UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

JAKOB TIARNAN RUMBLE,

Plaintiff,

v.

FAIRVIEW HEALTH SERVICES, d/b/a FAIRVIEW SOUTHDALE HOSPITAL, and EMERGENCY PHYSICIANS, PA,

Defendants.

Case No. 14-cv-2037 (SRN/FLN)

BRIEF OF TRANSGENDER LEGAL DEFENSE AND EDUCATION FUND, INC. AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFF'S OPPOSITION TO DEFENDANTS' MOTIONS FOR SUMMARY JUDGMENT

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CORPORATE DISCLOSURE STATEMENT

Transgender Legal Defense and Education Fund, Inc. ("TLDEF") is a private, non-profit organization. TLDEF does not have a parent company, and no publicly held company holds more than 10% of TLDEF's stock.

STATEMENT OF INTEREST

Transgender Legal Defense and Education Fund, Inc. ("TLDEF") is a national civil rights organization committed to achieving full recognition of transgender persons civil rights in the United States. Since its founding in 2003, TLDEF has represented transgender persons who have experienced health care discrimination through advocacy, administrative appeals, administrative charges of discrimination, and federal impact litigation throughout the country.

No party or party's counsel authored this brief in whole or part, and no party, party's counsel, or person other than *amici* and its counsel contributed money that was intended to fund preparing or submitting this brief.

INTRODUCTION

Ensuring that transgender Americans have equitable access to health care is of paramount importance to *amici*. A trip to the doctor's office or the emergency room should not be an invitation for abuse.

A growing body of evidence paints a troubling picture of transgender health care discrimination and its consequences. In addition to routinely being denied treatment by providers simply because they are transgender, many patients report being subjected to verbal harassment, assault and rough handling, and other poor treatment that undermines

their dignity and imperils their health. Researchers have long observed that discrimination in health care settings is a major driver of alarming health disparities in the transgender community. If problematic institutional practices and providers' implicit biases are left unaddressed, transgender Americans will continue to experience startling health disparities.

Section 1557 of the Affordable Care Act and the Minnesota Human Rights Act both prohibit discrimination in health care facilities. Because these remedial statutes are sensitive to disparate treatment that deprives transgender patients of the benefits of health care on an equal basis with other patients, both statutes necessarily prohibit disparate treatment targeting transgender patients. Drawing from civil rights jurisprudence, *amici* argues that many of the most common forms of anti-transgender bias in healthcare settings violate the Affordable Care Act and the Minnesota Human Rights Act.

ARGUMENT

I. PERVASIVE DISCRIMINATION IN HEALTH CARE SETTINGS HAS DETRIMENTAL EFFECTS ON TRANSGENDER PEOPLE.

A. Statistics paint a troubling picture of transgender health care discrimination in the United States.

Despite considerable advances in treatment for gender dysphoria and greater public investment in health care, transgender Americans experience startling rates of health care discrimination.

Many transgender patients undergo hormone therapy and reconstructive surgeries to align their secondary sex characteristics with their gender identity. Decades of research evidence that these procedures are a safe and effective means of treating gender

dysphoria. *See, e.g.*, Esther Gómez-Gil et al., *Hormone-Treated Transsexuals Report Less Social Distress, Anxiety and Depression*, 37 Psychoneuroendocrinology 662 (2012); Griet De Cuypere et al., *Sexual and Physical Health After Sex Reassignment Surgery*, 34 Archives Sexual Behavior 679 (2005) (noting high levels of satisfaction with treatment). Yet, many transgender patients who undergo gender dysphoria treatment report that they confront significant barriers to accessing other health care. Transgender men who have "used hormones or surgery for medical transition, those living full-time as their nonbirth gender, and those who had their preferred gender listed on their identification documents were more likely to experience health care discrimination." Deirdre A. Shires & Kim Jaffee, *Factors Associated with Health Care Discrimination Experiences Among a National Sample of Female-to-Male Transgender Individuals*, 2 Health & Soc. Work 134 (2015). Nationally, an astounding 41.8% of transgender men experience some type of discrimination in doctor's offices and hospitals. *Id.* at 134. Qualitative studies in Minnesota reveal similar trends. *See, e.g.*, Dylan Flunker, Sheila Nezhad, & John Salisbury, *Voices of Health: A Survey of LGBTQ Health in Minnesota 2014 Survey Results* 14 (2015), http://www.rainbowhealth.org/files/4714/2419/5548/2014_Voices_of_Health_Data_Release_Report.pdf (38% of transgender respondents experienced health care discrimination in their lifetime; 15% of transgender respondents experienced health care discrimination in last 12 months).

