meaning the sex originally listed on a person's birth certificate). Just as the non-transgender community contains a diversity of sexual orientations, so too does the transgender community. Transgender individuals are often in, or perceived as being in, same-sex relationships and therefore often face barriers to hospital visitation or medical decision-making rights, in addition to other barriers stemming from their gender identity or expression.

[4] Please note that the impact of these recommendations on the HEI survey is made clear to HEI participants throughout this document.

Contextualizing the Problem: LGBT Families and the American Healthcare System

According to U.S. Census data, LGBT individuals belong to every racial, ethnic, religious, age and socioeconomic group in America.[5] Approximately 8.8 million lesbian, gay and bisexual adults live in America, comprising an estimated 3% of the total population.[6] LGBT individuals reside in every county in America and live in both urban and rural communities.[7] Like all Americans, LGBT individuals enter into deeply committed relationships and raise children. According to the American Community Survey, there are roughly 777,000 same-sex couples in the United States.[8] Nearly 20% of these same-sex couples are raising children under the age of eighteen, and approximately 270,300 children live within households headed by same-sex individuals.[9]

Although LGBT families constitute a substantial and representative portion of the American population, their experience with the American healthcare system has been distinctively problematic.[10] The historical classification of homosexuality as psychopathology laid the foundation for the LGBT community's deep distrust towards the medical profession.[11] While LGBT patients indicate an overwhelming preference to disclose their orientation to healthcare providers, strong majorities of LGBT individuals express deep reservations about "coming out" to their physicians.[12] Unfortunately, research vindicates this reluctance.[13] Even in relatively progressive urban centers, anti-LGBT attitudes continue to pervade the medical community.[14] This atmosphere of distrust and unease produces significant health disparities among the LGBT population. Research has consistently demonstrated a link between health problems and LGBT

[5] Adam P. Romero, Amanda K. Baumle, M.V. Lee Badgett & Gary J. Gates, *Census Snapshot*, The Williams Institute, December 2007, available at http://www.law.ucla.edu/williamsinstitute/publications/USCensusSnapshot.pdf.

[6] It should be noted that these statistics do not account for America's populations of transgender individuals and LGBT minors. *See* Gary J. Gates, *Same Sex Couples and the Gay, Lesbian, Bisexual Population: New Estimates from the American Community Survey*, The Williams Institute, October 2006, available at http://www.law.ucla.edu/williamsinstitute/publications/SameSexCouplesandGLBpopACS.pdf.

[7] *See* Romero et al., *supra* note 5, at 1 (discussing the geographic distribution of LGBT individuals).

[8] Gary J. Gates, *Geographic Trends among Same-Sex Couples in the U.S. Census and the American Community Survey*, The Williams Institute, November 2007, available at http://www.law.ucla.edu/williamsinstitute/publications/ACSBriefFinal.pdf.

[9] *See* Romero et al., *supra* note 5, at 2 (discussing the number of children parented by same-sex couples).

[10] *See* Ilan H. Meyer, *Why Lesbian, Gay, Bisexual and Transgender Public Health?*, 91 Am. J. of Pub. Health 856, 856-59 (2001); Laura Dean, Ilan H. Meyer, Kevin Robinson, Randall L. Sell, Robert Sember, Vincent M. B. Silenzio, Deborah J. Bowen, Judith Bradford, Esther Rothblum, Jocelyn White, Patricia Dunn, Anne Lawrence, Daniel Wolfe & Jessica Xavier, *Gay, Bisexual and Transgender Health: Findings and Concerns*, 4 J. Gay & Lesbian Med. Assoc. 102, 102-51 (2000).

[11] Homosexuality was considered psychopathology by medical practitioners from about 1900 to 1970, and the Diagnostic and Statistical Manual listed homosexuality as a type of mental illness until 1973. *See* Julie A. Greenberg, *Symposium: Therapeutic Jurisprudence: Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 Ariz. L. Rev. 265, n. 160 (1999).

[12] *See* Harvey J. Makadon, Kenneth H. Mayer, Jennifer Potter & Hilary Goldhammer, *The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*, American College of Physicians (2008) (citing Valerie A. Geddes, *Lesbian Expectations and Experiences with Family Doctors*, 40 Can. Fam. Physician 908-20 (1994)); Makadon et al., at 6 (citing Charles Marwick, *Survey Says Patients Expect Little Physician Help on Sex*, 281 J. Am. Med. Ass'n 2173, 2173-4 (1999)).

[13] *See, e.g.*, Katherine A. O'Hanlan, *Lesbian Health and Homophobia: Perspectives for the Treating Obstetrician/Gynecologist*, 18 Current Probs. Obs. & Gyn. 93 (1995); Susan D. Cochran & Vicki M. Mays, *Physical Health Complaints among Lesbians, Gay Men and Bisexual and Homosexually Experienced Individuals: Results from the California Quality of Life Survey*, 97 Am. J. of Pub. Health 2048, 2048-2055 (2001).

[14] *See* Katherine A. O'Hanlan, *Do We Really Mean Preventive Medicine for All?*, 12 Am. J. Prev. Med. 411, 413 (1996) ("In a survey of nearly one thousand southern California physicians, one third of physicians in primary care specialties were found to have significantly homophobic attitudes.").

individuals' reluctance to "come out" to their providers.[15] This negative and sometimes unwelcoming medical environment can result in LGBT individuals delaying medical treatment and in serious illnesses remaining undiagnosed.

Fortunately, strong efforts are underway to shift this pattern of mistreatment to a norm of sensitivity and compassion. The American Medical Association ("AMA") has promulgated at least 28 different policies bearing on the importance of culturally competent care that address the unique needs of the LGBT community.[16] Notable healthcare organizations have courageously and proactively addressed past mistreatment through policy innovation and staff training.[17] The Joint Commission (formerly The Joint Commission on the Accreditation of Healthcare Organizations) has approved updates to its hospital accreditation standards in the realm of LGBT culturally competent care.[18] These collective healthcare industry efforts complement the continuing advances in state law that confer dignity and legal protection on LGBT families. Perhaps most importantly, President Barak Obama issued a presidential memorandum in April 2010 requiring, in part, that hospitals that participate in Medicare or Medicaid must "respect the rights of patients to designate visitors" and they may not deny visitation access based on "race, color, national origin, religion, sex, sexual orientation, gender identity, or disability." In addition, it requires these hospitals to respect all patients' advance directives.[19]

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[15] *See, e.g.*, Susan D. Cochran, Colleen Keenan, Christine Schober & Vicki M. Mays, *Cancer-Related Risk Indicators and Preventive Screening Behaviors among Lesbians and Bisexual Women*, 91 American Journal of Public Health 591, 591-97 (2001) (concluding that lesbians and bisexual women differ from heterosexual women in patterns of health risk and remain at greater risk for chronic diseases linked to smoking and obesity, including cancers and owing partly to restricted access to healthcare).

