

IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF WISCONSIN

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CODY FLACK,  
SARA ANN MAKENZIE,  
MARIE KELLY, and  
COURTNEY SHERWIN,

Plaintiffs,

v.

Case No. 18-CV-0309

WISCONSIN DEPARTMENT OF  
HEALTH SERVICES and  
LINDA SEEMEYER, in her official  
capacity as Secretary of the Wisconsin  
Department of Health Services,

Defendants.

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**DECLARATION OF DANIEL D. SUTPHIN, M.D.**

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**Daniel D. Sutphin, M.D.**, declares as follows under penalty of perjury,  
pursuant to 28 U.S.C. § 1746:

1. This declaration is based upon my personal knowledge and review of records provided to me by counsel for the Defendants relating to this case.

2. I am a practicing plastic surgeon presently working in the medically underserved area of Yuma County in southwest Arizona. I earned my Doctor of Medicine from the University of Tennessee, College of Medicine in Memphis in 2004. I am licensed to practice medicine in the states of

Tennessee, California, New Mexico, and Arizona. I am board certified by the American Board of Surgery and the American Board of Plastic Surgery.

3. In addition, after completing a general surgery residency and a plastic surgery residency at the University of Tennessee, I completed an additional year of fellowship training in reconstructive microsurgery at the University of California, San Francisco. I am a Fellow of the American College of Surgeons and a member of the American Society of Plastic Surgeons.

4. In the scope of my practice, I have provided surgical care to heterosexual, homosexual, bisexual, and transsexual patients of multiple racial and religious backgrounds. I also provide care for incarcerated patients, as well as uninsured and underinsured patients including undocumented immigrants. A detailed list of my credentials may be found in Exhibit A which is attached.

5. Opinions expressed in this declaration are based upon my knowledge and professional experience in the matters discussed. I have relied upon the same types of materials that other experts in my field of practice rely upon when forming and rendering opinions. I have reviewed the following case specific materials:

- Expert Witness Declaration of Stephanie L. Budge, PhD, LP (Dkt. 24)

- Supplemental Expert Witness Declaration of Stephanie L. Budge, PhD, LP (Dkt. 60)
- Expert Witness Declaration of Daniel Schumer, MD, MPH (Dkt. 25)
- Expert Witness Declaration of Jaclyn White Hughto, PhD, MPH (Dkt. 26)
- Supplemental Expert Witness Declaration of Jaclyn White Hughto, PhD, MPH (Dkt. 96)
- Expert Witness Declaration of Loren S. Schechter, M.D. (Dkt. 27)
- Expert Witness Declaration of Daniel P. Bergman, MS, LPC, NCC (Dkt. 28)
- Expert Witness Declaration of Amy M. DeGueme, MD, ECNU (Dkt. 29)
- Declaration of Clifford King, MD, PhD (Dkt. 30)
- Declaration of Trisha E. Schimek, MD (Dkt. 31)
- Declaration of Katherine M. Gast, MD, MS (Dkt. 32)
- Declaration of Beth E. Potter, MD (Dkt. 33)
- Declaration of Kathy Oriel, MD, MS (Dkt. 109)
- Declaration of Cody Flack (Dkt. 22)
- Supplemental Declaration of Cody Flack (Dkt. 91)
- Declaration of Sara Ann Makenzie (Dkt. 23)
- Supplemental Declaration of Sara Ann Makenzie (Dkt. 61)
- Second Supplemental Declaration of Sara Ann Makenzie (Dkt. 92)
- Declaration of Marie C. Kelly (Dkt. 93)
- Declaration of Courtney Sherwin (Dkt. 95)
- Plaintiffs' Amended Complaint (Dkt. 85)

- Memorandum of Law in support of Plaintiffs' Motion to Modify Preliminary Injunction (Dkt. 108)
- Plaintiffs' Amended Complaint (Dkt. 85)
- Memorandum of Law in support of Plaintiffs' Motion to Modify Preliminary Injunction (Dkt. 108)

6. Although pharmacologic and surgical methods of many forms can be used to produce various desired physical characteristics, individuals cannot change their sex. This fact is not a psychosocial, discriminatory, malicious or ill intended construct, but rather a biological reality.

7. Excluding the approximately 0.1-0.2% of individuals born intersex,<sup>1</sup> human infants are born male or female. This is an observed biological fact rather than an arbitrary, uninformed or unaware assigned designation.

8. Likewise, the male and female sexual reproductive organs are distinctly and self-evidently unique. They are perhaps one of the best biological illustrations of the truism that form relates to function. The inherent complexity of these systems is reflected in the degree of specialized medical care devoted to them in the fields of urology, gynecology, obstetrics and urogynecology. To this end, those individuals affected by gender dysphoria may desire surgical revision of their physical body such that it reflects the body of the sex the patient most identifies with. In layman's terms, such procedures are often broken into "top" or "bottom" surgery sub classifications.

