SOCIAL JUSTICE, CIVIL RIGHTS, AND BIOETHICS

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I. INTRODUCTION

Originally intended as a keynote address, this Article responds to events unfolding during and since the time period in which the address would have occurred. That confluence of events compels discussion of bioethics in a broad sense, as a lens through which to work toward social justice in America. Each event on its own illustrates pervasive systemic prejudice against vulnerable people resulting in increased risk of death. Combined and situated among other similar incidents too numerous to mention here, they present an opportunity for bioethicists to help change the impact of implicit bias, white privilege, and prejudice in shaping the very ability to live a healthy life in America.

Participants in this symposium are writing their contributions to this issue of the *Stetson Law Review* against an especially chaotic and disturbing background. A worldwide pandemic of COVID-19—a potentially fatal respiratory illness disproportionately impacting certain vulnerable populations in the United States—prevented this symposium from proceeding in person on its originally scheduled date.[1] Serial incidents of law enforcement violence against Black Americans during this period prompted nationwide protests.[2] Furthermore, the Trump Administration took legal steps further injuring those populations and the transgender community, a unique subset of those affected by COVID-19 and law enforcement violence.[3] An examination of recent

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1. Derrick Bryson Taylor, *A Timeline of the Coronavirus Pandemic*, N.Y. TIMES (Dec. 28, 2020), http://www.nytimes.com/article/coronavirus-timeline.html?auth=login-email&login=email (noting that the U.S. Centers for Disease Control ("CDC") advised against gatherings of more that 50 persons in mid-March; this symposium was to take place in mid-April).

2. Kareem Abdul-Jabbar, *Don't Understand the Protests? What You're Seeing is People Pushed to the Edge*, L.A. TIMES (May 30, 2020), http://www.latimes.com/opinion/story/2020-05-30/dont-understand-the-protests-what-youre-seeing-is-people-pushed-to-the-edge.

3. Jesse M. Ehrenfeld & Patrice A. Harris, *Police Brutality Must Stop*, AMA (May 29, 2020), http://www.ama-assn.org/about/leadership/police-brutality-must-stop.

governmental actions taken to deny health care access to the latter group[4] demonstrates the need for a broad conception of social justice in health care, which can and should be part of bioethics' focus.

This time of upheaval arising from prejudice and bias calls on us to recognize the ways in which government policies disadvantage and even kill vulnerable populations in the United States. For example, COVID-19, combined with law enforcement violence, results in early death most crucially and cruelly for Black and Hispanic Americans.[5] The government encourages and enables healthcare-related prejudice against transgender individuals.[6] Writing about what he terms the moral determinants of health, former administrator of the Centers for Medicare and Medicaid Services Donald Berwick pulls many threads together with the following list:

> In the US at the moment, 40 million people are hungry, almost 600,000 are homeless, 2.3 million are in prisons and jails with minimal health services (70% of whom experience mental illness or substance abuse), 40 million live in poverty, 40% of elders live in loneliness, and public transport in cities is decaying.[7]

The current lack of care and even outright cruelty rendering a variety of vulnerable populations susceptible to early death illustrate why there must be more attention paid to social justice in the United States' politically determined health care *non-system*.[8] What Daniel Dawes labels as the political determinants of health—voting, government, and policy[9]—have fostered social injustices and have exacerbated health inequities. This Article will illustrate these inequities by focusing on the Trump Administration's actions that have undermined health care access for millions of Americans. While the U.S. Supreme Court has acted as a check on some of the Administration's

4. Scott James, *Coronavirus Economy Especially Harsh for Transgender People*, N.Y. TIMES (June 16, 2020), https://www.nytimes.com/2020/06/16/us/coronovirus-covid-transgender-lgbtq-jobs.html.

5. Ehrenfeld & Harris, *supra* note 3.

6. James, *supra* note 4.

7. Donald M. Berwick, *The Moral Determinants of Health*, 324 JAMA 225, 225 (2020), https://jamanetwork.com/journals/jama/fullarticle/2767353.

8. George B. Moseley III, *History of Medicine: The U.S. Health Care Non-System, 1908-2008*, 10 AM. MED. ASS'N J. ETHICS 324, 324 (2008), https://journalofethics.ama-assn.org/article/us-health-care-non-system-1908-2008/2008-05.

9. DANIEL E. DAWES, THE POLITICAL DETERMINANTS OF HEALTH 45 (2020).

more socially unjust positions,[10] there remains much work to be done regarding Americans' health, and bioethicists can help.

This Article addresses important health inequities in America today. First, it examines how current social upheavals illustrate their impact in America. Next, it explores one regulatory move that has almost been lost in the midst of a myriad of other pressing issues: the Trump Administration's claim of a clash of civil rights regarding transgender access to health care. Finally, this Article will conclude by urging those at the intersection of law, medicine, and bioethics to do what they can to lessen the impact of current events on these vulnerable populations.

II. POLITICAL DETERMINANTS OF HEALTH HELP SHAPE THE DISTURBING LANDSCAPE

"Political determinants of health involve the systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either advance health equity or exacerbate health inequities."[11] Inadequate governmental response to COVID-19, institutionalized violence against Black Americans, and governmental support of denying health care services to vulnerable populations such as the transgender community are three examples of political determinants.