[16] These AMA policies include "B-1.50 Discrimination," "B-6.524 Council on Ethical and Judicial Affairs," "D-65.995 Health Disparities among Gay, Lesbian, Bisexual and Transgender Families," "D-65.996 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population," "D-160.979 Health Care Disparities in Same-Sex Partner Households," "D-295.995 Adoption of Sexual Orientation Nondiscrimination and Gender Identity in LCME Accreditation," "D-515.997 School Violence," "E-9.03 Civil Rights and Professional Responsibility," "E-9.12 Patient-Physician Relationship: Respect for Law and Human Rights," "E-10.05 Potential Patients," "G-630.130 Discrimination," "H-60.940 Partner Co-Adoption," "H-65.976 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population," "H-65.979 Sexual Orientation as an Exclusionary Criterion for Youth Organization," "H-65.983 Nondiscrimination Policy," "H-65.990 Civil Rights Restoration," "H-65.992 Continued Support of Human Rights and Freedom," "H-160.991 Health Care Needs of the Homosexual Population," "H-180.980 Sexual Orientation and/or Gender Identity as Health Insurance Criteria," "H-185.950 Removing Financial Barriers to Care for Transgender Patients," "H-185.958 Equity in Health Care for Domestic Partnerships," "H-215.965 Hospital Visitation Privileges for GLBT Patients," "H-225.961 Medical Staff Development Plans," "H-270.997 Legal Restrictions on Sexual Behavior Between Consenting Adults," "H-295.878 Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education," "H-295.955 Teacher-Learner Relationship in Medical Education," "H-295.969 Nondiscrimination Toward Medical School and Residency Applicants," and "H-440.885 National Health Survey." These AMA policies are available at http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.shtml.

[17] *See* Kaiser Permanente National Diversity Council, *A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgendered Population* (2000).

[18] In January 2010 The Joint Commission approved a set of requirements pertaining to effective communication, cultural competence and patient-centered care. Several important areas of culturally competent care are addressed in these proposed requirements, including protecting LGBT patients from discrimination. More information is available at www.hrc.org/hospital_standards.

[19] *See* Presidential Memorandum – Hospital Visitation, April 18, 2010 http://www.whitehouse.gov/the-press-office/presidential-memorandum-hospital-visitation

Addressing the Concerns of Administrators

Throughout months of data collection and policy review, we remained in constant dialogue with the HEI Advisory Council and participating hospital administrators. We took the concerns of participants into account in formulating these initial recommendations. Many administrators voiced the opinion that their particular institution already operated in an LGBT-inclusive fashion and therefore required no further changes to their operations. We do not doubt the sincerity of these statements and look forward to a time when inclusive policy and practice become redundant. However, we continue to hear stories of tragedy. In the healthcare setting, justice delayed can be justice forever denied. Explicitly LGBT-inclusive policy language and LGBT-specific staff training decreases the possibility of staff members interpreting policies based on their own conscious- or subconscious-biases.[20] These recommended policies and training programs inform the baseline on which facilities are measured in the HEI survey.

Legal Disclaimer

While crafting a national standard for the equal treatment of LGBT individuals in the healthcare setting is necessary and worthwhile, it remains a difficult task in an area dominated by patchwork state law. None of the information contained in the HEI Reports or in this document constitutes legal advice. The legal issues discussed are overwhelmingly state-centric and compliance with these laws requires expert legal advice from practitioners licensed in the hospital's home state. As a final note, this policy review refers to submitted hospital policies only in general terms. We provided assurances to participating institutions that submitted policies would remain confidential and these assurances have been scrupulously honored. Exemplar policy language that is included within this document was only included with the express authorization of the participating institution and carries no identifying information.

VISITATION POLICY DISCUSSION

Visitation Policy Review Findings

Information collected pursuant to the HEI survey confirms that nearly all participating institutions recognize liberal visitation policies as a key component to the healing process. While hospitals generally respect a patient's right to select visitors, provision must also be made for contingencies where a patient loses the capacity to designate visitors. Our policy review has found that it is a best practice for a hospital to institute comprehensive and institution-wide visitation policies. These policies should define persons properly admitted as visitors and detail the scope of their access.

While our policy review reveals that visitation policies vary somewhat in specificity and scope, a

[20] The more explicit the policy, the better the policy ensures inclusion is translated into practice, protecting all patients' and families' rights. Furthermore, many healthcare institutions already have ensured equal treatment of LGBT individuals and families in the realm of patient non-discrimination policies by explicitly enumerating "sexual orientation" and "gender identity" as protected classes. This enumeration in non-discrimination policies as well as other policies aimed at ensuring the health and safety of all, such as anti-bullying policies, is a well-established practice. Leading medical associations such as the American Medical Association, California Medical Association and American Academy of Family Physicians have adopted policies that prohibit discrimination against the LGBT community by including the terms "sexual orientation" and "gender identity." *See, e.g.*, California Medical Association, *Mission and History*, available at http://www.cmanet.org/publicdoc.cfm?docid=10&parentid=1; American Academy of Family Physicians, *Discrimination, Patient*, available at http://www.aafp.org/online/en/home/policy/policies/d/discrimination.html.

general structure common to most policies emerges. This structure first establishes a definition of permitted visitors and then enumerates specific restrictions on an otherwise general grant of visitor access. Delineating permitted visitors is typically achieved by crafting a general definition of "family." After this definition of "family" identifies permitted visitors, many hospitals then list certain limits on visitor access. These restrictions flow from the security, health and operational concerns of the hospital. For instance, safety concerns prompt many hospitals to restrict access to sensitive units (e.g. obstetrics and psychiatry), while health concerns lead many hospitals to prevent recently ill visitors from interacting with the patient population.

Given that defining "family" is the critical point of departure in crafting visitation policy, it is essential to the equal treatment of LGBT individuals that healthcare institutions adopt an explicitly LGBT-inclusive definition of "family." Simply stated, "family" is greater than the sum of one's biological and legal relationships.

Our policy review indicates that many leading healthcare institutions have already enacted LGBT-inclusive definitions of "family," including hospitals located in states where LGBT individuals are otherwise afforded little in the way of legal protection. However, some hospitals continue to use either overly restrictive or amorphously broad definitions of "family." Several administrators also have opined that written visitation policies are unnecessary. As a matter of operational integrity, the practice of many hospitals demonstrates that well-crafted visitation policies anticipate future problems, provide guidance to staff and minimize friction down the line.

