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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

ADREE EDMO (a/k/a MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF
CORRECTION; HENRY ATENCIO, in his
official capacity; JEFF ZMUDA, in his
official capacity; HOWARD KEITH
YORDY, in his official and individual
capacities; CORIZON, INC.; SCOTT
ELIASON; MURRAY YOUNG; RICHARD
CRAIG; RONA SIEGERT; CATHERINE
WHINNERY; and DOES 1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

**PLAINTIFF'S NOTICE OF MOTION AND
MOTION FOR PRELIMINARY INJUNCTION
AND MEMORANDUM OF POINTS AND
AUTHORITIES IN SUPPORT THEREOF**

Complaint Filed: April 6, 2017
Discovery Cut-Off: None Set
Motion Cut-Off: None Set
Trial Date: None Set

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INTRODUCTION

Plaintiff Adree Edmo moves for a preliminary injunction to address Defendants' failure to appropriately treat her serious medical condition of gender dysphoria. Two of the preeminent experts in the treatment of gender dysphoria have now evaluated Ms. Edmo and determined that Defendants' denial of necessary treatment causes her to suffer life-threatening physical and psychological harm. Ms. Edmo has already attempted to self-castrate twice in the absence of necessary treatment, and she will suffer irreparable harm in the absence of preliminary relief.

PROCEDURAL STATUS

Ms. Edmo filed her original complaint in this case in *pro per* on April 6, 2017 seeking injunctive relief as well as damages for, *inter alia*, Defendants' failure to provide her timely access to necessary medical treatment for her gender dysphoria. On April 14, 2017, the Court issued an Initial Screening Order permitting Ms. Edmo to move forward on many of her claims. In the fall of 2017, Ms. Edmo obtained counsel to represent her and filed a Second Amended Complaint on September 1, 2017. Defendants then filed a Motion for Dispositive Relief on November 1, 2017, for which the Court heard oral arguments on April 4, 2018.

Since filing the Second Amended Complaint, Ms. Edmo's counsel sought access from Defendants to her medical records in order to assess the urgency of Ms. Edmo's medical needs. Defendants refused to produce these records until the end of May 2018. Declaration of Lori Rifkin in Support of Plaintiff's Motion for a Preliminary Injunction ("Rifkin Decl.") ¶ 2. However, because of the gravity of Ms. Edmo's medical condition, Ms. Edmo's counsel retained two highly qualified medical experts to evaluate Ms. Edmo and review the incomplete medical records accessible by Ms. Edmo. *Id.* ¶ 3. Based on the assessments of these experts,¹ Plaintiff now moves the Court for a preliminary injunction 1) ordering Defendants to provide her immediate access to necessary medical treatment, including sex-reassignment surgery; and 2) prohibiting Defendants from enforcing their policy and/or practice of blanket denial of such

¹ The expert declarations of Dr. Randi Ettner ("Ettner Decl.") and Dr. Nicholas Gorton ("Gorton Decl.") are attached as Exhibits 1 and 2, respectively, to the Declaration of Lori Rifkin, submitted concurrently. Rifkin Decl. ¶¶ 4-5 & Exhs. 1-2.

treatment for transgender persons incarcerated in the Idaho Department of Corrections.

STATEMENT OF FACTS

Plaintiff's History of Gender Dysphoria

Ms. Edmo is a transgender woman—an individual whose female gender identity differs from the male sex assigned to her at birth. SAC ¶ 1. Prior to being incarcerated, Ms. Edmo lived full-time as a woman. *Id.* ¶¶ 3, 39. Ms. Edmo has been incarcerated since April 2012. *Id.* ¶ 1. In July 2012, Defendants diagnosed Ms. Edmo with gender dysphoria, a serious medical condition characterized by marked incongruence between the sex assigned at birth and a person's gender identity, strong cross-gender identification, and clinically significant distress or impairment of functioning. Ettner Decl. ¶¶ 17, 35-36; SAC ¶¶ 1, 40.