9. Very generally, “top” surgery refers to surgical obliteration of the breasts (thereby producing a more male physique) or augmentation thereof (to create a more feminine physique). “Bottom” surgery includes a series of procedures designed to obliterate the biologically native genitals (including the penis and scrotum or the vagina and labia as well as the uterus, ovaries and /or fallopian tubes) while fashioning a reasonable facsimile of those of the desired sex. Such surgeries are inherently more complex and irreversible.

10. A biological male seeking “bottom” surgery would pursue one or more of a series of surgeries including amputation of the penis (penectomy), surgical castration (orchiectomy), and fashioning of a neovagina (either from the remaining skin envelope of the inverted penis and scrotum or by cutting a segment of small bowel or more commonly large bowel and moving it to a position between the patient’s thighs where it may serve as a vaginal analog).

11. A biological female patient on the other hand seeking a “bottom surgery” is generally pursuing obliteration of the natal vagina and/or internal sexual organs including the uterus ovaries and fallopian tubes. The fashioning of a phallus of some form represents the sine qua non of such a transition. This may be attempted through surgical alteration of the clitoris and modification of the urethra (urinary tube) to exteriorize the same. This may allow the patient to void while standing. However, for a patient who wishes to engage in

penetrating intercourse, a neophallus must be constructed and then augmented with some form of permanent prosthesis to provide static or dynamic rigidity to the point that penetration can be achieved.

12. Such procedures represent the apex of technical and reconstructive complexity and generally require multidisciplinary surgical teams. These procedures are understandably irreversible as the patient, despite any future attempts at reversal, will never be able to achieve the degree of form and function present in the extirpated natal sexual organs.

13. Candid and expert surgeons detail this fact clearly in perioperative discussion and consent forms. Likewise, well defined consent for such procedures will outline not only generic risks potentially associated with most surgeries, such as infection, bleeding, pain and numbness, but also risks distinctive to such procedures including diversion of urinary stream, loss of erogenous sensation, and failure to achieve the natural and desired appearance of the external genitals (which may perpetuate a cycle of revisional surgery and scarring). More dramatic and life altering sex reassignment risks of “bottom” surgery include but are not limited to infertility, urinary incontinence, inadvertent bowel injury requiring a diverting intestinal ostomy (the intestine may be drawn out of the abdominal wall and diverted into a collecting bag), urethral stricture with associated increased risk of chronic urinary tract infection, and colovaginal fistula (or communication between the

residual colon and the “neovagina” allowing stool to issue from both).

14. Whether or not such risks are determined by the patient and physician to be justifiable, it goes without saying that surgical technique does not and cannot alter a person’s cellular and chromosomal identity.

15. Any attempt at reversal (e.g., a male to female patient transitioning back to male and desiring penile reconstruction after prior penectomy) is often higher risk and more technically complex. It will be performed at a tertiary center by a team of experts with a resultant cost reflective of the same.

16. Even for transgender patients in the midst of transition, attempted chemical obviation of the patient’s biologic sex can have a significant impact on surgical options available for sex reassignment. For example, Dutch authors Bouman et al. detail their experience with natal male patients given exogenous hormone therapy to circumvent physiologic puberty and masculinization. By the time such patients moved forward with penectomy and neovaginal reconstruction at an average of 21.1 years of age, their penile scrotal size was inadequate to complete penile scrotal inversion. As a result, an operation with inherently greater complexity using a segment of colon as a vaginal substitute was instead required.<sup>15</sup>

17. Contrary to the World Professional Association for Transgender Health (WPATH) categorization of hormonal therapy as “reversible” or “partly

reversible,”<sup>20</sup> the observations of these surgeons also point to another important fact; chemical castration may also lead to significant anatomic changes with tangible surgical consequences.

18. As surgeons, if we ignore or attempt to controvert such facts, we may do so at the potential peril of the patient.

19. The importance of accurately indicating the patient’s biological sex is pragmatically and clinically important. For instance, in male to female patients who have undergone neovaginoplasty utilizing a segment of colon, it is clinically relevant to know that the patient’s “vagina” is in fact a segment of colon with colonic mucosa rather than stratified vaginal squamous epithelium. Though the patient may appear and indeed feel feminine, an examining gynecologist will need to be aware that the cervix is physiologically absent and she or he will need to become familiar with prostate exams or else refer the patient to an urologist with greater familiarity with such otherwise routine assessment. In such a patient, what standard of surveillance for colonic columnar mucosa will be recommended to her over a twenty year period?<sup>10, 11,</sup>  
<sup>12</sup> Histologically, how does columnar mucosa behave on a cellular level when subjected to the otherwise physiologic and minor trauma that vaginal squamous mucosa tolerates over the same time without adverse effect?<sup>10, 11 12</sup>  
What do we tell the patients who inquire regarding the future risk of getting colon cancer in the neovagina?<sup>10, 11, 12</sup> Is it the same as that in biological

females? Questions such as these are relevant but unanswered.