Many patients experience outright denials of treatment simply because they are transgender. Jaime M. Grant et al., Nat'l Ctr. Transgender Equality & Nat'l Gay &

Lesbian Taskforce, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* 73 (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf [hereinafter *Injustice at Every Turn*] (20% of transgender men report being denied care by health providers). Verbal harassment in health settings is also all too common. One national survey found that 28% percent of transgender patients were verbally harassed in a doctor's office, emergency room, or other medical setting. *Injustice at Every Turn* at 74. Another national survey found that 20.9% of transgender patients were subjected to harsh or abusive language from health providers. Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 11 (2010), www.lambdalegal.org/health-care-report [hereinafter Lambda Legal, *When Health Care Isn't Caring*].

Assault and rough handling is also common. Nationally, just over 1% of all transgender patients report being physically assaulted in emergency rooms, with even higher rates in vulnerable sub-populations. *Injustice at Every Turn* at 74 (noting assaults rates of 6% for undocumented patients, 5% for patients who have worked in the underground economy, 4% for Asian patients, and 4% for patients who lost their jobs). An alarming 7.8% of transgender people endure physically rough or abusive treatment from health providers. Lambda Legal, *When Health Care Isn't Caring* at 11.

Due to a paucity of openly friendly health providers and facilities, many patients are forced to navigate health care settings that maintain policies and practices that are ill-suited to serving transgender people. *See, e.g.*, Lewis A. Raynor et al., *Exploratory*

Spatial Analysis of Transgender Individuals' Access to Health Care Providers in the State of Minnesota, 15 Int'l J. Transgenderism 129 (2014) (noting that in many areas in Minnesota there are no self-identified transgender friendly providers). In many instances, transgender patient's medical privacy is compromised by intake processes devised for nontransgender patients. *See, e.g.*, J. Michael Wilkerson et al., Univ. Minn. Sch. Pub. Health, *Results of a Qualitative Assessment of Inclusive Healthcare in the Twin Cities* 4 (2009), http://www.rainbowhealth.org/files/8313/6319/9596/Assessment_of_Inclusive_Healthcare.pdf (noting frequent occurrence of clinical staff in Twin Cities region asking transgender patients questions that forced patient to out themselves during intake process in front of other patients or staff who did not need to know about it). Similarly, medical records systems designed for nontransgender patients often fail to capture accurate identification information and introduce offensive, erroneous notations. *See* Madeline B. Deutsch et al., *Electronic Medical Records and the Transgender Patient: Recommendations from the World Professional Association for Transgender Health EMR Working Group*, 20 J. Am. Med. Info. Assoc. 700 (2013) (advising that electronic medical records should collect the patient's legal name, preferred name [if different from legal name], gender identity, sex assigned at birth, and inventory reproductive organs as a means to accurately record medically necessary data pertinent to treatment).

B. Unchecked implicit bias is a major driver of poor treatment.

A growing body of evidence suggests that the high rates of poor treatment reported by transgender patients are driven in part by knowledge gaps that are exacerbated by unchecked anti-transgender implicit bias.