From the time Ms. Edmo was a very young child, she understood herself to be a girl. Declaration of Adree Edmo in Support of Plaintiff's Motion for a Preliminary Injunction ("Edmo Decl.") ¶ 3. She describes her female gender identity as something she "never questioned . . . it's always been this way as long as I can remember." Ettner Decl. ¶ 15. Ms. Edmo assumed she would grow up to be as feminine as her older sisters, and her body would develop as theirs did rather than like that of her older brothers. Ettner Decl. ¶ 15; Edmo Decl. ¶ 3; Gorton Decl. ¶ 29. She had mostly female friends during her school years and "felt like one of them," and would even sometimes use the girls' restroom in grade school and high school. Gorton Decl. ¶¶ 26, 30. Ms. Edmo experienced mostly positive support for her gender identity as female from her immediate family, which she attributes in part to being Native American and growing up on the Shoshone Bannock reservation, because there is a history in Native American communities of accepting gender nonconforming people. *Id.* ¶ 27.

Ms. Edmo attended public elementary, middle, and high school, and one year of college at Idaho State University. Ettner Decl. ¶ 13. At around age 11 or 12, Ms. Edmo understood herself as "a girl in a boy's body," although she did not have a word to describe this at the time. Gorton Decl. ¶ 29. Her transition through puberty was "shocking and very depressing" to her,

and caused a dramatic increase in her gender dysphoria. Edmo Decl. ¶ 4; Gorton Decl. ¶ 29. As she moved into her teenage years, however, Ms. Edmo began to feel more confident about expressing her female identity and began wearing girls' clothing and makeup to school. Edmo Decl. ¶ 5. Ms. Edmo's immediate family and friends remained supportive, although she experienced some harassment and sexual assault as a result of her gender identity. Gorton Decl. ¶¶ 27-28; Edmo Decl. ¶ 6. By age 21, Ms. Edmo began to live as a woman full-time, using female pronouns and dressing in women's clothing. Edmo Decl. ¶ 7; Ettner Decl. ¶ 16; Gorton Decl. ¶ 33. Living as a woman, Ms. Edmo felt for the first time in her life "like others saw me as the real person that I am—as the woman I am." Edmo Decl. ¶ 8.

Although Ms. Edmo's incarceration beginning in 2011 impeded her ability to continue fully living as female, she has continually sought to do so even in the face of repeated disciplinary consequences, which, in turn, have affected her eligibility for parole. Edmo Decl. ¶¶ 19-20; Gorton Decl. ¶¶ 37-38. This has included altering the prison-issued male underwear to allow her to tuck her penis, wearing her hair long and in a traditionally feminine style, and making or obtaining her own facial make-up, despite IDOC's refusal to permit her access to women's underwear and female commissary items. Edmo Decl. ¶ 19; Gorton Decl. ¶¶ 36-41. In 2012, Ms. Edmo changed her name socially and in 2013, she legally changed her name. Edmo Decl. ¶ 11.

Standards of Care for Treatment of Gender Dysphoria

Gender dysphoria is a diagnosable and highly treatable condition recognized by the American Psychiatric Association and included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5"), as well as the World Health Organization's International Classification of Diseases-10. SAC ¶ 26; Ettner Decl. ¶ 34; Gorton Decl. ¶ 8. Like many other medical conditions, gender dysphoria can be ameliorated or cured through medical treatment. SAC ¶¶ 27-28; Gorton Decl. ¶ 10. The World Professional Association for Transgender Health ("WPATH"), the leading international organization focused on transgender health care, has established internationally accepted Standards of Care for the treatment of gender dysphoria. SAC ¶ 28; Gorton Decl. ¶ 11. The current version of the WPATH Standards

of Care, Version 7, was published in September 2011, and constitutes the prevailing standard of care used by medical and mental health professionals treating gender dysphoria. SAC ¶ 28; *Hicklin v. Precynthe*, No. 4:16-cv-02357-NCC, Dkt. No. 176, at 5-6 (E.D. Mo. May 22, 2018); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1186 (N.D. Cal. 2015) (WPATH Standards of Care are the accepted standards of treatment for transgender patients); *see also De'lonta v. Johnson*, 708 F. 3d 520, 522-23 (4th Cir. 2013); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 231 (D. Mass. 2012); *O'Donnabhain v. Comm'r of Internal Revenue*, 134 T.C. 34, 65 (U.S. Tax Ct. 2010).