20. The risk of breast cancer in transgender patients is still being defined. At present there are no randomized studies on the effects of long-term testosterone use on breast cancer risk.<sup>5</sup> In addition, although breast cancer has been reported in male to female transgender patients since 1968, these patients' risk of breast cancer remain unclear.<sup>2</sup>

21. Likewise, at present, there are no evidence based radiographic guidelines in place regarding appropriate imaging of transgender patients.<sup>6</sup>

22. After receiving a formal request to render an updated national coverage determination regarding gender reassignment surgery in 2016, the Centers for Medicare & Medicaid Services (CMS) conducted what may be the most comprehensive literature review of its kind to date. Subsequent to this rigorous analysis, it concluded: "(CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population."

23. WPATH acknowledges that presently there is no accrediting body with regards to gender reassignment surgery, nor for that matter even an ability to identify new surgeons competent in the field.<sup>3</sup>

24. Likewise, the WPATH SOC (7<sup>th</sup> ed.) guidelines so widely referenced throughout the Plaintiffs' complaint and supporting expert

witnesses' declarations have not been subject to external peer review to my knowledge (such as is typically done when producing standards of care<sup>23</sup>).

25. Thus is it is difficult to accept the fait accompli presented by the Plaintiffs and associated expert witnesses that describe the State of Wisconsin's current exclusion for gender reassignment surgery coverage as inconsistent with "peer reviewed scientific literature" and "prevailing standards of care." (Schechter Decl. (Dkt. 27:13) ¶ 43.)

26. As a surgeon, I do not offer elective procedures to patients unless I have a high degree of confidence that the methodology of the procedure in question is sound and that the expected result will consistently produce a specific outcome. For me to offer a procedure in a safe and efficacious manner, this must be true not only based on what a select group of surgeons can produce under select circumstances but must also be reproducible with my own hands and with the resources available at my disposal.

27. Poignant regret and vacillation regarding the surgical outcome of sex reassignment surgery as expressed by patients who have undergone such surgery has also even been described in media outlets such as Newsweek, the BBC, and [lgbtqnation.com](http://lgbtqnation.com).<sup>13, 14, 35</sup>

28. Indeed, one of the most prolific and widely recognized surgical experts in the field of gender reassignment surgery, Dr. Miroslav Djordjevic has noted a number of patients in his practice seeking reversal of their sex

reassignment surgeries.<sup>21</sup>

29. Given the above factors and the inherent variability of the transgender patient population,<sup>20, 36</sup> the candid surgeon cannot help but consider the definitive and truly immutable change many such procedures bring by default. Few clinicians have better described this imperative than Goin: “When a new patient requests an operation, the surgeon must ask himself or herself if this is someone whose perceptions of his or her body are more or less realistic or whether there is a severe body image distortion present that no operation can cure.”<sup>19</sup>

30. Expressing a similar candid caution, Dr. Charles L. Ihlenfeld has observed, “Whatever surgery did, it did not fulfill a basic yearning for something that is difficult to define. This goes along with the idea that we are trying to treat superficially something that is much deeper.”<sup>22</sup> Importantly, Dr. Ihlenfeld is a psychiatrist who, while working alongside Dr. Harry Benjamin (the pioneering founder of what has evolved into the current WPATH organization), treated transsexual patients as a regular part of his practice. I share his concern.

31. Accordingly, an individual or organization, who in their own professional deliberations, express reservation or declines to perform or endorse sex reassignment surgery cannot de facto be billed as harboring irrational malice or practicing wholesale discrimination towards those patients

who seek such procedures or those clinicians who perform them as part of their professional practice.

32. Furthermore, sex reassignment surgery has not achieved the level of de facto safety and wide familiarity such as suggested by the declarations of the plaintiffs' medical providers.