As aptly highlighted by Mr. Rumble's experts in this case, implicit bias[1] regularly leads to discrete act discrimination that actors have difficulty identifying as being bias-motivated. "Unlike *explicit bias* (which reflects the attitudes or beliefs that one endorses at a conscious level), *implicit bias* is the bias in judgment and/or behavior that results from subtle cognitive processes (e.g., implicit attitudes and implicit stereotypes) that often operate at a level below conscious awareness and without intentional control." Nat'l Ctr. for State Courts, *Helping Courts Address Implicit Bias: Frequently Asked Questions*, https://www.ncsc.org/~/media/Files/PDF/Topics/Gender%20and%20Racial%20Fairness/Implicit%20Bias%20FAQs%20rev.ashx (last visited Dec. 14, 2016).

Outside of the small subset that specialize in transition related care, many providers lack basic knowledge of the effects of transition related care and basic cultural competency. In one national survey, an alarming 50% of transgender patients reported having to teach health providers about transgender people in the course of receiving treatment. *Injustice at Every Turn* at 76. Qualitative research conducted in Minnesota reveals similar trends. *See, e.g.,* J. Michael Wilkerson et al., *Results of a Qualitative*

[1] A growing body of social science research and case law covering a wide array of biases evidences that decision-maker's implicit biases, driven by unconscious stereotyping about historically marginalized minority groups, regularly lead to discrete act discrimination which actors having troubling difficulty identifying as being bias-motivated. For a thorough account of the state of implicit bias research, see *State v. Saintcalle*, 178 Wash.2d 34, 46–49 (Wash. 2013) (*en banc*). For discussion concerning general acceptability of social framework analysis and implicit bias and use thereof to prove discrimination, see *Apilado v. N.A. Gay Amateur Athletic Alliance*, 2011 WL 13100729, *2–*3 (W.D.Wash. July 1, 2011).

Assessment of LGBT Inclusive Healthcare in the Twin Cities at 13. Provider knowledge gaps are more than an inconvenience for transgender patients. Researchers have linked provider knowledge gaps to poor treatment. For example, knowledge gaps upset typical power imbalances between patients and providers, leading some providers to stigmatize their transgender patients to reinforce expected patient-provider power inequalities. *See, e.g.*, Tonia Poteat et al., *Managing Uncertainty: A Grounded Theory of Stigma in Transgender Health Care Encounters*, 84 Soc. Sci. & Med. 22, 28 (2013) ("Interpersonal stigma and discrimination during transgender health care encounters served to reinforce the authority of the medical provider in the face of his or her uncertainty and ambivalence about transgender people and their care as well as the transgender patient's uncertainty about the provider's competence.")

Provider knowledge gaps should not be normalized. No health provider should be deemed exempt from taking the most basic steps to learn about the effects of gender transition care. These treatments are well documented in both mainstream medical journals and free, easily accessible practice guides. *See, e.g.*, Daniel Cabrera, *A Primer on the Needs and the Care of the Transgender Patient in the Emergency Department*, EMBlog Mayo Clinic (Nov. 3, 2015), http://emblog.mayo.edu/discussion/a-primer-on-the-needs-and-the-care-of-the-transgender-patient-in-the-emergency-department/; Louis J. Gooren, *Care of Transsexual Persons*, 364 New Eng. J. Med. 1251 (2011); Wylie Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. Clin. Endocrinological Metabolism 3132 (2009); R. Nick Gorton, Jamie Buth, & Dean Spade, Lyon-Martin Women's Health Servs., *Medical*

Therapy & Health Maintenance for Transgender Men: A Guide for Health Care Providers (2005), *available at* http://www.nickgorton.org/Medical%20Therapy%20and%20HM%20for%20Transgender%20Men_2005.pdf.