The WPATH Standards of Care set forth medical treatment options for gender dysphoria and require that a competent medical professional with knowledge and expertise in gender dysphoria evaluate a patient for appropriate and necessary treatment options, which, in addition to living in accord with the person's gender identity, may include hormone therapy, surgery to change primary and/or secondary characteristics, and/or psychotherapy addressing the negative impact of gender dysphoria and stigma on mental health. SAC ¶¶ 33-36, Ettner Decl. ¶¶ 40-41; Gorton Decl. ¶¶ 12-16. The Standards "explain that some individuals are unable to obtain relief from gender dysphoria without surgical intervention, and describe sex-reassignment surgery (or "SRS") as 'essential and medically necessary' for this group of patients." *Norsworthy*, 87 F. Supp. 3d at 1186 (quoting WPATH Standards of Care at 36); Ettner Decl. ¶¶ 55-56. The WPATH Standards of Care apply to incarcerated as well as non-incarcerated people. SAC ¶ 36; Ettner Decl. ¶ 43; Gorton Decl. ¶ 17.

Defendants' Inadequate Treatment of Plaintiff's Gender Dysphoria

Since Defendants diagnosed Ms. Edmo with gender identity disorder—now recognized as gender dysphoria—in 2012, she has continually sought appropriate treatment, including access to feminizing hormones, evaluation for and access to sex-reassignment surgery (also referred to as gender confirmation surgery), and the ability to live as a woman while incarcerated. SAC ¶ 4; Ettner Decl. ¶ 60; Edmo Decl. ¶¶ 27-28. However, Defendants have refused to provide Ms. Edmo with sex-reassignment surgery, have not adequately monitored and adjusted her feminizing hormones, and have denied her access to other medically necessary

treatments for reducing her gender dysphoria, including being called by her legal name and the appropriate pronouns and the ability to access and wear appropriate undergarments. SAC ¶¶ 4, 41-44, 49-51, 54; SAC Ex. B, at 39-40, 45; Ettner Decl. ¶¶ 60, 64-70; Gorton Decl. ¶¶ 36-41, 49-52, 55-65; Edmo Decl. ¶¶ 14, 17, 23, 27-28. Ms. Edmo is harassed by both correctional officers and other inmates for her appearance, mannerisms, and transitioning body.² Edmo Decl. ¶¶ 15-16. Defendants' refusal to treat Ms. Edmo as a woman is "a constant reminder that my body does not match my feeling of being a woman and female" and "torture above and beyond my prison sentence." Edmo Decl. ¶¶ 13, 16.

Although Defendants have provided Ms. Edmo with some feminizing hormones, they have failed to provide appropriate treatment for her continued severe gender dysphoria and attendant depression. Ettner Decl. ¶¶ 59-70. Ms. Edmo meets and exceeds the criteria for medically necessary sex-reassignment surgery as a result of her persistent, well-documented gender dysphoria and severe distress. Ettner Decl. ¶¶ 65-66; Gorton Decl. ¶¶ 84, 87-88. However, Defendants' medical providers are not qualified to assess and treat gender dysphoria and, even if they were qualified, IDOC policies and/or practices prohibit them from providing medically necessary and likely life-saving care through a categorical ban on sex-reassignment surgery. Ettner Decl. ¶ 64; Gorton Decl. ¶¶ 44, 47, 50-54, 73. The notes of several providers who purportedly treated Ms. Edmo for gender dysphoria show no attempts to assess Ms. Edmo's history as a transgender person. Gorton Decl. ¶ 47. The only record in the six years since Defendants diagnosed Ms. Edmo's gender dysphoria that could conceivably resemble an evaluation of Ms. Edmo's transgender history is a single note by one doctor dated December 14, 2016. *Id.*