33. "It's a major complicated operation compounded by significant preop considerations and significant postop care. They're work intensive...if it's too many in too short a time, the entire clinic staff can become overloaded," observes Dr. Bill Kuzon of the University of Michigan.<sup>30</sup> The plaintiffs' own witness, Dr. Loren Schechter, a surgical contributor to WPATH cautions regarding sex reassignment genital surgery that "we can't really dabble in this, as they are vastly more complex procedures."<sup>30</sup> Dr. Jess Ting, surgical director at the Mount Sinai Center for Transgender Medicine and Surgery, observes that sex reassignment surgery "operations are complex, and many come with perilous sets of complications."<sup>29</sup>

34. In fact, a number of surgeons with extensive experience in the field are now advocating formalized fellowship training in order to enhance the safety of sex reassignment surgeries for patients who elect to undergo them.<sup>8, 29</sup>

35. The number of various types of surgery now performed in gender reassignment is no less than 43.<sup>8</sup>

36. The efficacy of sex reassignment surgery, particularly with regard to complication rate and cost, remains unverified in terms of durable objective benefit.

37. The Dhejne study, the longest and most comprehensive of its kind to date covering virtually every psychiatric admission in Sweden since 1973, was conducted over a thirty year time span.<sup>9</sup>

38. The authors conclude, based on their findings, that “Even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons.”<sup>9</sup> Accordingly, while the nonsurgical transgender patient population is of significance, it is well to recall that in the case under consideration, the plaintiffs are seeking uniform financial sponsorship of surgery to facilitate gender reassignment.

39. Interestingly, the observations of Dhejne et al. were not dissonant with others conducted over the preceding four decades, including the work presented by Meyer in 1977 which led to the temporary cessation of the surgical gender reassignment program at Johns Hopkins.<sup>24</sup>

40. Even the American Psychiatric Association notes in its 2012 task force report on treatment of gender identity disorder that “The quality of evidence pertaining to most aspects of treatment in all subgroups was determined to be low” and “subjective improvement” is relied upon as “the

primary outcome measure.”<sup>16</sup>

41. Valid patient-reported outcome measures for the transgender patients that are sensitive enough to assess gender confirmation surgery without the influence of other gender related interventions remain lacking.<sup>17</sup> In addition, the high number of unreliable instruments used in current literature not only yields uncertain results but also precludes dependable comparison between different studies.<sup>17</sup>

42. Likewise, despite surgical sex reassignment, rates of mortality, suicidal behavior and psychiatric morbidity remain elevated in the transsexual population monitored over a 30 year period.<sup>9</sup>

43. Thus in keeping with all the above, there are valid reasons to question whether sex reassignment surgery is an option that the State of Wisconsin wishes to, or should be forced to, include as a standard component of its Medicaid plan.

44. Furthermore, as a surgeon certified by both the American Board of Surgery and the American Board of Plastic Surgery, neither Board has to date declared any defined standards of care for treating gender dysphoria, “widely accepted” or otherwise. Also, as they are noticeably absent in the Amended Complaint and Dr. Schechter’s declaration citing “major medical organizations” (Amend. Compl. (Dkt. 85:15) ¶ 51) and “broader medical community”(Schechter Decl. (Dkt. 27:10) ¶ 34), it is unknown whether the

American Board of Surgery, the American Board of Plastic Surgery, the American College of Surgeons, and the American Society of Plastic Surgeons are considered by the plaintiffs and Dr. Schechter as legitimate sources of valid guidance in the case under discussion. I am unaware of any such surgical body that has reached consensus that surgery is medically necessary and effective treatment for individuals with gender dysphoria.

45. Although the Amended Complaint references the American Medical Association (Amend. Compl. (Dkt. 85:14) ¶ 51), the AMA has for some years now been known to represent only approximately 15% of practicing United States physicians.<sup>28</sup> This hardly constitutes the quorum of 75% of such physicians noted in the 1950s.<sup>28</sup>

46. According to Hazen et al. reporting on female to male genital reconstruction options alone, “The vast majority of existing information on outcomes in female-to-male genital reconstruction is considered low-quality evidence. Existing studies on patient satisfaction are limited by a general lack of validated, standardized methods, a paucity of controlled studies, little prospective data collection, and poor response rates in long-term follow-up studies. In addition, there is enormous variation in follow-up periods. Emphasis is placed on the need to develop ‘standardized methods to assess the outcomes of surgery’ in terms of quality of life before and after surgery, and long-term data collection on preoperative versus postoperative sexual function/

satisfaction.”<sup>25</sup>

47. In addition, the authors of review found “Perhaps most notably . . . no reports of direct comparisons or analyses investigating how outcomes differ by surgical technique. Similarly, the factors influencing patients’ decisions to pursue (or forego) female-to-male transgender procedures have scarcely been considered. There exists no evidence or proposed algorithm to offer surgeons and female-to-male transgender patients guidance in determining the most appropriate technique.”<sup>25</sup>

48. It should be noted that the findings of these authors represent experienced and well qualified surgeons operating out of tertiary centers with internationally based faculty.