Visitation Policy Recommendations

The HRC Foundation encourages all healthcare institutions to embrace the example of their peers by adopting an explicitly inclusive definition of "family." The following definition of "family" reflects leading hospital policy provisions and incorporates the expert advice of healthcare providers, hospital administrators and legal counsel:

- [**HOSPITAL**] adopts the following definition of "**family**" for purposes of hospital-wide visitation policy: "**Family**" means any person(s) who plays a significant role in an individual's life. This may include a person(s) not legally related to the individual. Members of "**family**" include spouses, domestic partners, and both different-sex and same-sex significant others. "**Family**" includes a minor patient's parents, regardless of the gender of either parent. Solely for purposes of visitation policy, the concept of parenthood is to be liberally construed without limitation as encompassing legal parents, foster parents, same-sex parent, step-parents, those serving *in loco parentis*, and other persons operating in caretaker roles.

This definition of family was developed in consultation with the HEI Advisory Council, the Gay & Lesbian Medical Association and Joint Commission staff members. Like the majority of the definitions of "family" contained in submitted hospital policy, this definition establishes a broad and encompassing concept of family. The specifically enumerated members of family provide guidance to staff and prevent biased interpretation to the contrary. It should be noted that the concept of "domestic partners" contained in this definition encompasses not only domestic partnerships, but all legally recognized same-sex relationships, including civil unions and reciprocal beneficiary arrangements. The definition also focuses on a functional definition of parenthood as established by the individual's role as caretaker of a minor child. This is designed to ensure visitor access for the individuals most responsible for the care of a minor patient, even if this caretaker relationship lacks formal recognition under applicable state law.

This definition of "family" places hospital personnel on notice as to the unique nature of parenthood in the visitation context. While the definition requires that caretaker-individuals be granted access to visit minor patients, this caretaker status does not necessarily carry with it the rights that accompany legal parental status. For instance, applicable state law may dictate that only a biological or custodial parent may determine the course of medical care for a minor child.[21]

Implementation of Visitation Policy Recommendations

Depending on the participating hospital's existing policy design and institutional preferences, there are two principal avenues of compliance with this recommended standard:

- The hospital can include this definition of "family" within their existing stand-alone visitation policy.

- The hospital can explicitly incorporate this definition of "family" into their existing stand-alone visitation policy by direct reference to a companion "definitions" policy section, where this definition of "family" should be listed.

Questions in the HEI survey relating to visitation policy determine whether the participating institution has adopted this explicitly inclusive definition of "family" or a substantially similar definition. Substantially similar definitions must incorporate all of the above considerations in explicit fashion. The HEI survey requests documentation to identify this change in policy and to confirm staff training on this issue.[22]

SURROGATE MEDICAL DECISION-MAKING POLICY DISCUSSION

In the following discussion, surrogate medical decision-making refers to the legal procedures that are triggered by the mental incapacity of a patient and their subsequent inability to direct the course of their own medical treatment. Two major aspects of surrogate medical decision-making will be examined: advance healthcare directives ("AHD") and the default statutory law that selects a surrogate when an incapacitated patient lacks an AHD.

The Legal Context of Advance Healthcare Directives

In the following discussion, an AHD is understood generally to mean an individual healthcare instruction or a power of attorney for healthcare. Legal terms of art vary by state, but common names include healthcare powers of attorney, durable powers of medical attorney, healthcare proxies and living wills.[23] AHDs honor the right of a competent individual to control the course

[21] *See infra* notes 54-63 and accompanying text for a discussion on the parental right to consent for the medical treatment of a minor child.

[22] Since the release of the first edition of this paper, many HEI participants have updated their definition of "family" and/or their visitation policies in order to receive credit for the HEI-rated visitation policy questions. Notably, these participants include the Kaiser Permanente Network, one of the largest healthcare networks in the U.S., and Jackson Memorial Hospital (see note 1). The HEI 2010 report features all of these participants, indicating that they have achieved credit for HEI rating criteria 2a and 2b.

[23] Powers of medical attorney and healthcare proxies can include both the designation of a surrogate decision-maker agent as well as instructions for medical care preferences in the event of incapacity. In contrast, most living wills do not designate a surrogate agent and instead provide only for individual healthcare instructions in the event of incapacity. *Compare, e.g.*, Wisc. Stat. Ann. § 155.01 (2007) (durable power of medical attorney statute) *with* Wisc. Stat. Ann. § 154.01 (2007) (separate living will statute without provision for a surrogate decision-maker).

of their medical care in all circumstances, as well as the corollary right to designate agents to make these choices in the event of the individual's mental incapacity. An individual's instructions generally may extend to any healthcare decision that might arise. Unless limited by the principal in the AHD, a designated agent has the authority to make all medical decisions which the principal could have made.[24]

Every state has laws authorizing the use and regulating the scope of AHDs. This regulation often includes document drafting formalities, limits on the powers of designated agents and reciprocal recognition of AHDs executed in foreign jurisdictions.[25] Until relatively recent, state law bearing on AHD regulation remained haphazard, incomplete and sometimes internally inconsistent. Interstate legal conflicts relating to AHDs were common. In response to these problems, the National Conference of Commissioners on Uniform State Laws drafted a series of model legislative acts in the 1980s and 1990s to help standardize state AHD law.[26] While many states continue to vary in their treatment of AHDs, these model acts prompted a re-visitation of state law and much needed legislative changes. As a result, today's legal landscape governing AHDs is much more comprehensive and consistent across state lines.[27]

The Unique Importance of Advance Healthcare Directives to the LGBT Community

In light of the grave interests at stake, the right of every American adult to create an AHD and the obligation of every hospital to honor these documents is critically important. Individuals carefully draft their AHD to reflect personal preferences as well as nuanced religious and cultural beliefs. Since AHDs are triggered only at times of mental incapacity, individuals necessarily place tremendous trust in their designated agents, who will guide medical care at a time of the individual's utter vulnerability.