Defendants are also failing to adequately monitor Ms. Edmo's hormone regimen and have inappropriately removed her from one hormone, spironolactone, as a result of elevated enzyme levels found during Ms. Edmo's liver function test, even though this hormone is unlikely

² Correctional officers also recently threatened Ms. Edmo that she will not be permitted to attend attorney-client visits if she is wearing makeup and styles her hair in a feminine manner. Rifkin Decl. ¶ 6.

to be responsible for Ms. Edmo's elevated enzyme levels. Ettner Decl. ¶ 70; Gorton Decl. ¶¶ 49-63. While the proper course in response to abnormal labs is to immediately perform an adequate history and physical examination, Ms. Edmo's records contain no evidence of any evaluation to determine the actual cause of Ms. Edmo's abnormal liver function test results. Gorton Decl. ¶¶ 56, 65.

In the meantime, the unnecessary withdrawal of Ms. Edmo's spironolactone means that she is not receiving the appropriate dosage of feminizing hormones and is therefore experiencing recurring masculinization. Gorton Decl. ¶ 64. These unexpected and unwanted physical changes, including rapid facial hair growth and, in particular, the painful enlargement of her testicles, have considerably worsened Ms. Edmo's dysphoria and place her at significant risk of self-surgery or suicide if she does not get the medical treatment she needs. Gorton Decl. ¶ 39, 64; Edmo Decl. ¶ 26.

Defendants are also violating the Standards of Care by refusing to allow Ms. Edmo access to female underwear and a gaff (an undergarment commonly worn by transgender women to minimize the appearance of male genitals), canteen items available to female prisoners, and safe and effective means of hair removal. Gorton Decl. ¶ 36. These are medically necessary treatments to ameliorate her gender dysphoria. Ettner Decl. ¶ 69; Gorton Decl. ¶ 92. Moreover, Defendants have disciplined Ms. Edmo numerous times for actions and behaviors that are medically necessary for transgender patients, which has exacerbated Ms. Edmo's gender dysphoria. Ettner Decl. ¶ 60; Gorton Decl. ¶ 40, 93. For example, Defendants disciplined her for altering her prison-issued male underwear to resemble women's underwear or a gaff. Gorton Decl. ¶ 37. Ms. Edmo reports that her makeshift gaff, which she wears because she is denied access to both a proper gaff and women's clothing, has caused redness, swelling, and extreme pain on several occasions. *Id.* ¶ 39.

Plaintiff's Ongoing Substantial Risk of Serious Harm

As a result of Defendants' failure to treat her, Ms. Edmo has twice resorted to attempting auto-castration (removal of the testicles). SAC ¶ 45. This is not an act of self-mutilation or

intended self-harm, but rather “surgical self-treatment.” Ettner Decl. ¶ 62; Gorton Decl. ¶ 18; Edmo Decl. ¶ 34. Transgender women without access to appropriate care, particularly those who are imprisoned, are often so desperate for relief that they resort to life-threatening attempts at auto-castration in the hopes of eliminating the major source of testosterone that kindles the distress. Ettner Decl. ¶ 38. However, such self-surgery attempts are extremely dangerous, and can result in major loss of blood leading to death unless an individual is sent to a hospital in time, as Ms. Edmo was during her second attempt. Ettner Decl. ¶ 62; Gorton Decl. ¶ 74.