49. Unique to sex reassignment surgery is the concept that the impetus for state funding of a procedure shall be “strong desire” or “want.” According to the American Society of Plastic Surgeons, over 290,000 breast augmentations were completed in the U.S. alone in 2016.<sup>33</sup> It is understood that these patients indeed had a “strong desire” and “want” to alter the appearance of their otherwise physiologically normal breasts, which has also been my personal experience with these types of patients. Indeed, they found the discordance between the reality of their desire and the actual state of their body “distressing” to the point that they sought and underwent surgery. However, I am unfamiliar with any precedent or expectation that such

procedures would be considered “medically necessary” and thus covered by state insurance plans. This is true no matter how severely distressing the patient may find the degree of her breast ptosis, micromastia or postpartum involution to be.

50. The dissonance that many such procedures when performed on natal sex patients are considered cosmetic in nature but when performed on a transsexual patient somehow become reconstructive in nature is noted. (Schechter Decl. (Dkt. 27:8) ¶ 31.) Further expounding, Dr. Schechter states that “because these medically necessary procedures help transgender individuals ...reduce their dysphoria...these are appropriately categorized as reconstructive procedures.” (Schechter Decl. (Dkt. 27:8) ¶ 31.)

51. To that end, I submit that procedures performed to alleviate gender dysphoria are in fact better categorized as *ablative* or *neoconstructive* in nature. Ablative procedures are those designed to erase the phenotype characteristic of the native and undesired gender (e.g a mastectomy for a female to male transgender patient or a penectomy for a male to female transgender patient). Neoconstructive procedures are those involving establishment of non-natal sexual organs in a de novo fashion (e.g completion of a phalloplasty for a female to male transgender patient who in the natal state possesses no such organ).

52. As WPATH SOC 7<sup>th</sup> ed. relates that gender dysphoria is “broadly defined as discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth”. However, if a procedure may be qualified as reconstructive in nature on the basis of reducing dysphoria thus defined, why cannot cis women also obtain insurance coverage for a modest augmentation and mastopexy to alleviate their genuine and persistent somatic dysphoria caused by tremendous superior medial breast volume loss pursuant to massive weight loss?

53. The American Psychiatric Association dropped the term “Gender Identity Disorder” from clinical use (DSM V 2013) and replaced it with the term Gender Dysphoria. Contrary to the assertion of the Memorandum of Law in Support of Plaintiff’s Motion (Dkt. 108:2), it seems that the State’s position for coverage of surgery addressing organic disease alone for both cis and transgender patients does not disproportionately impact transgender patients, and in fact refrains from granting additional coverage privileges to transgender patients.

54. In sex reassignment surgery, organs uniquely characteristic of the male and female sex are removed and/or reasonable anatomic facsimiles fashioned in an effort to ameliorate the discordance between what the patient feels regarding their gender and the reality of their natal sex. It seems then that such a procedure, unique in all of medicine, in which an otherwise

physiologic organ is removed based on the seminal impetus of patient desire and perception, should be corroborated by a correspondingly exceptional quality of data.

55. Whatever the perceived subjective benefits of sex reassignment surgery may be, application of these now no less than 43 different such surgeries<sup>8</sup> involves “more”, not “less” in the sense of technical complexity, invasiveness, irreversibility, cost, resource allocation, and operative patient risk.

56. It should also be understood that the entire premise of gender reassignment surgery is built upon the unique and unprecedented notion that in the absence of organic disease (infectious, oncologic, traumatic, or biologically deformational), a person may now be declared a candidate for potentially radical surgery solely on the basis of that person’s own perception (in this instance provided the same is deemed of sufficient duration and earnest as outlined in WPATH guidelines). Interestingly, this is said to be valid even though the perception of the patient is entirely discordant with the observed reality of their biological state. Generally, such a schism would be considered delusional. However, for gender reassignment surgery to be plausible, one must embrace the concept that that which actually is (i.e. the physical body down to the chromosomal composition of the same) is actually errant and so must be conformed to suite the aspiration of the mind.

57. I know of no other occasion in medicine where otherwise healthy and intact organs can be surgically extirpated based the impetus of patient desire. This is to say nothing of the expectation for national or state coverage of the same.

58. Indeed, were the state to be required to provide coverage in this manner based on the premise that a highly invasive surgical procedure<sup>i</sup> may now be warranted to alleviate psychological morbidity, it is difficult conceptually to determine where clinicians and third party payors alike could draw a determination regarding which options are justifiably covered.

