

1 RICHARD B. KATSKEE*
2 AMERICANS UNITED FOR SEPARATION
3 OF CHURCH AND STATE
4 1310 L Street NW, Suite 200
Washington, DC 20005
Tel: (202) 466-3234; Fax: (202) 466-3234
katskee@au.org

5 GENEVIEVE SCOTT*
6 CENTER FOR REPRODUCTIVE RIGHTS
7 199 Water Street, 22nd Floor
New York, NY 10038
Tel: (917) 637-3605; Fax: (917) 637-3666
gscott@reprorights.org

8 JAMIE A. GLIKSBERG*
9 LAMBDA LEGAL DEFENSE AND
10 EDUCATION FUND, INC.
11 105 West Adams, 26th Floor
Chicago, IL 60603-6208
Tel: (312) 663-4413; Fax: (312) 663-4307
jglikberg@lambdalegal.org

JAMES R. WILLIAMS (SBN 271253)
GRETA S. HANSEN (SBN 251471)
LAURA S. TRICE (SBN 284837)
MARY E. HANNA-WEIR (SBN 320011)
SUSAN P. GREENBERG (SBN 318055)
H. LUKE EDWARDS (SBN 313756)
OFFICE OF THE COUNTY COUNSEL,
COUNTY OF SANTA CLARA
70 West Hedding Street, East Wing, 9th Fl.
San José, CA 95110-1770
Tel: (408) 299-5900; Fax: (408) 292-7240
mary.hanna-weir@cco.sccgov.org

LEE H. RUBIN (SBN 141331)
MAYER BROWN LLP
Two Palo Alto Square, Suite 300
3000 El Camino Real
Palo Alto, CA 94306-2112
Tel: (650) 331-2000; Fax: (650) 331-2060
lrubin@mayerbrown.com

Counsel for Plaintiffs

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13 **UNITED STATES DISTRICT COURT**
NORTHERN DISTRICT OF CALIFORNIA

14 COUNTY OF SANTA CLARA, TRUST
15 WOMEN SEATTLE, LOS ANGELES LGBT
16 CENTER, WHITMAN-WALKER CLINIC,
17 INC. d/b/a WHITMAN-WALKER HEALTH,
18 BRADBURY-SULLIVAN LGBT
19 COMMUNITY CENTER, CENTER ON
20 HALSTED, HARTFORD GYN CENTER,
21 MAZZONI CENTER, MEDICAL STUDENTS
22 FOR CHOICE, AGLP: THE ASSOCIATION
23 OF LGBTQ+ PSYCHIATRISTS, AMERICAN
ASSOCIATION OF PHYSICIANS FOR
HUMAN RIGHTS d/b/a GLMA: HEALTH
PROFESSIONALS ADVANCING LGBTQ
EQUALITY, COLLEEN MCNICHOLAS,
ROBERT BOLAN, WARD CARPENTER,
SARAH HENN, and RANDY PUMPHREY,

Plaintiffs,

vs.

25 U.S. DEPARTMENT OF HEALTH AND
26 HUMAN SERVICES and ALEX M. AZAR, II,
27 in his official capacity as SECRETARY OF
HEALTH AND HUMAN SERVICES,

Defendants.

Case No. 5:19-cv-2916

**DECLARATION OF WARD
CARPENTER, MD, CO-DIRECTOR OF
HEALTH SERVICES, LA LGBT
CENTER, IN SUPPORT OF
PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION**

1 I, Ward Carpenter, declare as follows:

2 1. I am the Co-Director of Health Services for the Los Angeles LGBT Center (LA LGBT
3 Center), where I was formerly the Associate Chief Medical Officer as well as the Director of
4 Primary and Transgender Care. I received my medical degree from the Robert Wood Johnson
5 Medical School and had my residency at St. Vincent’s Hospital Manhattan. I am board-certified in
6 Internal Medicine and I hold certification in HIV Medicine. I am licensed to practice in the state
7 of California. At the LA LGBT Center, I oversee all operations of the Federally Qualified Health
8 Center (“FQHC”), including personnel, finances, clinical programs (mental health, psychiatry,
9 primary care, HIV care, transgender health, substance abuse, and sexual health), nursing, case
10 management, quality, risk management, and clinical research. I also maintain a panel of patients
11 for whom I provide direct care. I submit this declaration in support of Plaintiffs’ Motion for
12 Preliminary Injunction to prevent the Denial-of-Care Rule from going into effect.

13 2. As the Co-Director of Health Services, I oversee the healthcare of over 17,000 patients
14 who come to the LA LGBT Center for their care; I personally provide care to a panel of 150 patients.
15 All of my patients identify within the LGBTQ communities, and approximately 30% of my patients
16 are people living with HIV. My patient population is also disproportionately low-income and
17 experiences high rates of chronic medical conditions, homelessness, unstable housing, extensive
18 trauma history, and discrimination and stigmatization in healthcare services. Many of these patients
19 come to me from different areas of California, other states, and even other nations to seek services
20 in a safe and affirming environment.