It is also common for patients like Ms. Edmo, who are in desperate need of medical treatment, to become more sophisticated in subsequent self-surgery attempts, placing them at substantial and increasing risk of serious and irreparable harm. Gorton Decl. ¶ 74. After her first attempt, Ms. Edmo resolved to be successful if she decided to attempt self-surgery again. Edmo Decl. ¶ 32. To this end, Ms. Edmo prepared for weeks before her second auto-castration attempt—she studied the anatomy of the scrotum, chose an incision site with a better chance of success, obtained gauze and alcohol swabs, boiled the razor blade to reduce chances of infection, and enlisted another inmate to call for help in the event she lost too much blood because she did not want to die. Gorton Decl. ¶ 74; Edmo Decl. ¶ 33. During her second attempt, Ms. Edmo made further surgical progress, but abandoned her efforts because the high blood loss prevented her from being able to see what she was doing. Gorton Decl. ¶ 74. She was taken to the hospital, where her testicle was repaired without any discussion of possibly removing the nearly-severed testicle. *Id.*; Edmo Decl. ¶ 33.

Dr. Gorton opines that it is medically necessary for Ms. Edmo to be referred to a surgeon for sex-reassignment surgery immediately, but at minimum within the next six months. Gorton Decl. ¶ 88. Dr. Gorton explains that Ms. Edmo has “well established and persistent gender dysphoria, a substantial portion of which is related to her male genitalia,” placing her at high risk of re-attempting self-surgery or suicide if she is denied this medically necessary care. *Id.*

Similarly, Dr. Ettner opines that because having male genitalia generates profound distress for Ms. Edmo, this anguish is very likely to result in further emotional deterioration and

self-harm. Ettner Decl. ¶ 61. Dr. Ettner further opines that Ms. Edmo is at great risk for succumbing to feelings of hopelessness and despair, leading to emotional destabilization and suicide. *Id.* ¶ 67. Dr. Ettner also explains that gender dysphoria intensifies with age, which is consistent with Ms. Edmo’s description of her experience. *Id.*; Edmo Decl. ¶ 36. Ms. Edmo scored 11 on the Beck Hopelessness Scale (BHS), relative to a study finding that of outpatients who ultimately committed suicide, 93.8% had BHS scores of 9 or higher. Ettner Decl. ¶ 30. Ms. Edmo also scored a 100—the highest score possible—on the Traumatic Symptom Inventory-2 scale that measures suicide ideation and suicide behavior. *Id.* ¶ 33. Dr. Ettner found this result “alarming” considering Ms. Edmo’s previous history of suicide attempts and the fact that she is currently receiving the maximum dose of her anti-depressant medication. *Id.*

Indeed, the most significant suicidality Ms. Edmo has experienced while incarcerated occurred because she felt hopeless after she requested sex-reassignment surgery and was told that she would “never” get the surgery. Gorton Decl. ¶ 77; Edmo Decl. ¶ 29. Defendants then placed her on suicide watch, where she was stripped of all her clothes and thus forced to see her body unclothed—a significant trigger for patients with gender dysphoria, which increased both her dysphoria and suicidal thoughts. Gorton Decl. ¶ 77; Edmo Decl. ¶ 30.

Further, Defendants’ mental health providers do not understand the difference between suicidality, non-suicidal self injury, and self-surgery, and have incorrectly assessed Ms. Edmo’s self-surgery attempts as either non-suicidal self-injury or suicidality. Gorton Decl. ¶¶ 66-67. Rather than intended self-harm, Ms. Edmo’s self-surgery is “health-seeking” behavior intended to remove testosterone from the body, thereby alleviating gender dysphoria. *Id.* ¶ 67. Ms. Edmo attempted self-surgery because she was “at a point beyond mental anguish . . . thinking: ‘If I don’t do this, I won’t be able to keep going.’” Edmo Decl. ¶ 34. Thus, questions routinely asked by Defendants’ mental health staff, such as whether Ms. Edmo wants to harm or kill herself, are insufficient to address her high risk for self-surgery. Gorton Decl. ¶ 71; Ettner Decl. ¶¶ 44, 68.