First, COVID-19 provides a case study of the effect of institutionalized health inequities in our health care non-system. By late May 2020, it had killed more than 100,000 Americans, with a disproportionate impact on the frail, the elderly with co-morbidities, and the immuno-compromised.[12] It also had a disproportionate impact on communities of color, killing African-Americans at nearly twice the number as should be expected based on share of population,[13] and also affecting Hispanics/Latinos, Native Americans, and some Asian populations to a greater extent than whites.[14]

10. *See, e.g.*, Dep't of Homeland Sec. v. Regents of the Univ. of Cal., 140 S. Ct. 1891, 1912 (2020); Bostock v. Clayton Cty., 140 S. Ct. 1731, 1742 (2020).

11. DAWES, *supra* note 9, at 44.

12. *United States Coronavirus (COVID-19) Death Toll Surpasses 100,000*, CENTER FOR DISEASE CONTROL & PREVENTION (May 28, 2020), https://www.cdc.gov/media/releases/2020/s0528-coronavirus-death-toll.html.

13. Maria Godoy & Daniel Wood, *What Do Coronavirus Racial Disparities Look Like State by State?*, NPR (May 30, 2020, 6:00 AM EST), http://www.npr.org/sections/health-shots/2020/05/30/865413079/what-do-coronavirus-racial-disparities-look-like-state-by-state.

14. *Id.*

As COVID-19 spreads through the nation, concern about it began to recede into the background in the face of the second matter: concern about law enforcement violence shortening the lives of Black Americans. In early 2020, police in Louisville, Kentucky killed Breonna Taylor, who was Black, while executing a no-knock search warrant.[15] During that same time period, there were three police-involved Black deaths within eight hours in Indianapolis, Indiana.[16] These were not the only such incidents, as the case of Tony McDade, a Black transgender man killed in Tallahassee, Florida, demonstrates.[17] Then a Minneapolis policeman killed George Floyd, a 42-year-old Black man, while three other policemen watched and while Mr. Floyd and a crowd of bystanders pleaded for the officer to stop.[18]

Exposure to such institutional racism—and even depictions of it—can result in what psychiatrists term racial trauma or race-based traumatic stress: "[A] traumatic response to race-related experiences that are collectively characterized as racism, including acts of prejudice, discrimination, or violence against a subordinate racial group based on attitudes of superiority held by the dominant group."[19] Stemming from a history of systemic racism, and amid the recent series of well-publicized deaths, George Floyd's murder sparked nationwide protests born of long-simmering anger and frustration due to not only mistreatment but traumatization and neglect.[20]

The combined effect of COVID-19 and police violence on both Black and Latino communities rises to the level of a public health problem,

15. Richard A. Oppel, Jr., Derrick Bryson Taylor & Nicholas Bogel-Burroughs, *What to Know About Breonna Taylor's Death*, N.Y. TIMES (Jan. 6, 2021), http://www.nytimes.com/article/breonna-taylor-police.html.

16. Nicholas Bogel-Burroughs, *Indianapolis Police Face Growing Questions After Killing 3 People in 8 Hours*, N.Y. TIMES (May 7, 2020), http://www.nytimes.com/2020/05/07/us/sean-reed-indianapolis-shooting.html.

17. Meredith Deliso, *LGBTQ Community Calls for Justice After Tony McDade, a Black Trans Man, Shot and Killed by Police*, ABC NEWS (June 2, 2020, 10:55 PM), http://abcnews.go.com/US/lgbtq-community-calls-justice-Black-trans-man-shot/story?id=71022981. The death of Ahmaud Arbery at the hands of non-policemen while jogging in his neighborhood outside Brunswick, Ga., also contributed to the sharpening picture of violence facing the Black community daily. *George Floyd, Tony McDade, Sean Reed and Breonna Taylor*, S. POVERTY L. CENTER (June 1, 2020), http://www.splcenter.org/news/2020/06/01/george-floyd-tony-mcdade-sean-reed-and-breonna-taylor.

18. Evan Hill et al., *How George Floyd Was Killed in Police Custody*, N.Y. TIMES (May 31, 2020), http://www.nytimes.com/2020/05/31/us/george-floyd-investigation.html (last updated Nov. 5, 2020).

19. J. Corey Williams et al., *Witnessing Modern America: Violence and Racial Trauma*, 86 CLINICAL COMMENT. e41, e41 (2019) (quoting Monica T. Williams et al., *Assessing PTSD in Ethnic and Racial Minorities: Trauma and Racial Trauma*, 38 DIRECTIONS PSYCHIATRY 179, 181 (2018)).

20. Abdul-Jabbar, *supra* note 2.

according to the American Medical Association ("the AMA").[21] Calling excessive police force "a communal violence that significantly drives unnecessary and costly injury, and premature morbidity and death," the AMA reminds us that "[i]n any season, police violence is an injustice, but its harm is elevated amidst the remarkable stress people are facing amidst the COVID-19 pandemic."[22]

Finally, this Article addresses cases such as that of Mr. McDade, the Black transgender man in Tallahassee, which highlights an intersection of multiple stressors: race and gender identity.[23] COVID-19 complicates matters further, according to the *New York Times*; a recent article about the economic impact of the pandemic indicates that "[i]nequity has been even worse for transgender people of color, who face higher rates of poverty, homelessness, violence and H.I.V. infection."[24] The Williams Institute at the University of California Los Angeles considered economic factors along with a variety of health conditions and social vulnerabilities to estimate the number of transgender adults in the United States who are especially vulnerable to COVID-19.[25] It estimated that almost 320,000 transgender adults, for example, have asthma, diabetes, or heart disease or are living with HIV; all of those conditions increase vulnerability to COVID-19.[26]

Life in such a vulnerable position is stressful. As Ilan Meyer has written, "when [an] individual is a member of a stigmatized minority group, the disharmony between the individual and the dominant culture can be onerous and the resultant stress significant."[27] As a Black, transgender individual, Mr. McDade was part of at least two stigmatized groups and at risk for law enforcement violence, COVID-19's negative economic and health impacts, and minority stress.[28] He ended up dead, as do many people in his situation.[29]

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21. Ehrenfeld & Harris, *supra* note 3.