It is also incumbent on providers to take steps to gain cultural competency. Leading provider associations such as the American College of Obstetricians and Gynecologists instruct their membership to take affirmative steps to gain cultural competence and encourage non-specialists to equitably integrate transgender patients into their practices. *See, e.g.*, *Committee Opinion No. 512: Health Care for Transgender Individuals*, 118 Obstetrics & Gynecology 1454 (2011) (advising that non-transgender specialist obstetricians-gynecologist should be prepared to assist or refer transgender individuals with routine treatment and screening). Other professional organizations like the American College of Emergency Physicians routinely publish practice notes advising practitioners on best practices. *See, e.g.*, Gretchen Henkel, *Respectful Communication Key to Reducing Barriers to Care for Transgender Patients in the ED*, *ACEP Now* (Mar. 7, 2014), http://www.acepnow.com/article/respectful-communication-key-reducing-barriers-care-transgender-patients-ed/?singlepage=1.

Health care facility administrators' anti-transgender implicit biases also negatively impact transgender patients' health care. Many administrators are primed to undervalue the needs of transgender patients due to decades of anti-transgender discrimination in the medical profession. *See generally* Keisa Fallin-Bennett, *Implicit Bias Against Sexual Minorities in Medicine: Cycles of Professional Influence and the Role of the Hidden*

Curriculum, 90 Academic Med. 549 (2015) (observing that physicians' implicit bias against LGBT patients has created a cycle that perpetuates professional climate reinforcing the bias). Much like providers who fail to take steps to obtain basic cultural competency, administrators with unchecked anti-transgender implicit bias may make decisions which negatively impact transgender patients and fail to identify these decisions as being discriminatory. Such bias-ridden policy decisions have deleterious effects on patient care. *See, e.g.*, Jaclyn M. White Hughto et al., *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*, 147 Soc. Sci. & Med. 222, 224 (2015) (providing an operative definition of structural-level stigma and further observing that transgender disfavoring institutional policies and practices are a barrier to health care).

C. Rampant discrimination in health care settings drives untenable health disparities.

Transgender Americans endure staggering rates of discrimination throughout the arc of life. *Adkins v. City of New York*, 143 F.Supp.3d 134, 139 (S.D.N.Y. 2015) (Rakoff, J.). But health care discrimination is often the most devastating. Indeed, research suggests that health care setting discrimination is a significant driver of health disparities in the transgender community.

The transgender community faces high rates of mental health distress and suicidality, substance use, cigarette smoking, and HIV and other sexually transmitted infections. *See* Sari L. Reisner et al., *Transgender Health Disparities: Comparing Full Cohort and Nested Matched-Pair Study Designs in a Community Health Center*, 1 LGBT

Health 177, 177 (2014) (summarizing findings of other studies). *See also* Ann P. Haas et al., Am. Found. for Suicide Prevention & Williams Inst., *Suicide Attempts Among Transgender and Gender Non-Conforming Adults* 8 (2014), http://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf (noting that 46% of transgender men and 42% of transgender women attempted suicide in their lifetime).

A growing body of evidence links transgender health disparities to structural, institutional, and interpersonal health care discrimination. Cameron Donald & Jesse M. Ehrenfeld, *The Opportunity for Medical Systems to Reduce Health Disparities Among Lesbian, Gay, Bisexual, Transgender and Intersex Patients*, 39 J. Med. Sys. 178, 178–79 (2015) (linking disparities to structural and legal factors, social discrimination, and a lack of affirming and sensitive health care provision). Entrenched anti-transgender bias within the medical profession suppresses efforts to increase provider education and makes large-scale efforts to build cultural competency across the profession difficult. *See generally* Keisa Fallin-Bennett, *Implicit Bias Against Sexual Minorities in Medicine.* Additionally, facilities and providers' failure to implement culturally competent practices drives many transgender Americans away from doctor's offices. Studies show that many transgender patients put off or simply forego routine preventative care, primary care, and even emergency care because they fear discrimination in health care settings. *See, e.g.*, Daphna Stroumsa, *The State of Transgender Health Care: Policy, Law, and Medical Frameworks*, 104 Am. J. Pub. Health e31, e32 (2014) (noting that 28% of transgender patients postpone care and 33% postpone preventative care because of discrimination and

disrespect). For patients who seek out care and encounter discrimination, negative experiences reinforce stigma, exacting a toll of transgender patients' mental and physical health. *See, e.g.*, Amaya Perez-Brumer et al., *Individual- and Structural-Level Risk Factors for Suicide Attempts Among Transgender Adults*, 41 Behavioral Med. 164 (2015) (finding individual and structural forms of stigma to be risk factors for suicide attempts).