59. Consider for instance the uncommon but well described state known as Body Identity Integrity Disorder.<sup>4</sup>

60. Those affected by this disorder perceive a subjective struggle to cope with the reality of their otherwise healthy and functional physical body in the face of an absolute and persistent desire to experience paralysis or amputation of some form.<sup>7</sup>

61. Patients who struggle with this disorder relate their desire for amputation in a manner that parallels the feelings of the Plaintiffs in terms of strength, duration and pervasiveness: “It supports my identity, I recognized

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<sup>i</sup> Some being of such technical complexity and potential morbidity to justify advocates of the same facilitating fellowship training such as that begun by Dr. Schechter in 2017.

myself even before the operation as a handicapped man.” “Since very young age I knew that my right leg is not belonging to me and I want to get rid of it at all costs.” “When I was a young child, I pretended that my stuffed animals had missing legs, or I immobilized their legs. Anyway, it got to a certain point where ... it basically came down to a question of being happy. I figured one way or another...long term I could only be happier without legs.”<sup>4</sup>

62. However, despite the morbidity of amputation, according to Noll et al. of twenty-one patients they identified who underwent amputation of one or more limbs to alleviate their BIID, none experienced regret. In fact, immediately after their surgery, participants reported, “When I awoke in the room, I felt relaxation and relief, lightness as never before. I had the feeling: ‘At last this is forever!’ I can’t stop to look at the leg. I felt light as a feather. I felt totally normal, as if it ever should have been this way.”; “When I woke up, the first I recognized was that BIID was gone. For sure this was the most overwhelming feeling in my life. I suffered for more than 40 years from BIID—and now it’s vanished.”; “I was elated”. This satisfaction seems to persist such that one year subsequent to amputation, many patients declare that, “At any time I would repeat this operation, only sometimes I regret I’ve not had it 10 years earlier.”; “I am happier than I was ever before”.

63. Thus, it can reasonably be asked whether a surgeon under these circumstances, accordingly to the logic used to justify gender reassignment

surgery, could offer such a patient an amputation (provided a mental health specialist (or two) of sound credentials determines the patient has demonstrated a clear and sustained desire for the surgery, complied with all conservative management options and has no other confounding psychopathology).

64. In regard to the case brought by the Plaintiffs, if in fact “the standards of care confirm, based on clinical evidence, that gender confirmation surgeries are medically necessary to help people alleviate an often lifelong struggle to find peace of mind and lasting comfort with their bodies” (Schechter Decl. (Dkt. 27:13) ¶ 43), although surgery of any form as a means of suicide prevention has never been plausible, it logically and morally follows that the declared gravity of the patient’s condition (i.e. clearly stated suicidal ideation apparently secondary to severe dysphoria) seems to warrant urgent surgical intervention irrespective of whether the State or any third party payor will support the same.

65. For instance, Dr. King states that he is prepared to perform “chest reconstruction surgery” for Mr. Flack, but only “if DHS approves a prior authorization for Wisconsin Medicaid coverage.” (Dkt. 30:2 ¶ 7.) At the same time, Mr. Flack’s therapist raises concern that “continued denial of this necessary surgery could lead to possible suicidality and an extended inpatient hospitalization.” (Dkt. 28:4 ¶ 13.) If Dr. King truly believed that providing the

bilateral mastectomy Mr. Flack seeks would remove an imminent threat to Mr. Flack's life, withholding treatment until Mr. Flack is approved for insurance coverage is problematic, to say the least. In my estimation, a more likely conclusion is that Dr. King does not share the opinion that Mr. Flack's life is threatened by withholding the requested surgical treatment pending an assurance of payment for the same.

66. This logic holds true for the Plaintiffs' other treating providers. Their willingness to provide surgical treatment—if the treatment is truly as urgent as the Plaintiffs declare—should not hinge on the availability of Medicaid coverage. However, as this availability seems contingent on Medicaid coverage, the more likely conclusion is that they do not see withholding treatment as creating an imminent threat to Plaintiffs' well-being.

67. During the past four years, I have provided expert testimony on two occasions in the following:

- *Robert Saucedo v. Triple J Excavation and Builders Trust of New Mexico*, WCA No. 14-01199, Deposition August 26 2016.
- *Bruce v. South Dakota, et al.* No. 17-5080 (D.S.D. 2017), Expert Declaration dated May 28, 2018, and Deposition taken July 17, 2018

68. I am being compensated on an hourly basis for all time devoted to review of records, literature and submissions related to the above said case at a rate of \$400 per hour. Any deposition to follow shall be at a rate of \$475 per

hour and \$550 per hour for in person court testimony. Travel related expenses including commercial airfare, ground transportation and room and board shall be compensated fairly. Compensation as outlined is independent of the opinions expressed, testimony provided or ultimate outcome of the case noted.

69. The above opinion is subject to the limitations of medical science reviewed herein. It should also be noted that to date, I have not met with nor professionally evaluated the plaintiffs.