22. *Id.*

23. Deliso, *supra* note 17.

24. James, *supra* note 4.

25. Jody L. Herman & Kathryn O'Neill, *Vulnerabilities to COVID-19 Among Transgender Adults in the U.S.*, UCLA WILLIAMS INST. (April 2020), http://williamsinstitute.law.ucla.edu/publications/transgender-covid-19-risk/.

26. *Id.*; *COVID-19 and the Human Rights of LGBTI People: What is the Impact of COVID-19 on LGBTI People?*, UNITED NATIONS HUM. RTS. OFF. HIGH COMMISSIONER (Apr. 17, 2020), http://www.ohchr.org/Documents/Issues/LGBT/LGBTIpeople.pdf [hereinafter *Human Rights*].

27. Ilan H. Meyer, *Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence*, 129 PSYCHOL. BULL. 674, 676 (2003).

28. Deliso, *supra* note 17; Ehrenfeld & Harris, *supra* note 3; *Human Rights*, *supra* note 26.

29. *See Hate Violence Against Transgender Communities*, NAT'L COALITION ANTI-VIOLENCE PROGRAMS (2013), https://avp.org/wp-content/uploads/2017/04/ncavp_transhvfactsheet.pdf (stating that "[t]ransgender people of color were 6 times more likely to experience physical violence from the police compared to White cisgender survivors and victims"); *see also* Jamie Wareham, *One*

Recent legal developments have thrust one of Mr. McDade's stress-producing minority descriptors into the headlines. Between late 2019 and early 2020, the Trump Administration finalized two sets of regulations supporting prejudice against lesbian, gay, bisexual, and transgender ("LGBT") individuals within health care facilities.[30] Pursuant to those regulations, a LGBT victim of law enforcement or other prejudice-based violence who visits a hospital for their injuries may be refused and may even be deprived of information about where they can obtain treatment if the refusal is based on religious or moral objections.[31] Without diminishing the importance of the long-overdue efforts to eliminate systemic racism in matters affecting people's health,[32] this Article primarily will focus on the prejudice these regulations display toward transgender individuals. As illustrated by the case of Mr. McDade, that prejudice amplifies the impact of the other systemic failures at the root of the crises currently gripping the United States.[33]

III. ACCESS TO HEALTH CARE FOR TRANSGENDER INDIVIDUALS

Bioethicists may feel insulated from charges alleging collaboration in health inequities because upholding justice is one of their discipline's traditional principles.[34] Social justice is as important as distributive justice; indeed, interest in speaking out regarding social justice issues is

in Three Black Trans Youth Attempt Suicide, FORBES (Feb. 15, 2020, 10:47 AM EST), https://www.forbes.com/sites/jamiewareham/2020/02/15/one-in-five-black-trans-youth-attempt-suicide/#35df195943b3 (reporting on a study finding that about one-third of Black trans youth attempt suicide).

30. *See* Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170, 26,580 (May 21, 2019, corrected June 7, 2019) (to be codified at 45 C.F.R. pt. 88) (regarding rejection for religious or moral reasons); *see also* Nondiscrimination in Health Programs and Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts. 438, 440, 460; 45 C.F.R. pts. 86, 92, 147, 155, 156).

31. *See* Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. at 26,580 (to be codified at 45 C.F.R. pt. 88) (regarding rejection for religious or moral reasons). Those regulations permit such refusals with respect to other persons as well, but the relevant population for purposes of this Article is the transgender community. More broadly, the Administration also, shortly thereafter, robbed transgender individuals of protection against discrimination in the provision of health care based on their gender identity. Nondiscrimination in Health Programs and Activities, Delegation of Authority, 85 Fed. Reg. at 37,160 (to be codified at 42 C.F.R. pts. 438, 440, 460; 45 C.F.R. pts. 86, 92, 147, 155, 156).

32. *See* P. Braveman & S. Gruskin, *Defining Equity in Health*, 57 J. EPIDEMIOLOGY & COMMUNITY HEALTH 254, 254–56 (2003).

33. Ehrenfeld & Harris, *supra* note 3.

34. Tom Beauchamp & James Childress, *Principles of Biomedical Ethics: Marking Its Fortieth Anniversary*, 19 AM. J. BIOETHICS, Oct. 2019, at 9, 10, https://doi.org/10.1080/15265161.2019.1665402.

increasing among medical professionals.[35] By requiring that health care resources be distributed among patients as justly as possible, the traditional bioethics canon requires just access for persons in need of health care services, regardless of irrelevant considerations such as race, nationality, ethnicity, disability, age, or gender identity.[36] Social justice to eliminate prejudices underlying these considerations is necessary to assure distributive justice.

