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Dear ECRI members, dear colleagues,

I want to describe to you a case that we handled in our legal counselling work that is in some ways illustrative of specific challenges that we face when it comes to discrimination in the health care sector.

A lesbian couple turned to our services, I will call them “B” and “O”. B and O wanted to have children and had recently visited a fertility clinic.

After they had they noticed on prints of their patient files that B had been accurately registered as “Patientin”, the German word for a female patient.

However, her wife O had been registered not only as a “Patient”, using the male gender, but had also received the gender marker “M” behind her name.

They now also noticed that letters they received from the clinic were addressed to Ms. B and Mr. O instead of Ms O.

At their next appointment couple asked their doctor to change the wrong gender entries and to delete “homosexuality” as a diagnosis.

To their surprise, the doctor brushed them off, telling them that “this is just how the software works” and that nothing could be done about it.

The couple was taken aback at this refusal and turned to our legal counselling team for advice.

In our assessment the clinic’s actions constituted possible discrimination both on grounds of gender and of sexual identity.

In line with our competence to try and mediate an amicable settlement, we wrote to the clinic and asked for an explanation. While we received no reply from the clinic, the doctor in charge called B and O on the phone. He complained to them that he felt unfairly accused of discrimination and that the two of them were causing him an extra amount of work. He again reiterated that his software only allowed opposite-gender couples and that there was nothing he could or would do about it.

The couple then decided to take an attorney and also file a complaint with the medical association.

The case I just described highlights a number of questions.

The first concerns the applicable grounds for discrimination. A High German court has decided that addressing a customer or client using grammar that goes against the persons

gender identity can constitute discrimination on grounds of gender according to the Equal Treatment Act. While that decision concerned a non-binary person, it is our legal experts' view that it should also be applicable for people whose gender identity and legal gender marker coincide.

The second applicable ground would be sexual identity because of the entry in the file that "diagnosed" the patient's homosexuality. Since treating homosexuality as a medical condition has no basis in modern medical standards it has a particularly degrading and discriminatory effect.

Another question is whether it is possible to speak of discrimination when the clinic justified its actions by referring to existing limitations of their software. Section 20 of the General Equal Treatment Act allows for unequal treatment when there is an objective justification for it.

However, not every justification is objective. In line with the pre-eminent legal comments, FADA takes the view that reasonable efforts must be made to avoid disadvantages. In our opinion, the simple fact that the software does only foresee male-female couples is not an objective reason for the clinic to simply accept this situation. It would be reasonable to try and update the software, replace it, or finding another way to accommodate the patients.

In any case, the biggest legal question under German law is, surprising as that may be, whether the Equal Treatment Act covers this case at all. Outside of employment, Germany's anti-discrimination law is mostly limited to so-called "bulk business" in access to goods and services – contractual relations that are standardised and do not differ from case to case.

Some experts have questioned whether a medical treatment contract qualifies as such bulk business. We firmly believe it does, because doctors accept patients independent of personal characteristics and treat them according to quality standards that should not differ from one patient to another.

We have elaborated this view in a legal opinion that you can find on our website. However, due to a lack of litigation and therefore a lack of decisions by higher courts, there is legal uncertainty around the ban of discrimination in healthcare.

Our own lack of litigation powers does not allow us to advance the jurisprudence here.

This persistent uncertainty makes it even more important to work with the healthcare sector to improve the way it deals with discrimination and to strengthen preventive work.

Earlier this year I presented the study "Diagnosis: Discrimination," to the German Minister of Health.

The study, which we commissioned, investigated the availability and effectiveness of complaint mechanisms within the healthcare system and revealed significant gaps.

The study was conducted in several steps. Initially, the existing contact points for patient's complaints were researched and this was followed up by an online survey where these institutions were for example asked to provide the number of discrimination cases they had

handled was carried out. This revealed that only a few institutions could provide concrete data, as many did not keep track of cases of discrimination they dealt with. In a second step, experts from communities and anti-discrimination counseling organisations were interviewed to determine their experiences with these counseling services. Finally, seven qualitative case studies were conducted on individual complaint structures.

The findings were sobering. It is extremely difficult to find a point of contact within the healthcare system, partly because there are many different institutions with their own mandates and responsibilities. Some offer psychosocial support, others focus on resolving conflicts, and still others are responsible for professional disciplinary proceedings. The problem is that these contact points vary depending on the healthcare setting. As a patient, it can be very challenging to know which institution is responsible for a specific case.

Even if these contact points take up cases of discrimination however, the entire process often remains opaque. Those affected often do not know what happens next, at what stage their case is, or how their complaint has been assessed. This leads to unsatisfactory outcomes for those affected.

The study recommends measures to remedy this situation. First, access to existing complaint mechanisms must be improved. Information about counseling and complaint possibilities must be disseminated comprehensively as well as in a targeted manner.

Second, existing contact points should be trained to be able to deal with cases of discrimination. It is important to establish a critical understanding of power dynamics and knowledge about discrimination as well as a basic legal understanding.

Third, the entire issue should be integrated into an overall strategy within institutions. In hospitals and practices, guidelines and collective agreements must be developed that both prevent discrimination and provide clear instructions on how to deal with experiences of discrimination. This requires that cases of discrimination be systematically recorded and evaluated in order to identify problem areas and address them specifically.

And fourth, improvements must also be made at the legal level.

Low-threshold procedures for the out-of-court enforcement of rights should be created, and we urgently need the clarification that German anti-discrimination law also applies to the area of health services.