For the many Americans that fail to execute AHDs, default state medical decision-making law provides a safety net.[28] This default law provides a statutorily-prescribed list of potential surrogate decision-makers. If an incapacitated patient lacks an AHD, the healthcare provider selects the patient's default surrogate from this list. The composition of these lists reflects the presumption that the most appropriate default surrogate is the spouse of the incapacitated individual.[29] As just one of hundreds of perverse effects stemming from the lack of legal

[24] Many states place specific restrictions on the decision-making power of a surrogate agent. These restrictions stem from state public policy concerns. While the restrictions vary greatly by state, some common limits include preventing surrogates from authorizing psycho-surgery, sterilization, abortions, and admissions to mental health facilities. *See, e.g.,* Ala. Code § 26-1-2(g) (2010); Ark. Code Ann. § 20-13-104 (2008); N.H. Rev. Stat. Ann. § 137-J:5 (2010).
[25] In addition to applicable state law, the Patient Self-Determination Act of 1990 requires any institution receiving federal funds (Medicare or Medicaid) to provide information on AHDs to patients. 42 U.S.C.S. § 1395cc (f) (2009).
[26] The Uniform Law Commissioners drafted the Model Health-Care Consent Act in 1982. This model legislative act was followed by the Uniform Rights of the Terminally Ill Act in 1985 and the Uniform Rights of the Terminally Ill Act in 1989. In 1993, the Uniform Health-Care Decisions Act ("UHCDA") consolidated and superseded these three model legislative acts, providing a comprehensive treatment of AHD issues and default incapacitated decision-making law.
[27] The American Bar Association provides comprehensive legislative charts that detail state law differences in the areas of AHDs and default surrogate-selection law. Available at http://www.abanet.org/aging/legislativeupdates/home.shtml.
[28] Research suggests that while the percentage of Americans executing some form of AHD remains low, that number is increasing. The Pew Research Center conducted a 2005 survey which found that 29% of the American population currently had a living will. This represented a 17% increase from 1990, when only 12% of survey respondents reported executed living wills. Older individuals are much more likely to have living wills; persons aged 78-92 years and 63-77 years reported having living wills 58% and 49% of the time, respectively. This survey did not provide the sexual orientation of the respondents. The survey is available at http://people-press.org/reports/pdf/266.pdf.
[29] By way of example, the UHCDA provides the following default surrogate-selection priority list: "An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health-care provider. In the absence of a designation, or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in descending order of priority, may act as

relationship recognition, most same-sex couples are not protected by default surrogate-selection law.[30]

It is important to stress that same-sex couples do not seek "special treatment" for their AHDs. Instead, America's estimated 8.8 million lesbian, gay and bisexual adult individuals and 777,000 same-sex couples seek only equal treatment for their AHDs.[31] Every validly executed AHD, regardless of the sexual orientation of the principal or designated surrogate agent, deserves and legally demands equal recognition. Unfortunately, the HRC Foundation and other national LGBT organizations have documented tragic incidents involving hospital refusals to honor valid AHDs simply because the AHD involved same-sex couples.[32] While it is often clear that these healthcare providers violated state law, hindsight supplies cold comfort to the same-sex couples whose emergency and end-of-life treatment decisions were flagrantly disregarded.

Advance Healthcare Directive Policy Review Findings

Submitted hospital policies bearing on AHDs are often thoughtfully crafted and carefully treat most relevant issues. Many policies define the types of AHD that are acceptable in the hospital's particular legal jurisdiction. Since few states use mandatory AHD forms, policies supply staff with guidance on properly identifying the document-drafting formalities required of a valid AHD.[33] These policies also detail the process by which hospital staff should document an AHD within the patient's medical records. Policies often state the institution's commitment to provide care in the absence of an AHD.

Some of the most promising policies bearing on AHD recognition for same-sex couples confront the obstacles that can hinder recognition of such AHDs. These best practices concern *reciprocity* and *presumptive validity* of AHDs, as well as the *definition of designated agent*.

Reciprocity involves a hospital's recognition of an AHD that was executed in another state. In today's increasingly mobile society, the issue of recognizing foreign AHDs is common. The vast majority of states include statutory provisions relating to the reciprocity of AHDs.[34] While there is some state-to-state variation in the deference accorded to a foreign AHD, most jurisdictions direct healthcare providers to follow a foreign AHD to the same extent that the provider would follow a domestic AHD.[35] Below are two examples of submitted hospital policy language which treat AHD reciprocal recognition:

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surrogate: (1) the spouse, unless legally separated; (2) an adult child; (3) a parent; or (4) an adult brother or sister." The UHCDA is available at http://www.law.upenn.edu/bll/archives/ulc/fnact99/1990s/uhcda93.pdf.

[30] *See infra* notes 38-53 and accompanying text for a discussion on default surrogate-selection law and the failure of these laws to adequately protect the interests of same-sex couples.

[31] *See supra* notes 5-9 and accompanying text for demographic information on the LGBT population.

[32] *See, e.g., Flanigan v. University of Maryland Hospital System*, Circuit Court for Baltimore City, Maryland (2002) (hospital ignored durable power of attorney and denied Bill Flanigan access to his domestic partner until after partner had lost consciousness, preventing Flanigan from communicating his partner's wish to decline life prolonging treatment), information available at http://www.lambdalegal.org/our-work/in-court/cases/flanigan-v-university-of-maryland.html.

[33] Common AHD document drafting formalities include the requirement that the document be signed in writing by the principal in the presence of one or more witnesses, with accompanying restrictions on who can serve as a witness to an AHD. *See, e.g.*, Me. Rev. Stat. Ann. tit. 18-A, § 5-802 (2008); N.J. Stat. Ann. § 26:2H-56 (2009); Ga. Code Ann. § 31-32-5 (2010).

[34] *See supra* note 26 for the ABA's comprehensive charts on AHD state law.

[35] The following statutory language provides an example of a reciprocity provision: "A written advance health care directive or similar instrument executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction or of this state, is valid and enforceable in this state to the same extent as a written advance directive validly executed in this state." *See* Cal. Prob. § 4676 (2008).

- "A living will or other type of advance directive from another state, even though it does not meet the requirements of [HOME STATE], is legally valid and enforceable in [HOME STATE] if it satisfies the legal requirements of the state in which it was executed."

- "A patient may have completed an AHD in another state which follows that state's law. Healthcare personnel should generally follow such an AHD to the same extent that they would follow one completed in [HOME STATE]. Questions about out-of-state AHD should be referred to your administrative manager or the administrator on call after hours."

Presumptive validity involves the presumption that a presented AHD is valid in the absence of actual knowledge to the contrary. Many states include statutory provisions that establish a general policy of presumptive AHD validity, although these provisions are not as common as reciprocity provisions.[36] The following submitted hospital policy treats presumptive validity:

- "Ordinarily, all adult patients are presumed to be competent to execute and revoke a [AHD], and all [AHDs] are presumed to be valid, unless a court has determined otherwise."

Designated agent definitions involve delineating the persons who can be appointed as the designated agent in an AHD. State law is very consistent with these definitions. The general rule is that any competent adult can be appointed as the designated agent so long as that person is not employed by the relevant healthcare institution.[37] The following submitted hospital policy language treats designated agent issues:

- "Who may serve as agent: any competent adult may be an agent, EXCEPT THAT: a [HEALTHCARE INSTITUTION] employee cannot be appointed as an agent during the patient's hospitalization unless that administrator or employee is related to the patient by blood, marriage, or adoption."