Just access should be equitable. "[E]quity in health is the absence of systematic disparities in health (or in the major determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige."[37] Writing on health equity, Braveman and Greskin consider all patients as having "the right to the highest attainable standard of health as indicated by the health status of the most socially advantaged group."[38]

Access to health care is necessary to achieve the highest attainable standard of health. To access health care in the United States, a person normally must be able to pay for it, either with cash or health care coverage.[39] Access to health care coverage is notoriously uneven in America; "approximately 137,600 transgender adults in the U.S. do not have health insurance."[40] An estimated 450,400 have not seen a doctor because of inability to pay, which may not be surprising when considering the estimated 667,100 who likely cannot afford it because they are living below 200 percent of the poverty level.[41] Someone in the most socially advantaged group of Americans would have sufficient cash or health care coverage to afford required health care.[42] Many transgender individuals in America do not.[43]

Similarly, someone in the most socially advantaged group of Americans would have available a sufficient supply of health care

35. Ruth Hailu, *A Reckoning for Health Care Professionals: Should They be Activists, Too?*, STAT (June 16, 2020), http://www.statnews.com/2020/06/16/doctors-protesting-racial-injustice/.

36. *See* Braveman & Gruskin, *supra* note 32, at 254–56.

37. *Id.* at 254.

38. *Id.*

39. *See* Roosa Tikkanen et al., *International Health Care System Profiles: United States*, COMMONWEALTH FUND (June 5, 2020), http://www.commonwealthfund.org/international-health-policy-center/countries/united-states (explaining payment options and noting that "[i]n addition, uninsured individuals have access to acute care through a federal law that requires most hospitals to treat all patients requiring emergency care, including women in labor, regardless of ability to pay, insurance status, national origin, or race").

40. Herman & O'Neill, *supra* note 25.

41. *Id.* At the time this data was collected, 200 percent of the poverty line was $25,520 per year for an individual living alone. *Id.*

42. David Mechanic, *Disadvantage, Inequality, and Social Policy*, 21 HEALTH AFF. 48, 50 (2002), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.21.2.48.

43. Herman & O'Neill, *supra* note 25.

providers to visit.[44] Yet, according to the Williams Institute, about 483,000 transgender adults worry that "if they express their gender identity, they could be denied good medical care."[45] A war over their access to health care is raging because we live in a time of increased attempts to impede access to health care based on providers' religious beliefs.[46]

Broadly speaking, the battle pits respect of religious liberty against transgender individuals' access to health care.[47] Here, the executive branch has "appropriate[d] the language of civil rights in the name of prejudice" in a regulatory struggle for the soul of health care access.[48] The government has announced multiple policies that directly and strikingly discriminate against transgender individuals, among others.[49]

Nearly four years ago, an executive order signaled that the "policy of the executive branch" would be "to vigorously enforce Federal law's robust protections for religious freedom."[50] Within that same year, 2017, the Department of Justice issued a memorandum instructing all federal departments "to implement and enforce all relevant religious freedom laws."[51]

The Department of Health and Human Services ("HHS") shortly thereafter created a Conscience and Religious Freedom Division within its Office of Civil Rights ("OCR").[52] The OCR characterized health care workers' rights to conscientiously object to the provision of care as

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44. Nancy E. Adler & Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies.*, 21 HEALTH AFF. 60, 68 (2002), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.21.2.60.

45. Herman & O'Neill, *supra* note 25.

46. *See* Julie Moreau, *'Religious Freedom' Rule Could Cause 'Significant Damage' to LGBTQ Health Care, Advocates Say*, NBC NEWS (May 4, 2019, 10:36 AM EDT), https://www.nbcnews.com/feature/nbc-out/religious-freedom-rule-could-cause-significant-damage-lgbtq-health-care-n1001996.

47. *See id.*

48. Kathy L. Cerminara, *Today's Crusades: A Therapeutic Jurisprudential Critique of Faith-Based Civil Rights in Health Care*, 13 ALB. GOV'T L. REV. 1, 6 (2020).

49. *See* Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170, 26,580 (May 21, 2019, corrected June 7, 2019) (to be codified at 45 C.F.R. pt. 88); *see also* Nondiscrimination in Health Programs and Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts. 438, 440, 460; 45 C.F.R. pts. 86, 92, 147, 155, 156).

50. Promoting Free Speech and Religious Liberty, Exec. Order No. 13,798, 82 Fed. Reg. 21,675, 21,675 § 1 (May 4, 2017).

51. Susan Morse, *Office of Civil Rights Final Rule Steps Up Enforcement of Conscience and Religious Rights*, HEALTHCARE FIN. (May 2, 2019), https://www.healthcarefinancenews.com/news/office-civil-rights-final-rule-steps-enforcement-conscience-and-religious-rights (discussing Memorandum from Jeff Sessions, Attorney Gen., U.S. Dep't of Justice, to Stakeholders, *Federal Law Protections for Religious Liberty* (Oct. 6, 2017)).

52. *HHS Announces Final Conscience Rule Protecting Health Care Entities and Individuals,* U.S. DEP'T HEALTH & HUM. SERVICES (May 2, 2019), https://www.hhs.gov/about/news/2019/05/02/hhs-announces-final-conscience-rule-protecting-health-care-entities-and-individuals.html.

"'civil right[s]'" and referred to such objectors as "'victims of unlawful discrimination.'"[53] It described statutory provisions setting forth those rights as "'conscience and antidiscrimination laws'" and made clear it would interpret them broadly.[54] The OCR has also taken steps to prevent a health care non-discrimination law from being interpreted to require service to transgender individuals.[55] Both actions improperly protect health care providers to the detriment of others.