21 3. I provide a wide spectrum of healthcare services, including, but not limited to, HIV
22 treatment, testing and prevention; STD testing, treatment and prevention; general primary care with
23 an LGBT focus; and comprehensive transgender care. I have worked in this field of medicine
24 continuously since 2004 and have personally cared for over 4000 people in that time. I have worked
25 in two Federally Qualified Health Centers, in New York and Los Angeles, as well as a private
26 practice in New York. I am a nationally-recognized expert in the field of transgender medicine.

27 4. Many if not most of the individuals in our very diverse patient population face
28 considerable stigma and discrimination – as people living with HIV, as sexual or gender minority

1 people, as people of color. Transgender people have a 41% lifetime risk of attempting suicide. This
2 shocking observation can be explained by the intense dysphoria inherent in living in a body and a
3 society that does not reflect and validate who you know yourself to be at a core level. In order to
4 avoid this tragic consequence, transgender people require compassionate, sensitive, and competent
5 care that often includes medical and/or surgical procedures that incidentally affect reproduction.
6 These patients have significantly improved mental health outcomes when able to proceed with the
7 treatments they need. Treatments for gender dysphoria have been deemed medically necessary by
8 the World Professional Association of Transgender Health and the Endocrine Society, in the same
9 way that the American College of Cardiology has deemed treatment for hypertension medically
10 necessary. In fact, in the course of treating gender dysphoria, endocrinologists and other healthcare
11 providers use the same medications to treat transgender people as they use to treat non-transgender
12 people with hormone deficiencies. Under the Denial-of-Care rule, medical personnel who are duty-
13 bound to treat someone for one condition – hypertension – could legally refuse to treat that same
14 person for another condition – gender dysphoria – that could become life-threatening if left
15 untreated despite having the necessary tools and expertise to do so. Healthcare discrimination like
16 this will have immediate negative consequences for a distinct and oppressed minority group and
17 cannot be empowered, as it is in the Denial-of-Care Rule.

18 5. There is every reason to believe that the Denial-of-Care Rule encourages healthcare
19 providers and staff to claim an absolute right to refuse care or opt out of serving patients with
20 particular needs, based on personal beliefs, and will result in more discrimination, mistreatment,
21 and denials of healthcare services against LGBT patients and patients living with HIV at other
22 clinics, doctors' offices, hospitals, pharmacies, and other healthcare facilities outside the LA LGBT
23 Center. Even before the Denial-of-Care Rule was proposed or issued, I and the other providers that
24 I supervise at the LA LGBT Center have had many patients who have experienced traumatic stigma
25 and discrimination – based on their sexual orientation, gender identity, HIV status, and/or other
26 factors. For example:

1 a. A transgender patient went to a urologist due to uncomfortable urination
2 lasting for several years after her vaginal surgery. She was repeatedly
3 referred to as “sir” and “he” despite repeated requests to use the correct
4 pronouns. When the patient confronted the clerk, the clerk said “this is what
5 your ID says, so this is how we will refer to you.” When she saw the doctor,
6 he also called her “sir,” completely humiliating her in the most
7 unprofessional manner. He did not close the door to the exam room during
8 their visit, so that the entire waiting room could hear his conversations with
9 her, and he asked her to remove her pants in full view of the waiting room.
10 She was so traumatized by this experience that four years later, she continues
11 to live with daily pain rather than risk being subjected to discrimination by
12 another transphobic urologist.

13 b. A transgender patient started bleeding profusely from her vagina one week
14 after surgery. Because there are so few trans-competent surgeons in the
15 United States, this patient’s surgeon was thousands of miles away. When
16 she finally spoke to an ER doctor, the physician looked disgusted and said
17 “what do you want me to do about it?” then walked away. She had to pack
18 her own vagina with gauze pads and leave the ER, not knowing if she would
19 live or die, and only coming to see us three days later after having lost a
20 significant amount of blood. These horrific incidents will increase as a result
21 of the Denial-of-Care Rule. The likely result: patients will die.

22 c. A gay male patient with a serious and concerning neurological condition
23 went to a neurologist. At this visit, the doctor had religious brochures
24 throughout the waiting room. On arrival in the exam room, he was given a
25 brochure about a particular Christian faith and asked if he had any questions.
26 The patient felt extremely uncomfortable with this insertion of religion into
27 what he felt should be a neutral space. As a result, he did not return for care
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and experienced a delay of several more months trying to find a new doctor he could trust.