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ARGUMENT

I. Legal Standard for Preliminary Injunction

“A plaintiff seeking a preliminary injunction must establish that [s]he is likely to succeed on the merits, that [s]he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [her] favor, and that an injunction is in the public interest.” *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2009); *Pimentel v. Dreyfus*, 670 F. 3d 1096, 1105 (9th Cir. 2012) (applying *Winter* to claim under 42 U.S.C. § 1983). “[S]erious questions going to the merits and a balance of hardships that tips sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest.” *Alliance for the Wild Rockies v. Cottrell*, 632 F. 3d 1127, 1135 (9th Cir. 2011) (internal quotation marks omitted).

While preliminary injunctions that order a party to take affirmative action are generally not granted “unless extreme or very serious damage will result,” *see Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F. 3d 873, 879 (9th Cir. 2009), this is exactly such a case. Defendants’ ongoing refusal to provide necessary medical treatment to Ms. Edmo places her at imminent risk of serious harm. Ms. Edmo has a history of suicide attempts and twice risked her life in attempts to remove her testicles herself. As set forth in detail *infra*, and in the concurrently-submitted declarations, two of the preeminent experts in the field of medical treatment for patients with gender dysphoria have assessed Ms. Edmo and found Defendants’ failure to appropriately treat her—including their denial of access to sex-reassignment surgery—to be life-threatening.

II. Plaintiff Will Succeed on the Merits of Her Claims

Ms. Edmo moves for preliminary injunctive relief on the basis of her Eighth Amendment claim for failure to provide adequate and necessary medical treatment for the serious medical condition of gender dysphoria, and on the basis of her sex discrimination claims under the

Fourteenth Amendment and the Affordable Care Act.³ Even at this early procedural stage in the case, the evidence decisively establishes that Ms. Edmo will succeed on the merits of these claims.

A. Defendants Are Denying Plaintiff Medically Necessary Treatment in Violation of the Eighth Amendment

It is well-established that “[d]eliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’ proscribed by the Eighth Amendment.” *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (internal citation omitted). Deliberate indifference may be “manifested by prison doctors in their response to the prisoner’s needs or by prison [officials or] guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.” *Id.* A plaintiff establishes deliberate indifference by showing a serious medical need such that failure to treat the condition could result in further significant injury or the unnecessary and wanton infliction of pain, and showing that a defendant engaged in a purposeful act or failure to respond to this medical need such that the plaintiff was harmed. *Jett v. Penner*, 439 F. 3d 1091, 1096 (9th Cir. 2006). Deliberate indifference may be demonstrated “when prison officials deny, delay or intentionally interfere with medical treatment, or it may be shown by the way in which prison officials provide medical care.” *Id.* (internal quotations and citations omitted).

Prison officials are liable for violations under the Eighth Amendment when they are deliberately indifferent to a substantial risk of serious harm to a prisoner, which the Supreme Court has described as “the equivalent of recklessly disregarding that risk.” *Farmer v. Brennan*, 511 U.S. 825, 836 (1994). As the United States Supreme Court explained in *Farmer*, “[d]eliberate indifference lies somewhere between the poles of negligence at one end and purpose or knowledge at the other.” 511 U.S. at 836; *see also Mandala v. Coughlin*, 920 F. Supp. 342, 353 (E.D.N.Y. 1996) (while a showing of medical malpractice or mere negligence does not

³ Ms. Edmo is also likely to succeed on the merits of her other claims, including her Americans with Disabilities Act claim. *See* Pl.’s Response to Defs.’ Mot. for Dispositive Relief, ECF No. 44 at 18-23. However, given that the law on those claims is less clearly established, Plaintiff’s motion for a preliminary injunction focuses more narrowly on her Eighth Amendment, Fourteenth Amendment, and ACA claims.

suffice, neither must a defendant's act or omission be "for the very purpose of causing harm or with knowledge that harm will result" (internal quotations and citations omitted)).