Advance Healthcare Directive Recommendations

Because the recognition of AHDs places important interests at stake and since same-sex couples face uniquely harsh legal consequences when AHDs are not honored, healthcare institutions should take steps relating to AHD recognition to ensure the equal treatment of LGBT couples in the healthcare setting.

The above policies provide some example of best healthcare practices in the AHD arena. These express affirmations of the hospital's intent to honor every valid AHD are valuable and could prevent the tragedies stemming from the failure to recognize the AHDs of same-sex couples. However, many AHD-policies already express the institution's commitment to follow all

[36] The following statutory language provides an example of a presumptive validity provision: "In the absence of knowledge to the contrary, a physician or other health care provider may presume that a written advance health care directive or similar instrument, whether executed in another state or jurisdiction or in this state, is valid." *See* Cal. Prob. § 4676 (2008).

[37] The following statutory language provides an example of a designated agent definition provision: "Unless related to the principal by blood, marriage or adoption, an agent may not be an owner, operator or employee of a residential long-term health-care institution at which the principal is receiving care." *See* Me. Rev. Stat. Ann. tit. 18-A, § 5-802 (2008).

applicable state and federal AHD law.[38] These commitments would necessarily encompass the above legal concepts of reciprocity, presumptive validity and the definition of a designated agent.

While the current HEI survey does not request updates to AHD policy, it is extremely important that hospitals modernize their staff-training programs and educational materials to highlight the issue of AHDs for the LGBT community. Therefore, the HEI survey asks hospitals whether they provide training modules to staff that are specifically tailored to the special case of AHDs and same-sex couples. These training modules must make explicit mention of LGBT individuals and detail the unique consequences that can result from a failure to recognize the AHD of a same-sex couple. The training modules should reiterate the staff's duty to follow all applicable state and federal AHD law, especially in the areas of reciprocity, presumptive validity and the definition of designated agents. Hospitals participating in the HEI survey are required to provide details of these training modules, including the content and frequency of these trainings, as well information about staff participation.

The Legal Context of Default Surrogate-Selection Protocol

Patients have the right to control the course of their medical care. If the patient loses capacity, a judicially appointed guardian or an AHD-designated agent controls the course of the medical treatment. In the event that no appointed guardian or AHD exists, default medical decision-making law provides a mechanism for the selection of a default surrogate medical decision-maker. The composition of these prioritized lists of individuals reflects the presumption that family members remain the best situated to control the course of medical care for incapacitated patients.[39]

In contrast to largely standardized AHD law, default surrogate-selection law remains relatively incomplete and inconsistent across state lines. One persistent and critical difference between legal jurisdictions in this area is the composition of surrogate priority lists. Many states with LGBT relationship recognition laws list "domestic partner" at the same priority level as "spouse." A substantial number of states make provision for the use of a "close friend" category of individuals within their priority lists. This category typically is at the bottom of the list. In contrast, many other states make no provision for the "close friend" category of individuals, and instead restrict their priority list membership to those related to the patient by blood or marriage.

The Impact of Default Surrogate-Selection Law on the LGBT Community

Given that a strong majority of the population lacks AHDs, default surrogate-selection law continues to play an important role in the American healthcare system.[40] Current state default surrogate-selection law adequately addresses the needs of most different-sex couples. Unfortunately, default surrogate-selection priority lists—heavily focused on the surrogate's ties to the patient based solely on blood and marriage—fail to address the needs of the LGBT community. Research suggests that older LGBT individuals are often estranged from biological family and instead create "families by choice."[41] These LGBT individuals provide care for

[38] The following example of policy language expresses this general commitment to follow the applicable law regulating AHDs: "[HOSPITAL] complies with all state and federal regulations, accreditation requirements and court decisions regarding the right of an adult patient to make determinations about his or her medical treatment, and prohibits discrimination based on whether or not the patient has executed an advance directive for healthcare."
[39] *See supra* note 28 for an example of a surrogate priority list that emphasizes biological and familial relations.
[40] *See supra* note 27 for statistics on the number of Americans with some form of AHD.
[41] In 2005, MetLife conducted a survey of LGBT Baby Boomers. The results of this study revealed a high occurrence of care-giving among LGBT individuals. MetLife, *Out and Aging: The MetLife Study of Aging Lesbian and Gay Baby*

nonrelatives and partners at rates higher than the general population. In the vast majority of circumstances, these "families by choice" trigger neither the biological relationships nor the legal recognition of marriage that normally confer surrogate status on an individual.

Nationally, LGBT individuals face a confusing default surrogate-selection landscape that can be classified loosely into a Three-Tiered System. Tier 1 States offer some type of legal relationship recognition to LGBT couples. The surrogate priority lists in these relationship recognition states often place a same-sex spouse/domestic partner on substantially equal footing with a similarly-situated different-sex spouse.[42] Tier 2 States use surrogate priority lists which include the "close friend" category of individuals as a possible selection for surrogate.[43] Tier 3 States use surrogate priority lists which do not include the "close friend" class of individuals.[44]

Default Surrogate-Selection Policy Recommendations

The patchwork nature of default surrogate-selection law frustrates the creation of a national standard for the equal treatment of LGBT individuals in the healthcare setting. For purposes of the HEI survey, it is fundamentally unfair to hold hospitals located in Tier 3 States to the same comparative standard as hospitals located in LGBT-friendly Tier 1 States. Outdated default surrogate-selection law can prohibit the otherwise desired implementation of fair-minded hospital policies.[45] Legal liability concerns require that surrogate-selection hospital policies accurately reflect the content of state law.

In response to the inherent confusion of patchwork surrogate-selection law, a Three-Tiered System has been crafted. This system will place HEI-participating hospitals into three distinct tiers. A participating hospital's placement into a tier is determined by that hospital's home state law governing default surrogate-selection. The Three-Tiered System is designed to educate hospital administrators and to serve as a legislative resource.[46] A hospital's placement within the Three-Tiered System will be updated as further developments occur in relationship recognition

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Boomers (2006), available at http://www.asaging.org/networks/lgain/OutandAging.pdf. As reported in this survey, a substantial percentage of LGBT Baby Boomers cared for nonrelatives or partners. *Id*. at 8.