- d. A person living with HIV was referred to a surgeon for a routine procedure. The surgeon sent a note back to the patient’s primary care physician asking him to refer the patient to someone “who was more familiar with treating patients like him.” Again, this patient waited another two months to have this surgery, which could have caused severe or life-threatening complications.
- e. A lesbian woman went to her doctor and was told that lesbians are not at risk for HPV and, therefore, she did not need cervical cancer screening. This patient knew enough to find a new doctor, but many patients would accept this information as fact and never receive a Pap smear, significantly increasing their chances of dying from cervical cancer. This type of medical error based on discriminatory stereotypes demonstrates what will happen when medical personnel are invited to discriminate instead of focusing on the health needs of patients in their care.
- f. A gay man went to his primary care physician with urinary burning and discharge. Because his healthcare provider did not ask, the provider did not know that this patient was sexually active with men. Therefore, the provider did only one test, which was negative, and sent him to a urologist. The urologist did another test, which was negative, then performed a procedure to look inside this man’s bladder with a camera. It was not until he came to the LGBT Center that we performed a proper medical history and exam and were able to treat him immediately for his sexually transmitted infection. We also determined that he had sex with five other people from the time of his first symptoms to the time he was finally treated, weeks later. Had any of these providers stopped to ask the man about his sexual practices, they would have immediately tested him and treated him for a sexually

1 transmitted disease. Instead, he saw three providers, received hundreds of
2 dollars in unnecessary testing and passed his infection along to five other
3 people who themselves had to go down similar testing and treatment paths.

4
5 6. In sum, the message of these examples is clear: when patients are discriminated against,
6 stereotyped, and mistreated in medical establishments as a result of healthcare providers' personal
7 moral or religious beliefs, patients stop seeking care or their care is detrimentally delayed out of
8 fear of repeated discrimination and denials of care. As a result, their conditions remain untreated
9 for a much longer period of time, if they ever get treatment, resulting in much more acute
10 conditions, ultimately costing the healthcare system millions of dollars in unnecessary expense
11 while harming patients and public health. When medical staff fail to care for every patient in the
12 best way that they can, putting patients' best interests at the center of medical care, medical mistrust
13 is worsened, care is delayed, and healthcare becomes more expensive.

14 7. These incidents reveal that many healthcare providers and other staff harbor explicit or
15 implicit biases against LGBT people and people living with HIV. Because of legal requirements,
16 healthcare facility non-discrimination policies, and professional norms, many of them have kept
17 their personal beliefs and feelings in check. By empowering healthcare staff to think that they have
18 the right to act on their personal beliefs, even at the expense of patient needs, the Denial-of-Care
19 Rule is very likely to result in many more incidents of discrimination and greater harm to LGBT
20 individuals and patients living with HIV who are struggling with mental health or substance use
21 issues, including the patients whom I treat and whose treatment I supervise.

22 8. Such experiences are not only insulting and demoralizing for the patient, but can
23 jeopardize the patient's health, when a screening or treatment is denied or postponed, or the patient
24 is discouraged from seeking medical care out of fear of repeated discrimination. Many if not most
25 of my and the LA LGBT Center's transgender patients express strong distrust of the healthcare
26 system generally, and a demonstrative reluctance to seek care outside the LA LGBT Center unless
27 they are in a crisis or in physical or mental stress. This is because they want to avoid discrimination
28 or belittlement. Such incentives to avoid regular check-ups and other medical care can result in

1 disease processes that are more advanced at diagnosis, less responsive to treatment, or even no
2 longer curable in the case of some cancers. Already, my patients are arriving at the LA LGBT
3 Center with more acute medical conditions than they would otherwise have because the increase in
4 religious-based discrimination has caused patients to fear receiving necessary medical care.

5 9. With existing health and healthcare disparities that harm the LGBTQ community –
6 particularly the shortage of LGBTQ/HIV culturally competent providers – the Denial-of-Care
7 Rule’s vague and confusing language will further exacerbate existing barriers to healthcare and
8 result in negative community health outcomes. Good medical care is based on trust as well as frank
9 and full communication between the patient and their provider. In many, if not most encounters,
10 providers need patients to fully disclose all aspects of their health history, sexual history, substance-
11 use history, lifestyle, and gender identity in order to provide appropriate care for the patients’
12 health, both physical and mental. Incomplete communication, or miscommunication, can have
13 dangerous consequences. For instance, a patient who conceals or fails to disclose a same-sex sexual
14 history may not be screened for HIV or other relevant infections or cancers; and a patient who fails
15 to fully disclose their gender identity and sex assigned at birth may not undergo medically-indicated
16 tests or screenings (such as tests for cervical or breast cancer for some transgender men, or testicular
17 or prostate cancer for some transgender women). Patients need to be encouraged to fully disclose
18 all information relevant to their healthcare and potential treatment, which can only be achieved
19 when patients are assured that the information they provide will be treated confidentially and with
20 respect. The Denial-of-Care Rule endangers the provider-patient relationship, and is likely to harm
21 many patients’ health, by discouraging patients from full disclosure, and by encouraging providers
22 to avoid topics that may offend their personal moral or religious beliefs in their encounters with
23 patients.