A. Objections to Providing Health Care

Assertions of providers' religious beliefs standing in the way of patients' health care access date back at least to the 1960s and 1970s, when the United States Supreme Court first explained its understanding of fundamental constitutional rights to make decisions regarding whether to have children.[56] Since that time, with support from both legal and bioethics scholars, some health care professionals have refused to participate in practices violating their religious beliefs.[57] More recently, health care institutions and a variety of people working in health care other than health care professionals have been permitted to assert such objections.[58] This includes both for-profit and not-for-profit corporate entities seeking to advance their religious beliefs as part of their corporate purposes.[59] It includes not only physicians and nurses but also anyone who is asked to "assist in the performance of" activities to which they object on religious or moral grounds.[60]

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53. *HHS Takes Major Actions to Protect Conscience Rights and Life*, U.S. DEP'T HEALTH & HUM. SERVICES (Jan. 19, 2018), http://www.hhs.gov/about/news/2018/01/19/hhs-takes-major-actions-protect-conscience-rights-and-life.html.

54. Cerminara, *supra* note 48, at 17. The Office of Civil Rights ("OCR") always enforced these provisions, giving some credence to the *civil rights* characterization. *Id.*

55. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts. 438, 440, 460; 45 C.F.R. pts. 86, 92, 147, 155, 156).

56. *See* Roe v. Wade, 410 U.S. 113 (1973); *see also* Ronit Y. Stahl & Ezekiel J. Emanuel, *Physicians, Not Conscripts — Conscientious Objection in Health Care*, 376 NEW ENG. J. MED. 1380, 1380–81 (2017) (recounting history of such provisions beginning with the Church Amendment).

57. Stahl & Emanuel, *supra* note 56, at 1380–81.

58. *Id.* at 1381.

59. *See* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 688 (2014).

60. 45 C.F.R. § 88.3 (2019). *But see* Washington v. Azar, 426 F. Supp. 3d 704, 721 (E.D. Wash. 2019). This regulation was ruled unconstitutional and the case is up for appeal. The court in *Washington* stated:

> Finally, the Rule is arbitrary and capricious because HHS failed to conduct a reasoned analysis of the requirements of basic medical ethics in adopting the Rule. HHS failed to consider that the Rule's new statutory definitions, which would allow an employee to refuse to participate in life-saving treatment without notice and permits health care entities and

At the same time, the universe of activity in which health care workers may refuse to participate has expanded through the regulatory definition of what it means to "assist in the performance" of a procedure or activity.[61] That phrase "means to take an action that has a specific, reasonable, and articulable connection to furthering a procedure or a part of a health service program or research activity undertaken by or with another person or entity."[62]

Historically and ethically speaking, the activity in which a person could refrain from participating was a particular program or treatment violating their religious or moral beliefs.[63] For example, a nurse was protected if she objected to assisting in an abortion based on her religion, as long as the patient had another pathway to the care.[64] Under the new regulations, however, assisting in the performance of an activity "may include counseling, referral, training, *or otherwise making arrangements for the procedure or a part of a health service program or research activity*, depending on whether aid is provided by such actions."[65] Preparation of a room for a patient seeking an abortion is considered to be within the protected scope of activity.[66] Examples in regulatory comments, all involving abortion, illustrate what the government views as the line between refusals to participate that the rule protects and those it does not by reminding readers that the objections must be based on *articulable connections* to objected-to activity that are both *reasonable* and *specific*.[67] Nevertheless, the scope of objections that are protected are broader than they were both previously and historically.

Thus, what had previously been a right to object to participating in certain procedures has become an asserted right to object to more. For

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providers to withhold basic information from patients, would contravene medical ethics and deprive patients of the ability to provide informed consent.

Id.

61. 45 C.F.R. § 88.2 (2019).

62. *Id.*

63. Stahl & Emanuel, *supra* note 56, at 1381.

64. NANCY BERLINGER, *Conscience Clauses, Health Care Providers, and Parents*, *in* FROM BIRTH TO DEATH AND BENCH TO CLINIC: THE HASTINGS CENTER BIOETHICS BRIEFING BOOK FOR JOURNALISTS, POLICY MAKERS, AND CAMPAIGNS 35–40 (The Hastings Center, 2008).

65. 45 C.F.R. § 88.2 (emphasis added).

66. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170, 23,186–87 (May 21, 2018) (codified at 45 C.F.R. § 88). "*Health service program* includes the provision or administration of any health or health-related services or research activities, health benefits, health or health-related insurance coverage, health studies, *or any other service related to health or wellness, whether directly; through payments, grants, contract, or other instruments; through insurance; or otherwise*." *Id.* at 23,264 (first emphasis in original, second added).