III. SECTION 1557 OF THE AFFORDABLE CARE ACT AND THE MINNESOTA HUMAN RIGHTS ACT PROHIBIT COMMON FORMS OF TRANSGENDER HEALTH CARE SETTING DISCRIMINATION.

This Court should broadly construe both Section 1557 of the Affordable Care Act and the Minnesota Human Rights Act ("MHRA") to prohibit common forms of transgender health care discrimination. Both statutes are remedial civil rights laws which should be liberally construed to reach common evils that transgender patients face in health care settings. *See, e.g.*, *Daniel v. Paul*, 395 U.S. 298, 307–08 (1969) (liberally construing statute to ensure that discriminatory denials of access are meaningfully combatted by remedial civil rights law); *Frieler v. Carlson Mktg. Grp., Inc.*, 751 N.W.2d 558, 573 (Minn. 2008) ("we have consistently held that the remedial nature of the Minnesota Human Rights Act requires liberal construction of its terms") (citing *Cummings v. Koehnen*, 568 N.W.2d 418, 422 (Minn. 1997)).

To aid the Court in its construction of Section 1557 and the MHRA, *amici* highlights some of the most common forms of discrimination that transgender patients face. Albeit not an exhaustive list, transgender discrimination in healthcare settings often takes the form of: (1) denial of gender identity, (2) disclosing transgender status to non-

necessary parties, and (3) delays in provision of care. As explored in greater detail below, each of these acts reflect a fundamental discomfort with, and a lack of understanding of, transgender patients.

A. Denial of a Transgender Patient's Gender Identity

Gender identity denial encompasses discrete acts, policies, and practices that have the effect of refusing the asserted gender identity of a transgender person. Gender identity denial can arise in myriad situations in healthcare settings. Administrative policies may default to classifying transgender patients according to their sex assigned at birth rather than the sex which aligns with their gender identity. For example, intake forms that classify transgender patients only by their sex assigned at birth deny a patient's gender identity. Similarly, housing policies that place transgender patients into sex-segregated wards based on sex assigned at birth also deny gender identity. Gender identity denial may also manifest in interpersonal exchanges between patients, providers, and support staff. For example, misgendering[2] a patient in conversation or in medical records is also a form of gender identity denial.

Gender identity denials are discriminatory. In addition to being disrespectful, gender identity denials manifest a literal rejection of the fact of the patient's gender transition. For a transgender man like Mr. Rumble, such refusals reinforce the erroneous belief that he is not truly male, that he is "other." *Cf. Lusardi v. Dep't of the Army*, 2015 WL 1607756 at *11 (EEOC 2015) ("[misgendering] sent the message that Complainant

[2] *Misgendering* refers to the use of gendered pronouns and/or gender referents that are inconsistent with the person's gender identity.

was unworthy of basic respect and dignity because she is a transgender individual"). Gender identity denials in health settings are particularly harmful since many patients enter care settings with already compromised capacities to cope with disparagement. *See, e.g.*, Lindsey Bever, *Transgender Boy's Mom Sues Hospital, Saying He 'Went Into a Spiral' After Staff Called Him a Girl*, Wash. Post (Oct. 3, 2016), https://www.washingtonpost.com/news/to-your-health/wp/2016/10/03/mother-sues-hospital-for-discrimination-after-staff-kept-calling-her-transgender-son-a-girl/?utm_term=.6866eee1dcf5.

