Do No Harm

Testimony of Stanley Goldfarb, MD

September 16, 2025

Chairman Smith, Ranking Member Neal, and Members of the Committee, thank you for the opportunity to testify today. My name is Dr. Stanley Goldfarb, and I serve as the Chairman of Do No Harm. Do No Harm is an organization of medical professionals devoted to keeping divisive and un-scientific identity politics out of the practice of medicine. Our mission is to defend the timeless standards of medical excellence against divisive political trends that undermine patient trust and public health.

Nonprofit hospitals enjoy extraordinary privileges under federal law, most notably their tax-exempt status. This taxpayer subsidy, worth billions of dollars each year, is designed to help hospitals provide care to the underserved in their communities. But instead of focusing on curing disease, expanding access to care, and saving lives, too many of these institutions are squandering their taxpayer-backed resources on ideological experiments. Rather than placing patients at the center of their mission, they have chosen to embrace controversial and counterproductive diversity, equity, and inclusion—or DEI—programs and to promote radical gender ideology, including dangerous interventions on children. These practices are not only deeply misguided but are inconsistent with the intent of Congress and the expectations of the American taxpayer.

The problem could not be clearer. We are witnessing hospitals that should be committed to serving the sick diverting their attention to political activism. They are spending millions on DEI bureaucracies and on so-called "gender-affirming care" for children when these resources could be put to far better use expanding cancer treatment, building trauma centers, or making primary

care more available and affordable. This is a profound betrayal of their public mission.

It is also at odds with the national priorities recently established through a series of Executive Orders issued earlier this year. Executive Order 14170 restored fairness and merit in federal programs, Executive Order 14187 aims to protect children from the harmful effects of pediatric medical transition, and Executive Order 14279 specified that higher education accreditors, including those that accredit medical schools, must terminate unlawful discrimination masquerading as DEI, eliminate ideological biases, and focus on enhancing merit and providing the highest quality care. In addition, the Department of Justice has transmitted the Victims of Chemical or Surgical Mutilation Act to Congress, a legislative measure designed to shield children from irreversible procedures disguised as medicine. The priorities of the American people and their elected representatives are clear. Yet many nonprofit hospitals have been and continue to act in direct opposition to those priorities.

The evidence is overwhelming. At Massachusetts General Hospital, administrators announced in April 2024 that they would scale back child neglect and abuse reports for mothers who test positive for drugs, not because it benefits patients, but because they feared that mandatory reporting was perpetuating what they called "structural racism." At Yale University, clinicians at the Yale Child Study Center are now interrogating children about their "racial and ethnic experiences" and instructing providers to discuss their own racial and ethnic identities and biases. Duke University Health System, which received over one billion dollars in federal funding in fiscal year 2023 alone, was the subject of a federal civil rights complaint in March of this year for implementing race-based preferences in hiring and medical school admissions, while promoting the notion that white males are "agents of oppression." Corewell Health in Michigan requires every employee to sign a pledge in support of DEI or risk termination. Just two years ago, the Mayo Clinic pledged $100 million to "eliminate racism and advance

belonging"—money spent on indoctrination sessions about microaggressions, "systemic biases," and the supposed dangers of color blindness and meritocracy. Similar DEI pledges, training mandates, and equity bureaucracies exist at Memorial Health in Illinois, Baton Rouge General Hospital, MaineHealth, Kaiser Permanente, and Providence—just to name a few—all of which have chosen to build political infrastructure rather than use these dollars to expand access to real medical care.

This politically charged approach to health care management is intellectually bankrupt. In very unscientific ways, DEI proponents often conclude that treatment outcomes that differ between groups can only be the result of systemic biases, without ever diligently analyzing more medically relevant variables. DEI policies also prioritize reverse discrimination in hiring and promotion instead of providing patients the most qualified health care professionals available. These cynical policies are built on the false premise that our medical institutions are mired in bigotry. America's doctors, nurses, and other health care professionals are not racist, sexist, or homophobic. They are deeply committed and caring people who work tirelessly every day out of love for the common humanity they see in all their patients.