67. *See id.* at 23, 186–87.

persons of some religions, "being transgender is deemed as 'unnatural' according to God and therefore a 'sin.'"[68] For those individuals, furthering the transgender individual's lifestyle is a sin, whether it involves treatment, a prescription, a procedure to which their religion objects, or more general treatment.[69] They argue that to take part at any step in the chain of causation leading to a sinful act means that the religious objector has become complicit in that act—and thus complicit in that sin.[70] The United States Supreme Court accepted this complicity-based objection, for example, as it held invalid penalties imposed on closely held, for-profit corporations for refusing to offer health plans covering certain contraceptives.[71] The religious belief underlying the objection was that the corporation would have been complicit in the sins committed by its employees, or its employees' spouses using contraception, if forced to offer those plans.[72] The corporations thus could not be penalized for refusing to offer such plans.[73]

B. Services Mandate

Another step in the movement to protect religious interests is not as obviously religious in nature. The OCR also proposed regulations governing Section 1557 of the Patient Protection and Affordable Care Act ("ACA") that eliminate protection for persons of fluid gender identity.[74] Section 1557 was historic, explicitly applying nondiscrimination law to health care for the first time ever, by providing that:

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68. *See, e.g.*, Moshoula Capous-Desyllas & Cecillia Barron, *Identifying and Navigating Social and Institutional Challenges of Transgender Children and Families*, 34 CHILD ADOLESCENT SOC. WORK J. 527, 539 (2017) (describing challenges for family with a transgender child stemming from religious beliefs "wherein being transgender is deemed as 'unnatural' according to God and therefore a 'sin.'"); *id.* at 536 (describing a religious family member as likely saying transgenderism was "against God's nature" and a friend as praying that a transgender child would "stop sinning").

69. *See* Kami Kosenko et al., *Transgender Patient Perceptions of Stigma in Health Care Contexts*, 51 MED. CARE 819, 821 (2013). Although the study did not investigate providers' motives for their actions, the study did find that "[o]ne in [five] problematic interactions reported by participants involved health professionals refusing to care for transgender patients. This included the providers' denial of desired medical treatments (eg, hormone treatments or referrals for gender reassignment) *and their refusal to meet or make appointments with transgender patients*." *Id.* (emphasis added).

70. *See generally* Capous-Desyllas & Barron, *supra* note 68, at 539.

71. *See* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 688 (2014).

72. *See id.* at 682, 702–03.

73. *Id.* at 682.

74. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts. 438, 440, 460; 45 C.F.R. pts. 86, 92, 147, 155, 156).

> Except as otherwise provided for in this title . . . an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 . . . title IX of the Education Amendments of 1972 . . . the Age Discrimination Act of 1975 . . . or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance. . . . The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.[75]

In the language adopting Title IX's concept of *sex*, the statute, for the first time, prohibited *health programs* (including health care providers and insurers) from discriminating "on the basis of sex."[76] Initially, regulations promulgated under Section 1557 defined "on the basis of sex" to include "discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, *sex stereotyping, and gender identity*."[77]

In 2019, however, in response to a judicial ruling, the HHS proposed drastic revisions to those regulations.[78] Significantly for the purposes of this Article, it proposed eliminating all definitions, including the definition of "on the basis of sex."[79] Thus, it "would entirely eliminate . . . specific provisions related to gender identity nondiscrimination."[80] Significantly, "[t]he preamble notes that covered entities can *choose* to grant protections to LGBT people but are not required to do so."[81] For example, such optional protections could not conflict with other federal laws, the HHS says, although the Supreme Court has since ruled that the term "on the basis of sex" includes gender identity for purposes of Title VII of the Civil Rights Act of 1964, a law to which Title IX of the Education Amendments of 1972 looks for interpretative guidance.[82] In other

75. 42 U.S.C. § 18116 (2018) (internal footnote references omitted).

76. *Id.*; 20 U.S.C. § 1681 (2018).

77. 45 C.F.R. § 92.4 (2016), *repealed by* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts. 438, 440, 460; 45 C.F.R. pts. 86, 92, 147, 155, 156) (emphasis added).

78. *See* Franciscan Alliance, Inc. v. Azar, 414 F. Supp. 3d 928 (N.D. Tex. 2019); Nondiscrimination in Health and Health Education Programs and Activities, Delegation of Authority, 85 Fed. Reg. at 37,161–62.

79. Nondiscrimination in Health and Health Education Programs and Activities, Delegation of Authority, 85 Fed. Reg. at 37,161–62.

80. Katie Keith, *HHS Proposes to Strip Gender Identity, Language Access Protections from ACA Anti-Discrimination Rule*, HEALTH AFF. (May 25, 2019), http://www.healthaffairs.org/do/10.1377/hblog20190525.831858/full/.

81. *Id.* (emphasis in original).

82. Bostock v. Clayton County, 140 S. Ct. 1731, 1737 (2020); Keith, *supra* note 80.

words, at this time of this writing, legal and medical pundits are in a state of suspended animation—of watchful waiting—regarding the actual state of the law of Section 1557.

Rather than commenting on the law surrounding it, this Article trains its sights on the Section 1557 gender identity issue as another indication of the increased protection being given to religious freedom at the expense of access to health care. One reason the lawsuit prompting revised Section 1557 regulations arose was that a group of religious health care organizations protested the definition of "on the basis of sex" as including gender identity.[83] They argued that the definition infringed upon their religious liberty to refuse to provide certain treatments (and perhaps to refuse to serve certain patients).[84] The argument is the flip side of the conscientious objection argument.[85] Specifically, these institutions use the conscientious objection regulations to assert religious or moral objections to providing procedures or treatments they view as sinful or serving someone whose lifestyle they view as sinful.[86] Here, in interpreting Section 1557, they object to a regulatory definition of "on the basis of sex" that would affirmatively require them to serve that population.[87]

Most striking is that OCR has narrowly interpreted the phrase "on the basis of sex" in Section 1557's regulations yet has emphasized its broad interpretation of the many statutory provisions it terms *conscience and anti-discrimination laws*.[88] OCR asserts both Section 1557 and the statutory conscience clauses are civil rights statutes.[89] With respect to the conscience clause provisions, the OCR has emphasized

83. *Franciscan Alliance, Inc.*, 414 F. Supp. 3d at 943.