Mr. Rumble was subjected to at least two discrete instances of gender identity denial which are particularly alarming. First, at intake Rumble was given a hospital identification bracelet with an "F" marker. This bracelet had the effect of classifying Rumble as female for duration of his hospital stay and broadcasted that erroneous gender classification to all personnel whom Rumble encountered. The bracelet speaks for itself—it is *per se* discriminatory to label a transgender male as female simply because he is transgender. *Cf. United States et al. v. Southeastern Okla. State Univ. et al.*, 2015 WL 4606079 at *2 (W.D. Okla. July 10, 2015) (transgender woman who presented herself as female but whose employers treated her as if she were male alleged viable claim of sex discrimination under Title VII). Moreover, there is no nondiscriminatory reason to classify a transgender person by their sex assigned at birth if the aim is to issue identification to help personnel within the hospital accurately track patients. Rules which mandate labeling transgender persons by their sex assigned at birth "inaccurately describe the discernable appearance of the [individual] by not reflecting the holder's lived gender

expression of identity . . . [when presented to others] for the purposes of identification, the third-person is likely to conclude that the furnisher is not the person described." *K.L. v. State, Dep't of Admin., Div. of Motor Vehicles*, 2012 WL 2685183 at *7 (Alaska Super. Ct. Mar. 12, 2012).

Second, Defendant Fairview issued medical records which labeled Rumble as female and, after Rumble's stay, transmitted a bill to Rumble indicating that his insurer had denied coverage due to a "gender mismatch" caused by Fairview's record platform containing mixed gender markers for Rumble. *See, e.g.*, Exhibit 1, Michael Rock Dep. 241:9–21, May 19, 2016. The inclusion of female gender markers in Rumble's medical records, over Mr. Rumble's protests at intake, is discriminatory. There is no legitimate reason for Fairview to ignore a patient's request to record identification information in medical records so that it accurately reflects the patient's identity. With fleetingly few exceptions (e.g., incapacity), patients are *always* in the best position to advise of their appropriate identification information. Neither facility-wide policies nor individual personnel should be empowered to reject a patient's asserted identification simply because that patient is transgender. At most, Fairview and its agents have a duty to ensure that the information collected is accurate—they are not privileged to impose their own independent judgment as to the correctness of patients' asserted identity. Refusals to defer to a patient's self-identification are offensive and, as demonstrated in this case, may result create a cascade of problems down the line.

To the extent that Defendant Fairview claims that labeling Mr. Rumble as female on his identification bracelet and medical records is nondiscriminatory because these

labels were mandated by policy or practice such defense is unavailing. Many discriminatory acts are deemed by the perpetrators to be nondiscriminatory because they flow from a purportedly neutral institutional practice or policy. But, such purportedly "neutral" practices can nevertheless give rise to "effects that are indistinguishable" from other discriminatory acts and liability must thus attach. *See, e.g.*, *Watson v. Fort Worth Bank and Trust*, 487 U.S. 977, 990 (1988). Indeed, the testimony of Defendant Fairview's 30(b)(6) witness Dr. Michael Rock coupled with insights provided by Mr. Rumble's experts on implicit bias demonstrate that Fairview's administration was insensitive to how policies and practices voluntarily adopted by Fairview relegated transgender patients to second-class status. *See, e.g.*, Exhibit 1, Michael Rock Dep. 241:18–24 (claiming that transgender patients must accept that computer system's failure to recognize gender identity of patient is merely reflective of the fact that "there is a time where a – a transition time where things are difficult" for transgender people). Moreover, it is no defense that Fairview's computer system that manages patient profiles automated the process of denying Mr. Rumble's gender identity. As the Supreme Court observed in *Ariz. Governing Comm. for Tax Deferred Annuity and Deferred Comp. Plans v. Norris*, broad remedial civil rights laws hold covered entities responsible for discrimination that flows from acts and design decisions made by third-parties providing services to covered entities. 463 U.S. 1073, 1088–91 (1983).