The evidence overwhelmingly shows that Ms. Edmo has a serious medical need cognizable under the Eighth Amendment. Defendants' own doctors diagnosed Ms. Edmo with gender dysphoria, which is recognized by the medical field as a serious medical condition. Ettner Decl. ¶ 34; Gorton Decl. ¶ 8. Courts have consistently considered gender dysphoria to be a serious medical condition for the purposes of the Eighth Amendment. *E.g.*, *Fields v. Smith*, 653 F.3d 550, 555 (7th Cir. 2011) (discussing cases finding that Gender Identity Disorder is a "serious medical need" for purposes of the Eighth Amendment); *Hicklin v. Precynthe*, No. 4:16-cv-02357-NCC, Dkt. No. 176, at 5 (E.D. Mo. May 22, 2018) ("Gender dysphoria is an objectively serious medical need."); *Norsthworthy*, 87 F. Supp. 3d at 1170. In support of this motion, Ms. Edmo submits evidence from Dr. Ettner and Dr. Gorton as well as her own declaration and medical records demonstrating "that, notwithstanding years of treatment in the form of hormone therapy and counseling, she continues to experience severe symptoms of gender dysphoria." *Norsthworthy*, 87 F. Supp. 3d at 1186. These symptoms include severe "[p]sychological and emotional pain [she] experiences as a result of her gender dysphoria," that place her mental and physical health in serious jeopardy and "means that she is unable to complete her existence or complete who she is." *Id.* (internal alterations and quotations omitted).

Defendants' failures to appropriately monitor and adjust Ms. Edmo's feminizing hormones, assess and provide her access to sex-reassignment surgery, and provide other medically necessary treatments that allow her to live in accord with her female gender identity—as well as Defendants' punishment of Ms. Edmo for expressing her gender identity—put Ms. Edmo at life-threatening risk. This includes heightened risk of re-attempting self-surgery, and of emotional destabilization that may lead to other self-harm, including suicide. Ettner Decl. ¶¶ 61, 67; Gorton Decl. ¶ 88.

The evidence also overwhelmingly establishes that Defendants' actions and omissions in denying Plaintiff necessary treatment for her serious medical need are deliberate. Plaintiff has

repeatedly and exhaustively requested appropriate medical treatment including assessment for sex-reassignment surgery through every avenue available to her in the prison system, including filing grievances through IDOC's administrative grievance process, as well as repeatedly asking Corizon medical providers for assessments and referrals. Edmo Decl. ¶¶ 27-28; *see Norsworthy*, 87 F. Supp. 3d at 1189 ("Despite access to the relevant Standards of Care and evidence that SRS was medically necessary for Norsworthy, Defendants failed to provide her SRS, or to refer her to a specialist for further evaluation.") (citing *Hoptowit v. Ray*, 682 F. 2d 1237, 1253 (9th Cir. 1982)). Defendant IDOC officials and supervisors have not only denied her individual appeals, Defendants have also adopted and enforced a blanket policy and/or practice prohibiting provision of sex-reassignment surgery to people incarcerated in IDOC facilities, regardless of whether such treatment is medically necessary. *See Norsworthy*, 87 F. Supp. 3d at 1191 (blanket policy barring sex-reassignment surgery conflicts with requirement that medical care be individualized based on a particular patient's needs). Defendants are also actively contesting this lawsuit, while still refusing to provide Ms. Edmo adequate and necessary medical treatment, further evidencing the deliberateness of their decisions.

Defendants have been repeatedly placed on notice of the substantial risk of serious harm resulting from their ongoing denial of necessary treatment to Ms. Edmo: refusal of such treatment has resulted in Ms. Edmo twice attempting to perform self-castration and separately attempting suicide, as well as ongoing serious psychological, emotional, and physical distress. *Farmer*, 511 U.S. at 837; *see also Lolli v. Cnty. of Orange*, 351 F. 3d 410, 421 (9th Cir. 2003) ("Much like recklessness in criminal law, deliberate indifference to medical needs may be shown by circumstantial evidence when the facts are sufficient to demonstrate that a defendant actually knew of a risk of harm.").