70. I may supplement these opinions and facts in response to information produced by the Plaintiff, in further response to the Plaintiffs' expert disclosures, and/or as new data within my field of expertise becomes available.

Dated: 11/16/2018

Signed: s/Daniel D. Sutphin, MD FACS  
Daniel D. Sutphin, MD FACS

Daniel David Sutphin MD, FACS  
Plastic & Reconstructive Surgery

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### Education and Medical Training

<b>Fellowship</b> <i>University of California, San Francisco, CA</i> Microsurgical Fellow & Clinical Instructor/Division of Plastic & Reconstructive Surgery	08/01/11—07/31/12
<b>Residency</b> <i>University of Tennessee, Chattanooga, TN</i> Department of Plastic & Reconstructive Surgery	07/01/09—06/30/11
<b>Residency</b> <i>University of Tennessee Medical Center, Knoxville, TN</i> H. Filston Chief Administrative Resident/Department of Surgery	07/01/08—06/30/09
<b>Residency</b> <i>University of Tennessee Medical Center, Knoxville, TN</i> Department of Surgery	07/01/05—06/30/08
<b>Internship</b> <i>University of Tennessee Medical Center, Knoxville, TN</i> Department of Surgery	07/01/04—06/30/05
<b>Doctor of Medicine</b> <i>University of Tennessee College of Medicine, Memphis, TN</i>	08/01/00—05/28/04
<b>Undergraduate Degree</b> <i>Carson Newman College, Jefferson City, TN</i> B.A. Biology	08/01/96—05/13/00

### Professional Work History

<b>Attending Plastic &amp; Reconstructive Surgeon</b> <i>Yuma Regional Medical Center Yuma AZ</i>	11/01/17-present
<b>Attending Plastic &amp; Reconstructive Surgeon</b> <i>Bristol Regional Medical Center Bristol TN</i>	03/06/17-08/19/2017

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<i>Attending Plastic &amp; Reconstructive Surgeon</i> <i>Mountain View Regional Medical Center Las Cruces NM</i>	08/29/12--01/20/17
<i>Clinical Instructor/UCSF Division of Plastic Surgery</i> <i>San Francisco General Hospital, San Francisco, CA</i>	08/01/1--07/31/12
<i>Clinical Instructor/UCSF Division of Plastic Surgery</i> <i>UCSF Moffit Long Hospital, San Francisco, CA</i>	08/01/1--07/31/12
<i>Clinical Instructor/UCSF Division of Plastic Surgery</i> <i>UCSF Mt. Zion Hospital, San Francisco, CA</i>	08/01/1--07/31/12
<i>Staff Physician/ Plastic Surgery</i> <i>St Mary's Medical Center, San Francisco, CA</i>	08/01/11- 07/31/12

### **Licensure and Certifications**

State of Arizona Medical License (54960)	2017-present
State of New Mexico Medical License(MD2012-0616)	2012-present
State of California Medical License (A 115038)	2010-present
State of Tennessee Medical License (MD0000045114)	2009-present
American Board of Surgery Certified (No. 054687)	10/21/09
American Board of Plastic Surgery Certified (No. 8500)	11/16/2013

### **Additional Certifications**

ACLS/PALS certification	2004-2012
Advanced Trauma Life Support: Provider certification	2005-2009
Advanced Trauma Life Support: Instructor certification	2005-2009
Fundamentals of Microsurgery / UTMCK GME	2008

### **Professional Memberships**

Fellow of the American College of Surgeons	2016-present
American Society of Plastic Surgeons	2014-present

### **Research Grants**

University of Tennessee Medical Center Physicians Medical Education Research Fund Grant \$10,000 (USD): Principle Investigator: Type A Botulinum Toxin induced antibody production: a murine model of antibody production as a function of variance in dose and frequency of administration	2006-2008
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University of Tennessee Medical Center 2007  
Plastic Surgery Fund Research Grant  
\$10,780 (USD): Principle Investigator: Type A  
Botulinum Toxin induced antibody production:  
a murine model of antibody production as a function  
of variance in dose and frequency of administration