[42] An example of a default surrogate-selection priority list in a Tier 1 State is as follows: "In the absence of a durable power of attorney for health care…the following individuals, in the order of priority set forth below, shall be authorized to grant, refuse or withdraw consent on behalf of the patient with respect to the provision of any health-care service, treatment, or procedure: (1) A court-appointed guardian or conservator of the patient; (2) The spouse or domestic partner of the patient; (3) An adult child of the patient; (4) A parent of the patient; (5) An adult sibling of the patient." *See* D.C. Code § 21-2210 (2009).

[43] An example of a default surrogate-selection priority list in a Tier 2 State is as follows: "In the absence of a durable power of attorney for health care or the appointment of a guardian of the person, or if neither the attorney in fact nor guardian is available to consent, a health care decision for an incapacitated person may be made by the following persons or members of the incapacitated person's family who are available to consent, in the order stated: (1) The spouse, if not legally separated; (2) An adult child; (3) A parent; (4) An adult sibling; (5) A grandparent or an adult grandchild; (6) An adult aunt or uncle, adult cousin, or an adult niece or nephew; (7) Close friend." *See* S.D. Codified Laws § 34-12C-3 (2009).

[44] An example of a default surrogate-selection priority list in a Tier 3 State is as follows: "Any of the following persons, in order of priority stated, when persons in prior classes are not available or willing to serve, may serve as a surrogate pursuant to the provisions of this section: (1) A judicially appointed guardian; (2) The patient's spouse; (3) An adult child of the patient; (4) One of the patient's parents; (5) An adult sibling of the patient; (6) Any one of the patient's surviving adult relatives who are of the next closest degree of kinship." *See* Ala. Code § 22-8A-11 (2008).

[45] Healthcare providers that select surrogates outside the confines of the default priority lists could forfeit their liability shield for the medical decisions made by such surrogates. *See, e.g.*, Idaho Code § 39-4504 (3) (2008) (stating that in order to protect against civil liability, healthcare providers must obtain consent from a surrogate medical decision-maker in good faith compliance with state default surrogate-selection law).

[46] The Human Rights Campaign will continue to update the Three-Tiered System as further advances in relationship recognition and default surrogate-selection law arise. *See* http://www.hrc.org/issues/12648.htm. *See also infra* note 58 for additional information on state legislative developments in relationship recognition.

and medical decision-making law, so that administrators can utilize this resource to understand the proper time to update their policies on default surrogate-selection.

- **Tier 1: "LGBT-Inclusive" Surrogate-Selection States (14 States and the District of Columbia)** → California, Colorado, Connecticut, District of Columbia, Hawaii, Iowa, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New Mexico, Oregon, Vermont, Washington.[47]

- **Tier 2: "Second Class Status" Surrogate-Selection States (16 States)** → Alaska, Arizona, Delaware, Florida, Idaho, Illinois, Mississippi, New York, North Dakota, Pennsylvania, South Dakota, Tennessee, Utah, West Virginia, Wisconsin, Wyoming.[48]

- **Tier 3: "Legal Stranger Status" Surrogate-Selection States (20 States)** → Alabama, Arkansas, Georgia, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, Texas, Virginia.[49]

The Three-Tiered System places similarly-situated hospitals on comparative footing with one another and will inform the creation of a national standard for equal treatment of LGBT individuals. In the years ahead, the hospital's particular obligations to advance equal treatment of LGBT individuals in the healthcare setting will correspond to their placement within a given tier. It is important to stress that the Three-Tiered System is only a loose comparative structure. Even within these tiers, state law bearing on surrogate-selection varies.[50] However, the critical inquiry in the placement of states within these tiers is whether the state's default surrogate-selection law treats LGBT couples as substantially equal to different-sex couples. This is necessarily an intrastate inquiry, not an interstate comparison.

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[47] The following legal authority dictates a state's Tier 1 status: **California**: Cal. Prob. § 4716 (2008); **Colorado**: Colo. Rev. Stat. § 15-22-102 (2010); **Connecticut**: Conn. Gen. Stat. § 19a-571 (2007) and *Kerrigan v. Comm'r of Pub. Health*, 289 Conn. 135 (Conn. 2008); **District of Columbia**: D.C. Code § 21-2210 (2009); **Hawaii**: Haw. Rev. Stat. § 327E-5 (2008); **Iowa**: Iowa Code § 144A.7 (2008) and *Varnum v. Brien*, 2009 Iowa Sup. LEXIS 31 (Iowa Apr. 3, 2009); **Maine**: Me. Rev. Stat. Ann. tit. 18-A, § 5-805 (2008); **Maryland**: Md. Health-Gen. Code Ann. § 5-605 (2008); **Massachusetts**: *Goodridge v. Dep't of Pub. Health*, 440 Mass. 309 (Mass. 2003); **New Hampshire**: N.H. Rev. Stat. Ann. § 457.46 (2010); **New Jersey**: N.J. Stat. Ann. § 37:1-32 (2009); **New Mexico**: N.M. Stat. Ann. § 24-7A-5 (2008); **Oregon**: Ore. Rev. Stat. Ann. § 106.340 (2010); **Vermont**: Vt. S. 115 (2009); **Washington**: Wash. Rev. Code Ann. § 7.70.065 (2009).

[48] The following legal authority dictates a state's Tier 2 status: **Alaska**: Alaska Stat. § 13.52.030 (2009); **Arizona**: Ariz. Rev. Stat. Ann. § 36-3231 (2008); **Delaware**: Del. Code Ann. tit. 16, § 2507 (2009); **Florida**: Fla. Stat. § 765.401 (2008); **Idaho**: Idaho Code § 39-4504 (2008); **Illinois**: 755 Ill. Comp. Stat. 40/25 (2007); **Mississippi**: Miss. Code Ann. § 41-41-211 (2008); **New York**: N.Y. Pub. Health Law § 2965 (2007); **North Dakota**: N.D. Cent. Code § 23-12-13 (2008); **Pennsylvania**: 20 Pa. Cons. Stat. § 5461 (2008); **South Dakota**: S.D. Codified Laws § 34-12C-3 (2009); **Tennessee**: Tenn. Code Ann. § 68-11-1806 (2008); **Utah**: Utah Code Ann. § 75-2a-108 (2008); **West Virginia**: W. Va. Code § 16-30-8 (2008); **Wisconsin**: Wisc. Stat. Ann. § 50.06 (2007); **Wyoming**: Wyo. Stat. § 35-22-406 (2008).