84. *Id.*

85. *See generally* Stahl & Emanuel, *supra* note 56 (discussing the basis of the conscientious objection argument).

86. *See* Ishmeal Bradley, *Conscientious Objection in Medicine: A Moral Dilemma*, CLINICAL CORRELATIONS (May 28, 2009), https://www.clinicalcorrelations.org/2009/05/28/conscientious-objection-in-medicine-a-moral-dilemma/ ("Conscientious objection in medicine is the notion that a health care provider can abstain from offering certain types of medical care with which he/she does not personally agree."); *see also* Udo Schuklenk, *Conscientious Objection in Medicine: Accommodation Versus Professionalism and the Public Good*, 126 BRIT. MED. BULL. 47, 47 (Mar. 28, 2018) ("Defenders of conscientious objection maintain that in a liberal society respect for a professional's conscience is of sufficient importance that conscientious objectors ought to be accommodated.").

87. Plaintiff's Brief in Support of Their Motion for Partial Summary Judgment or, in the Alternative, Preliminary Injunction at 19, 22; Franciscan Alliance, Inc. v. Burwell, 227 F. Supp. 3d 660 (N.D. Tex. 2016) (No. 7:16-cv-00108-O).

88. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts. 438, 440, 460; 45 C.F.R. pts. 86, 92, 147, 155, 156).

89. *See generally id.* (discussing the "underlying civil rights statutes" and their "longstanding statutory interpretations" throughout the new rule).

that civil rights acts should be interpreted broadly.[90] Yet the same OCR has refused to broadly define the terms of Section 1557, opting in the current version of regulation to omit definitions altogether.[91] Instead of providing definitions, it has decided to allow individual interpretation in the field, a sharp contrast with the detailed definitions it issued with respect to the conscience clause regulations. The only consistently broad action it has taken has been to adopt interpretations that would most broadly prevent access to health care for transgender persons.

IV. SOCIAL JUSTICE, CIVIL RIGHTS, AND BIOETHICS

Along with serving other goals, both of the instant regulatory actions represent efforts by the federal government to fulfill its promise of safeguarding religious freedom. First, with respect to the transgender population, the agencies' actions strip away hard-won civil rights gains in health care achieved when Section 1557 was passed and the OCR defined "on the basis of sex" to include gender identity.[92] Then, should any transgender individuals have slipped into the practice of a health care provider regulated by the federal conscience clause statutes, conscience clause regulations give objecting providers the power to refuse service to those individuals.[93]

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90. 45 C.F.R. § 88.1 (2019).

91. *See, e.g.*, Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. at 37,209 (explaining that "[t]he four civil rights statutes underlying Section 1557 have implementing regulations containing appropriate definitions, protections, and enforcement mechanisms. As explained herein, the Department has now deemed most of the parallel provisions in the 2016 Rule to be unnecessary, superfluous, or unduly burdensome. Therefore the Department considers it appropriate to finalize a Section 1557 rule that is shorter than the 2016 Rule and relies more substantially on those underlying regulations.").

92. Katie Keith, *HHS Strips Gender Identity, Sex Stereotyping, Language Access Protections From ACA Anti-Discrimination Rule*, HEALTH AFF. (June 13, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200613.671888/full/ ("[T]he new rule removes protections against discrimination based on sex stereotyping and gender identity afforded by the 2016 rule.").

93. Cerminara, *supra* note 48, at 12.

> The Administration's regulatory actions leave the transgender community with nowhere to turn if experiencing difficulty obtaining mental or physical health care services. Interpreting section 1557 as omitting "gender identity" from the list of prohibited grounds for discrimination in health care means there is not an explicit source of civil rights protection for that population. Should an institutional health care provider decide to serve the community, individuals or associated entities within that health care provider can refuse "to perform" and "to assist in performance of" all types of services—not particular, specified services—if asserting a sincerely held religious belief or moral conviction that the transgender existence is unacceptable. The combination of these regulatory actions signal that the Trump Administration has given its seal of approval to refusals to care for the transgender population.

Id.

By transforming conscience clauses into anti-discrimination statutes and sending the message that they will enforce religious freedoms broadly and with zest, American health care regulatory agencies are permitting some people to assert civil rights to the great detriment of the health of other people, and in fact to the great detriment of the public health. Broad interpretation of the religious freedom underlying these regulations is unwarranted. Whether based on the Free Exercise Clause of the First Amendment or on the Religious Freedom and Restoration Act (RFRA),[94] these interpretations infringe on patients' rights to ethical medical care.

Professors Douglas Nejaime and Reva Siegel have argued convincingly that claims of "religious exemptions from laws . . . on the ground that the law makes the objector complicit in the assertedly sinful conduct of others" differ greatly from the types of free exercise claims RFRA represents.[95] According to them, most free exercise cases are asserted by practitioners of a religious practice that legislators did not consider when they developed the law, and seek permission to engage in that practice.[96] The practices in question thus affect few, if any, other people and cost little to implement.[97] In contrast, complicity-based claims exist because religious believers object to something other people are doing, arguing that they become complicit in the others' sins through the action the law is attempting to require.[98] As they are based on others' actions, complicity-based claims necessarily involve both material and dignitary harm to others resulting from the refusal.[99]

This is where bioethicists should step up to ensure justice and health equity in the face of prejudice disguised as religious belief. Nothing in the regulations requires health care providers, institutional or individual, to violate their ethical principles.[100] While the law says they may discriminate in the name of their religions, it does not require

94. 42 U.S.C. § 2000bb (2018).