### Research, Presentations and Publications

- Sutphin, D. Rotation Flap Procedures. 2017  
Emedicine from WebMD. Available at:  
<http://emedicine.medscape.com/article/1821831-overview>.  
Updated May 23 2017
- Griner D, Sutphin D, Sargent L. Surgical Management of 2015  
Gorlin Syndrome: A 4-Decade Experience Using  
Local Excision Technique. Annals of Plastic Surgery  
2015 April
- Illustrator Grabb and Smith's Plastic Surgery, 7th Edition. 2014  
Chapter 73: Soft Tissue Upper Extremity Reconstruction  
Thorne, Charles H (eds.). Philadelphia: Lippincott Williams & Wilkins  
ISBN 978-1-4511-0955-9
- Sutphin D, Sargent L. Cornu Cutaneum in a Patient 2012  
of African Descent: Implications and Management  
of an Uncommon Lesion. Annals of Plastic Surgery.  
68(5):481-483, May 2012.
- Sutphin, D. Southern Medical Journal 2012  
Original Contributions Reviewer
- Sutphin DD, Lee S, Lucas A, Bogdan Y. 2011  
Facial Soft Tissue Trauma. eMedicine from WebMD.  
Available at: <http://emedicine.medscape.com/article/2065124>
- Sutphin D, Sargent L. Surgical Management of Gorlin's Syndrome: 2011  
a four decade experience using local excision technique  
Invited poster presentation, 28th Annual UT College of Medicine  
Research Week . Chattanooga, TN April 15
- Sutphin, et al. Antibody formation to botulinum type A: 2011  
clinical implications and the state of the art.  
Invited lecture, BIT 3rd Annual International Antibody Congress,  
Beijing, China March 23-25
- Sutphin DD. Femoral Sheath and Inguinal Canal. 2010  
eMedicine from WebMD.  
Available at: <http://emedicine.medscape.com/article/1818180>
- Illustrator "Iliofemoral triangle: Femoral Sheath and Inguinal Canal" 2010  
eMedicine from WebMD.  
Available at: <http://emedicine.medscape.com/article/1818180>
- Sutphin D, Sargent L. Cornu corneatum of the scalp in a patient 2010  
of African descent: implications and management of an  
uncommon lesion. Accepted for presentation, 53rd Annual Scientific Meeting of the  
Southeastern Society of Plastic and Reconstructive Surgeons.  
Palm Beach, FL June 12-16
- Sutphin et al. Type A Botulinum Toxin induced antibody production: 2009

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a murine model of antibody response. *Aesthetic Surgery Journal*.  
Vol 29(5) 414-418; commentary 418-420. PMID: 19825472

Nagarsheth K, Sutphin D, Mancini G, Solla J. 2009  
Laparoscopic repair of spigelian hernia mimicking post operative ileus  
following perineal rectosigmoidectomy.  
Society of Laparoendoscopic Surgeons Annual Meeting,  
Boston, MA September 9-12

Sutphin et al. Type A Botulinum Toxin induced antibody production: 2009  
a murine model of antibody production as a function of variance  
in dose and frequency of administration. 52nd Annual Scientific  
Meeting of the Southeastern Society of  
Plastic and Reconstructive Surgeons.  
Rio Grande, PR June 6-10

Nickloes T., Sutphin D, Radebold K. Lipomas: A clinical synopsis. 2009  
Emedicine from WebMD.  
Available at <http://emedicine.medscape.com/article/191233>

Sutphin D, Stevens S, et al. Acute mesenteric ischemia secondary 2008  
to drug eluting stent thrombosis following clopidogrel cessation.  
*Journal of Vascular and Endovascular Surgery*.  
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Sutphin D, Stevens S, et al. Drug eluting stent thrombosis: 2007  
surgical implications and the state of the art.  
TN Chapter of American College of Surgeons Annual Meeting.  
Paris Landing, TN. July 28

### Professional Honors & Awards

UTCOM 28<sup>th</sup> Annual Research Week 2011  
*3<sup>rd</sup> place presentation/ Surgical Mangement of Gorlin's Syndrome:  
a four-decade experience using local excision technique*

UTMCK Department of Surgery Resident Performance Award 2009  
ACS National Resident Surgical Jeopardy 2008  
*UTMCK Program Representative, San Francisco CA*

Kimball I. Maull 17<sup>th</sup> Annual Research Day 1st place Award: 2008  
*"Type A Botulinum Toxin induced antibody production:  
a murine model of antibody production as a function of variance  
in dose and frequency of administration"*

Kimball I. Maull 15<sup>th</sup> Annual Research Day 3rd place Award: 2006  
*"Type A Botulinum Toxin induced antibody production:  
a murine model of antibody production as a function of variance  
in dose and frequency of administration"*

### Additional Honors

South Atlantic Conference All-Academic Football Team 1996-1998  
Member /Carson Newman College Football Team 1996  
1996 NCAA Division II Runner Up  
Olympic Torch Relay Runner 1996

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### **Professional Service & Leadership**

Yuma Regional Medical Center Peer Review Quality Committee	2018
New Mexico Medical Review Commission	2016-17

REFERENCES FOR DECLARATION OF DANIEL D. SUTPHIN, M.D.

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