[49] The following legal authority dictates a state's Tier 3 status: **Alabama**: Ala. Code § 22-8A-11 (2008); **Arkansas**: Ark. Code. Ann. § 20-9-602 (2008); **Georgia**: Ga. Code Ann. § 31-9-2 (2009); **Indiana**: Ind. Code Ann. § 16-36-1-5 (2009); **Kansas**: Kan. Stat. Ann. § 65-4974 (2007); **Kentucky**: Ky. Rev. Stat. § 311.631 (2008); **Louisiana**: La. Rev. Stat. Ann. 40:1299.58.5 (2008); **Michigan**: Mich. Comp. Laws Ann. § 333.5653 (2007); **Minnesota**: no applicable statute; **Missouri**: Mo. Rev. Stat. § 431.061 (2009); **Montana**: Mont. Code Ann. § 50-9-106 (2007); **Nebraska**: no applicable statute; **Nevada**: Nev. Rev. Stat. Ann. § 449.626 (2008); **North Carolina**: N.C. Gen. Stat. § 90-322 (2008); **Ohio**: Ohio Rev. Code Ann. 2133.08 (2009); **Oklahoma**: Okl. St. tit. 63, § 3102A (2008); **Rhode Island**: no applicable statute; **South Carolina**: S.C. Code Ann. § 44-66-30 (2007); **Texas**: Tex. Code Ann. § 166.039 (2007); **Virginia**: Va. Code Ann. § 54.1-2986 (2008).

[50] For example, many Tier 3 States only make provision for surrogate-selection for end-of-life medical care (not for normal medical care). *See, e.g.*, Mont. Code Ann. § 50-9-106 (2007); Nev. Rev. Stat. Ann. § 449.626 (2008).

While a participating hospital's placement within the Three-Tiered System does not currently trigger added HEI obligations, we encourage hospitals to review and update their existing AHD and surrogate-selection policies in light of a hospital's placement within a given tier.[51]

- **Tier 1: "LGBT-Inclusive" Surrogate-Selection States →** Recent political changes have brought rapid progress in the legal recognition of same-sex relationships. Hospitals located in Tier 1 States should keep abreast of these continuing judicial and legislative developments, and should incorporate relationship recognition law into any existing hospital policies.[52] For example, hospitals located in these states should update existing surrogate-selection priority lists to include newly recognized relationships (e.g. same-sex marriage, domestic partnerships and civil unions) at the appropriate surrogate priority level.

- **Tier 2: "Second Class Status" Surrogate-Selection States →** Hospitals located in Tier 2 States should review current protocol relating to the selection of surrogates. Particular attention should be paid to situations involving the obvious existence of a same-sex significant other who satisfies the "close friend" category of individuals.[53] While the hospital must comply with default surrogate-selection law, procedures should be in place to assist providers in efficiently proceeding through a priority list when a same-sex significant other is available and known to be the most knowledgeable person to make healthcare decisions on behalf of the incapacitated patient. For example, many default surrogate-selection statutes require the "close friend" individual to file an affidavit under penalty of perjury attesting to their close relationship with the incapacitated patient. Hospitals in Tier 2 States should keep form affidavits for this purpose on file and readily accessible in these situations.

- **Tier 3: "Legal Stranger Status" Surrogate-Selection States →** Hospitals located in Tier 3 States should educate LGBT individuals as to the consequences of Tier 3 State surrogate-selection law.[54] Because many LGBT individuals remain unaware of these state law distinctions, hospitals located in Tier 3 States should specifically target LGBT individuals for education on the importance of AHDs near the point of patient intake.

PARENTAL CONSENT FOR TREATMENT OF A MINOR POLICY DISCUSSION

Law of Medical Decision-Making Rights for Minor Children

American law provides adult patients with numerous avenues to control the course of their medical care. Adults can execute AHDs to designate a surrogate, and in the absence of an AHD default surrogate-selection law identifies a surrogate. However, minor children are expressly omitted from these medical decision-making schemes.[55] The law generally regards minors as

[51] HEI participants completing the survey on behalf of a larger healthcare network with facilities located in more than one state should ensure that each facility updates their policies in compliance with applicable state law and the Three-Tiered System.
[52] *See infra* note 56 for additional information on state legislative developments in relationship recognition.
[53] Depending on the factual circumstances and given the numerous preceding classes of individuals enjoying higher priority, same-sex partners in Tier 2 States have little chance to be designated as a "close friend" surrogate medical decision-maker for their incapacitated partner.
[54] Because no provision is made for the selection of a "close friend" category of individuals in Tier 3 States, same-sex partners in these states effectively have no chance to be designated as a surrogate medical decision-maker.
[55] Advance healthcare directive and default surrogate-selection law clearly state that only adults are covered by these statutory schemes. However, emancipated minors generally are covered by these schemes. Emancipated minor status is

mentally incapable of entering into important decisions.[56] For this reason, state law bearing on adults' medical-decision making rights is inapplicable to minors. Minors are not permitted to enter into AHDs and are not provided for in default surrogate-selection statutes.

In the case of minors, the general legal rule requires healthcare providers to secure the informed consent of a minor child's parent before embarking upon a course of medical treatment. The rule is derived both from constitutional and common law jurisprudence developed over centuries, as well as the general cultural norm that parents know the best course of action for their minor children.[57] Some states have statutorily codified the parental right to make medical decisions for their children.[58] However, many states do not bother to codify this parental right and it instead remains established in common law case precedent.

Patchwork Parenting Law for LGBT Families

For purposes of consent for the treatment of a minor child, defining "parent" is the determinative issue. Different legal jurisdictions recognize various individuals as "parents" in their law bearing on parental consent for the treatment of a minor child. These parental individuals could include biological parents, custodial parents, adoptive parents, foster parents, step-parents and those serving *in loco parentis*. In the case of "traditional" families, the general legal rule governing consent for the treatment of a minor child is often easily applicable in practice. However, as alternate forms of family continue to increase, simplistic common law rules formulated when "traditional" families where the overwhelming norm fail to address diverse family structures.

For LGBT families, the determination of parentage for medical consent purposes is complicated by the widespread variance in relationship recognition and adoption law. This patchwork state law produces uncertain outcomes, especially when same-sex couples secure relationship recognition and/or adoptions in one state and later move to a different state. Currently, five states and the District of Columbia permit same-sex marriage.[59] Seven states have at least some form of state-level relationship recognition.[60] In comparison to relationship recognition, the law of

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contingent on an individual's factual circumstances. Typical categories of emancipated minors include those minors that are married, divorced, parents, pregnant, living independently or as members of the armed forces. *See* Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 Am. J. L. & Med. 409, 422 (2002) (describing categories of individuals eligible for emancipated minor status).

[56] The Supreme Court of the United States has observed that a minor's lack of life experience necessarily limits the legal autonomy "for making life's difficult decisions." *Troxel v. Granville*, 530 U.S. 57, 68 (2000) (quoting *Parham v. J.R.*, 442 U.S. 584, 602 (1979)); *see also Tinker v. Des Moines*, 393 U.S. 503 (1969); *In re Gault*, 387 U.S. 1 (1967).