95. Douglas Nejaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2516 (2015).

96. *Id.* at 2520.

97. *See id.*

98. *Id.*

99. *Id.* at 2566–78. Nejaime & Siegel wrote their article before the U.S. Supreme Court decided Little Sisters of the Poor v. Pennsylvania, 140 S. Ct. 2367 (2020), which presented a complicity-based RFRA claim. The Court, however, based its ruling on administrative law principles rather than RFRA. *Id.* at 2386. Therefore, the argument Nejaime & Siegel made remains a viable one.

100. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170, 23,200 (May 21, 2018).

them to do so.[101] The Trump Administration has indicated that it is relying on health care providers to act ethically in the face of laws authorizing unethical actions.[102] Therefore, bioethicists have an opening within which to assist medical providers in determining their ethical duties to patients in such circumstances.

Guiding medical providers in the ethical provision of health care requires consideration of justice. Considering justice involves considering burdens and benefits for both patients and providers when judging the propriety of an action. It is not ethically appropriate to privilege medical providers over patients in this calculus. As bioethicist Craig Klugman states, a rule ignoring the impact on patients "violates healthcare providers' most important duties: To do no harm, and to put patients' needs above one's own."[103] To understand how important it is for a medical provider to put patients' needs above their own, one merely has to witness the many health care providers treating patients with COVID-19 at great personal risk to themselves.[104]

To the extent that OCR has extended conscience protections to support staff, such as scheduling personnel, it remains appropriate to consider harm to patients that could result from those protections.[105] Studies have determined that transgender individuals refrain from seeking physical health care because of anticipated discrimination[106] and that the mere presence of laws permitting discrimination on the books has been associated with increased mental distress among the population subject to the discrimination.[107] Transgender individuals

101. *See id.* ("The rule's definition of 'referral or refer for' ensures that doctors can use their own professional, medical, and ethical judgment without being coerced by entities receiving Federal funds to violate their moral or religious convictions.").

102. *See id.*

103. *Debate Over Whether 'Conscience Rule' Engenders Diversity or Paternalism*, RELIAS MEDIA (July 1, 2019), http://www.reliasmedia.com/articles/144615-debate-over-whether-conscience-rule-engenders-diversity-or-paternalism.

104. *E.g.*, *CDC Covid Data Tracker*, CDC, https://covid.cdc.gov/covid-data-tracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fcases-in-us.html#health-care-personnel (select "Unique Populations," then click "Healthcare Personnel") (last updated Jan. 7, 2021).

105. Lawrence Gostin, *The "Conscience" Rule: How Will It Affect Patients' Access to Health Services?*, JAMA HEALTH F. (May 15, 2019), https://jamanetwork.com/channels/health-forum/fullarticle/2759640 ("The rule's expansive definition of covered entities could, for example, extend to a pharmacist filling a prescription for contraceptives, a receptionist scheduling an appointment for sexually transmitted disease treatment, or an ambulance driver transporting a woman for an emergency abortion.").

106. Kristie L. Seelman et al., *Transgender Noninclusive Healthcare and Delaying Care Because of Fear: Connections to General Health and Mental Health Among Transgender Adults*, 2 TRANSGENDER HEALTH 17, 19 (2017).

107. Julia Raifman et al., *Association of State Laws Permitting Denial of Services to Same-Sex Couples with Mental Distress in Sexual Minority Adults*, 75 JAMA PSYCHIATRY 671, 675 (2018),

already "experience enormous psychological distress across their lives."[108] More than a half a million transgender persons are estimated to have attempted suicide during their lifetimes.[109] The result of a transgender version of racial trauma[110] is long-term inability to access health care due to political determinants of health.

In short, it is incumbent upon bioethicists to remind all of those working within the health care industry and even those operating the institutions compromising the health care industry, of their ethical obligations. Sometimes it is not enough to obey the law; when obeying the law can result in harm to patients, more than a simple refusal to participate is required. A religion that considers an adherent complicit in sin if they are doing what is necessary to uphold their professional obligations is not the sort of religion the American government law should privilege.

V. CONCLUSION

In conclusion, it is time to stand against health-harming cruelty the federal government is displaying at this time. While not all bioethicists may be cut out to be policy-debating activists, at a minimum each clinical bioethicist must strive for justice in health care in areas in which they have professional obligations. Attacking social injustice through attention to the social and political determinants of health will impact the ability of each patient with a bioethics consult to lead a healthy life. Increasing consideration of social justice with respect to individual health-related decisions can result in an increase in social justice in health care overall. Grass-roots efforts to combat the assertion of civil rights to block health care access in individual cases can provide individual narratives through which to change political determinants of health that result in injustice and inequity. Bioethicists can and should enable that.

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6129969/ (Between 2014 and 2016, mental distress caused by state laws allowing denial of service increased by 46 percent for sexual-minority adults).

108. Robin Fretwell Wilson, *Being Transgender in the Era of Trump: Compassion Should Pick up Where Science Leaves Off*, 8 U.C. IRVINE L. REV. 583, 586 (2018).

109. *See* Herman & O'Neill, *supra* note 25, at 2.

110. *See generally* Williams et al., *supra* note 19.