Yet, physicians are increasingly told that implicit bias contributes to healthcare disparities, and that racial concordance—matching patients with doctors of the same racial background—improves outcomes. However, the evidence supporting this claim is far from true. An analysis by Do No Harm found that four out of five systematic reviews on racial concordance in medicine showed no improvement in health outcomes. A sixth review, published in late 2024 and focused on addiction treatment, similarly found no benefit. It's important to critically examine the scientific and ethical implications of this idea. Promoting racial concordance as a solution reinforces divisions reminiscent of segregation, suggesting that black patients should see black doctors and white patients should see white doctors. This is not a path we should pursue. What patients truly seek is high-quality care—regardless of their physician's race.

Radical ideology in our health care system is also seriously affecting our most precious patients—America's children. Between 2019 and 2023, nearly 14,000 minors underwent some form of medical intervention marketed as so-called "gender-affirming care," including puberty blockers, cross-sex hormones, and irreversible surgeries. Of those, more than 5,700 were subjected to irreversible sex-change surgeries. Many of the hospitals most deeply involved are nonprofits. Among them are Boston Children's Hospital, the Children's Hospital of Philadelphia, Seattle Children's, Children's Minnesota, and Children's Hospital Los Angeles, which collectively performed sex change interventions—that includes medications and/or surgeries—on over 1,000 children in just five years. At Boston Children's alone, 301 minors received these "treatments," including more than 150 who underwent surgery. Children's Hospital Los Angeles "treated" 265 children, 165 of whom were subjected to surgery. Seattle Children's performed surgeries on 50 minors, in addition to prescribing puberty blockers and cross-sex hormones to nearly 250 more. These are not isolated incidents. In June of this year, the FBI launched a criminal investigation into Boston Children's and Children's Hospital Los Angeles, citing concerns over their handling of such procedures.

Other hospitals have pursued equally reckless policies. At the Children's Hospital of Orange County, the division chief of endocrinology had openly claimed that children can know their gender identity "as soon as they can talk" and encouraged parents to immediately seek medical intervention. That same hospital subjected nearly 60 children to gender procedures between 2019 and 2023, including 26 surgeries. Administrators at Connecticut Children's Hospital went so far as to design a portal to help children from states with legal protections for minors obtain gender interventions in Hartford. At Carroll Hospital in Maryland, administrators adopted a policy requiring staff to use the preferred pronouns of patients, including minors, regardless of their biological sex, legal name, or medical history, even in room assignments, forcing the possibility that a teenage girl could be made to room with a boy.

Nations whose health care systems have long been admired by proponents of gender transitions for children have been rapidly rolling back those policies. The United Kingdom, Sweden, Finland, and others have taken significant steps to protect children and close this dark chapter of medical history.

These practices do more than waste taxpayer resources. They actively erode parental rights, displace community values, and put children at risk of permanent disfigurement. When hospitals instruct doctors to ask babies for their pronouns, when they embed gender ideology into electronic health records, or when they restrict parental access to a child's medical file unless the child gives permission, they are putting ideology ahead of family and medicine. That is not health care, it is political indoctrination.

The consequences for patients and taxpayers alike are enormous. Hospitals that were meant to serve their communities are instead squandering resources on divisive ideologies that have no place in medicine. They are taking billions in federal subsidies while openly undermining the will of the people whom they serve. They are betraying parents who trust them to care for children. They are failing taxpayers who trust them to use their privileged status to serve the common good.

This Committee has rightly asked the question: where is the money going? Is it going to oncology wards, emergency rooms, or rural clinics? Is it going to increase access to care or reduce the crushing costs of medicine? The answers to these questions are unfortunately troubling. You can see from this testimony that much of this money is unfortunately being directed elsewhere. It is going to DEI bureaucrats, equity consultants, gender ideology trainers, and surgeons who perform irreversible procedures on children, many of whom grow up to deeply regret decisions they never should have been allowed to make. Taxpayers are being forced to underwrite all of this, and it must end now.

Tax exemption is a privilege, not an entitlement. It is granted so that hospitals can provide measurable benefits to their communities. Those who fail to honor this obligation should lose the benefit that comes with it. Institutions that substitute ideology for medicine do not deserve special treatment under the law. They deserve scrutiny, accountability, and reform.

Chairman Smith, Ranking Member Neal, and Members of the Committee, your leadership on this issue is vital. By exposing these abuses and demanding change, you are defending both taxpayers and patients. The American people should not be compelled to subsidize ideological agendas in the name of health care. It is time to restore hospitals to their proper mission: serving the sick, healing the injured, and advancing medicine free from politics.