B. Disclosing Transgender Status to Unnecessary Parties

Robust state and federal medical privacy laws require providers and health facilities to take basic precautions to ensure privacy is maintained. However, many

facilities refuse to treat a patient's transgender status like the sensitive medical information that it is. Though transgender patients have recourse under medical privacy laws, they are also protected under federal and state nondiscrimination laws. Plainly, treating a transgender patient's sensitive medical information as if it is not protected medical information is discriminatory.

The fact that someone is transgender and the details concerning their treatment are sensitive medical facts. Like any other medical condition, a patient's diagnosis with gender dysphoria and the details concerning their past, current, and future treatment are sensitive medical information that must be protected from unauthorized disclosure to unnecessary medical personnel and third parties such as other patients. *State v. Stavish*, 868 N.W.2d 670, 679 n.4 (Minn. 2015) (observing that under federal and state law that providers and covered entities may not disclose protected health information—which broadly includes information that relates to a patient's past, present, or future medical condition or treatment and which is received or transmitted by a health provider—to third parties without written authorization of the patient).

Policies and practices like the ones Mr. Rumble was subjected to at Fairview failed to respect Rumble's right to privacy because he is transgender. For example, intake personnel at Fairview forced Rumble to orally out himself as transgender to unnecessary facility personnel and within earshot of other patients during the intake process. *See* Doc. 142-2, Exhibit D, Jakob Rumble Dep. 126–29, Jan. 26, 2016 (describing intake process). Similarly, Fairview personnel broadcasted that Dr. Lehrman, one of Rumble's treating physicians during his in-patient stay, is an OB-GYN thereby divulging Mr. Rumble's

genital configuration (and implicitly, Rumble's transgender status) to all the other patients, visitors, and unnecessary personnel in the men's ward. Doc. 141 at 10 (admitting Lehrman's specialty was listed on room's outward facing room whiteboard).

In its summary judgment motion, Fairview implies that its repeated failure to keep Mr. Rumble's transgender status and his treatment private are excusable because their actions were taken based upon Mr. Rumble's genital configuration and because the challenged policies and practices do not harm nontransgender patients. *See, e.g.,* Exhibit 1, Michael Rock Dep. 253:21–24, May 19, 2016 (justifying taking these actions because of Rumble's genital configuration); Doc. 141 at 10–11 (arguing that listing physician's specialty as OB-GYN on room whiteboard is not discriminatory because all patients "have their provider specialties listed"). Neither excuse is sufficient to carry Fairview's burden at summary judgment since both evidence that Fairview subjected Mr. Rumble to poor treatment because he is a transgender man. *See White v. Dep't of Corr. Servs.*, 814 F.Supp.2d 374, 387 (S.D.N.Y. 2011) (denying summary judgment on Title VII claim where there is direct evidence of a discriminatory policy). Rumble's genital configuration is directly related to his transgender status and medical treatment. "Although [Fairview] contends that it discriminated against [Rumble] based on his genitalia, not his status as a transgender person, this is a distinction without a difference here." *Roberts v. Clark Cnty. Sch. Dist.*, 2016 WL 5843046 at *9 (D.Nev. Oct. 4, 2016). Moreover, it is inapposite that nontransgender persons may find Fairview's policies and practices inoffensive. As the Ninth Circuit observes, animus "motivated comments or action may appear innocent or only mildly offensive to one who is not a member of the targeted group, but in reality by

intolerably abusive or threatening when understood from the perspective of a plaintiff who is a member of the targeted group." *McGinest v. GTE Serv. Corp.*, 360 F.3d 1103, 1116 (9th Cir. 2004).

C. Delays in Provision of Care

All patients deserve timely access to treatment. While facilities and individual medical providers are free to use nondiscriminatory priority classifications and triage procedures to manage patient flow, significant delays in provision of care to a patient simply because they are transgender are discriminatory.