24 10. The Denial-of-Care Rule causes LGBT patients and patients living with HIV to lose
25 trust in their healthcare providers (either out of fear of discrimination or on account of being denied
26 care on religious grounds). As a result, there will be an increase in demand for my and my
27 department’s services that will limit my ability to provide adequate care and time to my patients.
28

1 This will increase wait times for my patients, and the delays in care may worsen conditions for
2 which my patients are seeking treatment and outcomes of care.

3 11. The Rule will cause LGBT patients to attempt to hide their LGBT identities when
4 seeking healthcare services, especially from religiously-affiliated healthcare organizations, in order
5 to avoid discrimination. The Denial-of-Care Rule endangers the provider-patient relationship, and
6 is likely to harm many patients' health, by discouraging patients from full disclosure about their
7 gender identity, sexual orientation, or medical histories. Patients will avoid raising any topics,
8 questions, facts that they fear could possibly offend their healthcare providers' personal beliefs,
9 resulting in harm to patients. When patients are unwilling to disclose their sexual orientation and/or
10 gender identity to healthcare providers out of fear of discrimination and being refused treatment,
11 their mental and physical health is critically compromised.

12 12. The Denial-of-Care Rule is also likely to cause an increase in demand for my healthcare
13 services because I have seen a spike in behavioral and mental-health issues resulting from religious
14 or moral-based discrimination and denials of healthcare services.

15 13. The Denial-of-Care Rule is in direct conflict with the oath I swore as a doctor and many
16 of the federal, state, and insurance rules, regulations, and statutes that I am required to follow. This
17 has personally caused me great confusion and stress as it is unclear how I can work collaboratively
18 with colleagues who may discriminate against my patients without violating either current medical
19 ethical and legal standards of care or the Denial-of-Care Rule.

20 14. As a healthcare provider with the LA LGBT Center, I receive various forms of federal
21 funding directly and indirectly via federal programs, including but not limited to those governed
22 by the Centers for Medicare and Medicaid Services through Medicaid and Medicare
23 reimbursements as well as funding under the Ryan White Comprehensive AIDS Resources
24 Emergency Act of 1990 and funding from the Centers for Disease Control and Prevention. These
25 funds and related benefits account for a significant portion of my work and the healthcare services
26 that I, and those that I supervise, provide to patients. Without such funding, we could not provide
27 proper treatment to our patients, especially because a large portion of the population that we serve
28 relies heavily on Medicaid and Medicare for its healthcare needs. I may be, therefore, subject to

1 the restrictions of HHS's Denial-of-Care Rule and have a reasonable fear that I could be sanctioned
2 and lose federal funding for the work that I do as a result of nondiscrimination policies that I enforce
3 in my department and amongst the staff that I supervise, which is vital to providing proper care to
4 my patients and other patients whose care I supervise. If such a loss of funding were to occur, it
5 would result in service reductions if not closure of our programs in their entirety.

6 15. One of the guiding ethics of medicine is to treat all patients equally. We do not treat
7 blue-eyed people better than brown-eyed people. We do not treat women better than men. We do
8 not provide better care to blonde-haired people than red-haired people. Medical personnel see
9 people at their most vulnerable; the trust placed in us is sacred. To tie an employer's hands, to not
10 permit an employer to make respectful and equal treatment of all patients part of a job description,
11 hurts patients by preventing them from accessing needed care even at trusted facilities and
12 practices. If we at the LA LGBT Center need to provide care to the LGBT community, we cannot
13 be forced to hire and continue working with someone who refuses to provide care to this community
14 without violating the LA LGBT Center's mission, medical ethics, and established standards of care.

15 16. As LA LGBT Center's Co-Director of Health services, my responsibility includes
16 enforcing our nondiscrimination mandate with respect to all of our providers and staff, including
17 those working on federally funded research. I, therefore, have a reasonable fear that the ability to
18 provide federally funded healthcare services and conduct federally funded research could be
19 severely impeded, potentially putting patients and research participants at risk, if the Denial-of-
20 Care Rule is allowed to take effect. I could also be subject to sanctions as someone who oversees
21 the LA LGBT Center's clinical research.

22 I declare under penalty of perjury under the laws of the United States of America that the
23 foregoing is true and correct.

24 Dated: June 6, 2019

Respectfully submitted,


Ward Carpenter