[57] Children were historically regarded as parent's chattels. As "owners," parents enjoyed both the benefits of having children and incurred the obligations in undertaking their care. The constitutional protections for these rights are deeply rooted in the common law. The parent's right to control the upbringing of their minor children was the first judicially identified fundamental liberty interest, stemming from the right to privacy. *See Troxel*, 530 U.S. at 66 (citing *Stanley v. Illinois*, 405 U.S. 645, 651 (1972); *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972); *Quilloin v. Walcott*, 434 U.S. 246, 255 (1978); and *Santosky v. Kramer*, 455 U.S. 745, 753 (1982)).

[58] There are several exceptions to the general rule requiring parental consent for the treatment of a minor. One exception to the rule of parental consent is that qualifying minors may provide consent for treatment of venereal or communicable sexually transmitted diseases. Some states permit adolescent minors to consent for treatment of substance abuse. Some states allow minors to consent to family planning and pregnancy related services. Some states permit minor consent for the treatment of sexual assault. *See* Hartman, *supra* note 54, at 416-22 (describing piecemeal legislative exceptions to general rule of parental consent for the treatment of a minor child).

[59] These states are Massachusetts (2004), Connecticut (2008), Iowa (2009), New Hampshire (6/2009), Vermont (as of 9/1/2009) and the District of Columbia (12/2009). The Human Rights Campaign provides legislative updates detailing the most current advances in relationship recognition law, available at http://www.hrc.org/issues/marriage/marriage_laws.asp.

[60] These jurisdictions are California (domestic partnerships—1999; partner rights subsequently expanded in 2005); Hawaii (reciprocal beneficiaries—1997); Maine (domestic partnership—2004); Nevada (domestic partnership—

adoption for same-sex couples is much less certain. Adoption proceedings are adjudicated on a case-by-case basis, granted at the discretion of a judge and necessarily fact-specific. Currently, 10 states and the District of Columbia allow same-sex couples to petition for joint adoption.[61] Additional states permit second parent adoptions for same-sex couples.[62]

Parental Consent for Treatment of Minor Children Policy Review Findings

Submitted hospital policies reveal a consistent approach to the issue of consent for the treatment of minor children. Most hospitals establish the baseline practice that a healthcare provider must obtain the informed consent of a minor child's parent prior to the commencement of medical treatment. Obtaining informed consent generally requires the healthcare provider to disclose a litany of information.[63] Once this consent is obtained, the healthcare provider must document the consent and include documentation in the medical records of the minor child. Many policies incorporate by reference the piecemeal legislative exceptions to the general rule which permit a minor to consent for their own treatment.[64] Some policies also include provisions to addressing contingencies where parents disagree on the proper course of treatment for a minor child.

For the purposes of the LGBT community, the most critical issue in these policies hinges on the definition of "parent." The hospital's determination of a putative decision-maker's parentage is the threshold question and all rights relating to control of a minor's medical treatment flow from that finding. Some institutions fail to define the term "parent," listing only the word "parent" without providing further guidance. Other institutions utilize a more traditional and restrictive definition of parent, typically centering on the biological or custodial parent. Several distinctive policies utilize more progressive ideas that address the realities of being a parent in modern America, including same-sex parents, foster parents, step-parents, and those serving *in loco parentis*.

6/2009); New Jersey (civil unions—2007); Oregon (domestic partnerships—2008); Washington (domestic partnerships—2007; partner rights subsequently expanded in 2009). In contrast, 29 state constitutions include amendments prohibiting same-sex marriage and 10 additional states have statutory bans on same-sex marriage. The Human Rights Campaign provides a comprehensive treatment of relationship recognition law, which is available at http://www.hrc.org/issues/marriage.asp.

[61] Joint adoption involves extinguishing the parental rights of biological parents and subsequently transferring these rights to a joint set of adoptive parents. Joint adoption is available to qualifying same-sex couples at a statewide level in the following jurisdictions: California, Connecticut, District of Columbia, Illinois, Indiana, Maine, Massachusetts, New Jersey, New York, Oregon, and Vermont. Two states (Nevada and New Hampshire) have authorized joint adoptions in certain jurisdictions, although not at a statewide level. The Human Rights Campaign provides a comprehensive treatment of LGBT parenting law, available at http://www.hrc.org/documents/parenting_laws_maps.pdf.

[62] Second parent adoption involves preserving the parental rights of one legal parent while also investing parental rights in a second legally recognized parent. Second parent adoption is available to qualifying same-sex couples at a statewide level in the following jurisdictions: California, Colorado, Connecticut, District of Columbia, Illinois, Massachusetts, New Jersey, New York, Pennsylvania, and Vermont. Second parent adoption is available to qualifying same-sex couples in select jurisdictions within the following states: Alabama, Alaska, Delaware, Hawaii, Iowa, Louisiana, Maryland, Minnesota, Nevada, New Hampshire, New Mexico, Oregon, Rhode Island, Texas, and Washington. The Human Rights Campaign provides a comprehensive treatment of LGBT second parent adoption, available at http://www.hrc.org/documents/parenting_laws_maps.pdf.

[63] To secure informed consent, submitted policies require providers to offer an explanation of the material risks and dangers of the proposed treatment, the benefits of the treatment and its likelihood of success, the medically acceptable alternatives to that treatment, and a description of the tasks comprising the treatment.

[64] *See supra* note 57 for details on these piecemeal legislative exceptions. In an effort to guide staff in this complex area, some policies utilize decisional matrices that anticipate various factual circumstances. Many policies also direct staff to contact legal counsel in the event of ambiguous factual circumstances.

Parental Consent for Treatment of Minor Children Policy Recommendations

In crafting the definition of "parent" for the purposes of consent for the treatment of minor children, hospitals face a clear conundrum. Institutions adopting a restrictive definition of "parent" could deny otherwise valid parental figures the prerogative to make medical decisions for their minor children. Institutions adopting a more expansive and LGBT-inclusive definition of "parent" could face higher legal liability exposure. In addition, these institutions could incur increased administrative costs in determining the parentage of non-traditional parental figures.

Because this area remains confusing for healthcare providers and sensitive from a legal liability perspective, the HEI survey will be a key tool in seeking additional data on this subject. The interaction of inconsistent substantive law on parental consent with disparate relationship recognition and adoption law creates an environment antagonistic to a national standard for the equal treatment of LGBT individuals. These permutations make it unfair to rate participating hospitals on issues outside of their control. Future HEI surveys will seek input from participants on more state-specific issues in the area of parental consent for the treatment of minor children.

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