There is nothing inherent to being transgender that makes a patient exponentially more difficult to treat or accommodate in modern medical practice. The medical maladies transgender patients present with are no less knowable than conditions experienced by nontransgender patients. Thus, where transgender patients present with medical needs totally unrelated to treatments for gender dysphoria, there is no justifiable reason to delay care. Discriminatory intent should be inferred where providers protest, hesitate, or significantly delay providing care to a transgender patient for a condition they typically treat in nontransgender patients. *Cf. Miller v. Spicer*, 822 F.Supp. 158, 165 (D.Del. 1993) (finding inference of discrimination where hospital transferred gay man believed to be HIV-positive to another facility on pretense that hospital's experienced tendon-repair surgeon lacked appropriate expertise to perform tendon-repair).

Even where transgender patients present with a condition where their gender transition is medically relevant, there is no nondiscriminatory reason to significantly delay provision of care. It is discriminatory to justify significant delays in care by

claiming one lacks experiential capacity to care for transgender people. The effects of gender transition treatments are well documented. See discussion *supra* Part I-B. Neither facilities nor providers should be permitted to exempt themselves from taking basic steps to ensure they can provide competent treatment to transgender persons. *Cf. Harvey v. Duncan*, 2016 WL 1639693 at *5 (S.D.Ill. Apr. 26, 2016) (finding sickle cell patient's allegations that emergency room personnel failed to timely triage, unreasonably delayed administering sufficient medication to manage pain associated with sickle cell attack, and otherwise knowingly allowed serious medical needs to go untreated to state plausible claim of discrimination).

In this case, Mr. Rumble complains that Fairview physicians delayed treating him for several hours in the emergency department simply because he is transgender. *See* Doc. 177 at 8–9 (arguing that emergency personnel waited several hours before examining Rumble, failed to administer appropriate medication to manage Rumble's pain, and unreasonably delayed ordering appropriate lab work and other medications). Contested issues of fact and credibility should ultimately be weighed by a jury. But, as a matter of law, this Court should hold that a significant delay in treatment because a patient is transgender is discrimination. Without such a finding, unchecked anti-transgender bias will continue to deprive these patients of meaningful, equitable access to health care.

Though the delay Mr. Rumble endured was not fatal, many other transgender patients are not so fortunate. Just over two decades ago Tyra Hunter, a Black transgender woman in Washington, D.C., died because first responders and later emergency

department personnel were so shocked by the fact that she was transgender that they delayed treating her injuries incurred from a car accident. *See generally* Scott Bowles, *A Death Robbed of Dignity Mobilizes a Community*, Wash. Post (Dec. 10, 1995), https://www.washingtonpost.com/archive/local/1995/12/10/a-death-robbed-of-dignity-mobilizes-a-community/2ca40566-9d67-47a2-80f2-e5756b2753a6/?utm_term=.352e115365e7. In Ms. Hunter's case, a few minutes of hesitation was the difference between life and death.

CONCLUSION

A trip to the doctor's office or emergency department is not an invitation for abuse. Our robust antidiscrimination laws command that all Americans be afforded equitable access to health care. Many of the most common forms of transgender discrimination are prohibited by Section 1557 and the Minnesota Human Rights Act. For all the foregoing reasons, *amici* urge the Court to deny Defendants' summary judgment motions.

Dated: December 23, 2016

Respectfully submitted,

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L.R. 7.1 CERTIFICATE OF COMPLIANCE

This brief complies with this Court's Order regarding amicus briefs [Doc. 123], Fed. R. App. P. 32(g)(1), and L.R. 7.1 because this brief contains 4829 words, including all text, headings, footnotes, and quotations, other than parts of the brief exempted by these rules. This brief was prepared using Microsoft Word 2016.

This brief complies with the type size requirements of L.R. 7.1 because this brief has been prepared using at least font size 13, is double-spaced (except for headings, footnotes, and quotations that exceed two lines) and is submitted on 8 ½" by 11" paper with at least one inch margins on all four sides.

Dated: December 23, 2016

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CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing brief with the Clerk of the United States District Court for the District of Minnesota via the CM/ECF system this 23rd day of December, 2016. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Respectfully submitted,

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