Defendants' provision of Ms. Edmo with some treatment for gender dysphoria further supports her deliberate indifference claim. This partial treatment shows that Defendants recognize that she has a serious medical condition warranting treatment while also refusing to provide the medically necessary care her condition requires. *See Hicklin*, No. 4-16-cv-01357-

NCC, Dkt. No. 176, at 6 (“providing [only] counseling and/or psychotropic medication to a severely gender dysphoric patient whose condition warrants medical intervention is a departure from the [WPATH] standards of care . . . [and] puts a person at serious risk of psychological and physical harm” in violation of the Eighth Amendment); *Norsworthy*, F. Supp. 3d at 1187 (“Just because defendants have provided a prisoner with some treatment consistent with the Standards of Care, it does not follow that they have necessarily provided her with *constitutionally adequate* treatment.”) (internal alterations omitted) (quoting *De’lonta v. Johnson*, 708 F. 3d 520, 526 (4th Cir. 2013)); *see also Ortiz v. City of Imperial*, 884 F. 2d 1312, 1314 (9th Cir. 1989) (a plaintiff alleging deliberate medical indifference “need not prove complete failure to treat”). Just as Defendants would be deliberately indifferent if they denied surgery to a patient requiring an operation and instead simply prescribed the patient painkillers, Defendants’ refusal to provide Ms. Edmo with access to a crucial medical intervention required to treat her condition constitutes deliberate indifference to a serious medical need. *See* Ettner Decl. ¶ 68; *Fields*, 653 F. 3d at 556 (holding statute barring Wisconsin corrections officials from providing transgender inmates hormone therapy and sex-reassignment surgery unconstitutional under the Eighth Amendment, and recognizing that “[r]efusing to provide effective treatment for a serious medical condition serves no valid penological purpose and amounts to torture”).

B. Defendants Are Discriminating Against Plaintiff on the Basis of Sex in Violation of the Fourteenth Amendment and the Affordable Care Act

Defendants’ refusal to provide Ms. Edmo with medically necessary care because she is transgender discriminates based on sex. Defendants are withholding care from Ms. Edmo based on their belief that a transgender person should not receive certain medical treatment such as sex-reassignment surgery and access to traditionally female underwear, despite this treatment being the accepted standard of care for treating gender dysphoria.

Discrimination against transgender people constitutes discrimination based on sex. *Schwenk v. Hartford*, 204 F. 3d 1187, 1201-02 (9th Cir. 2000); *see also Martin v. Barron*, 286 F. Supp. 3d 1131, 1144 (D. Idaho 2018) (“[T]o conclude discrimination based on gender identity or

transsexual status is not discrimination based on sex is to depart from advanced medical understanding in favor of archaic reasoning.”). Such discrimination is subject to heightened scrutiny when evaluating whether it violates the Equal Protection Clause. *Whitaker v. Kenosha Unified Sch. Dist. No. 1*, 858 F. 3d 1034, 1051 (7th Cir. 2017) (holding that discrimination against a transgender student is “inherently based upon a sex-classification and heightened review applies”); *Glenn v. Brumby*, 663 F. 3d 1312, 1317 (11th Cir. 2011) (“[D]iscrimination against a transgender individual because her gender-nonconformity is sex discrimination,” under the Equal Protection Clause, “whether it’s described as being on the basis of sex or gender”); *Smith v. City of Salem*, 378 F. 3d 566, 572-73 (6th Cir. 2004) (same); *Stockman v. Trump*, No. 5:17-cv-01799-JGB-KK, Dkt. No. 79, at 19 (C.D. Cal. Dec. 22, 2017) (applying intermediate scrutiny to claims of transgender servicemembers as sex-based discrimination); *Karnoski v. Trump*, No. C17-1297-MJP, 2017 WL 6311305, at *7 (W.D. Wash. Dec. 11, 2017) (same); *Olive v. Harrington*, No. 1:15-cv-01276, 2016 WL 4899177, at *5 (E.D. Cal. Sept. 14, 2016) (“Discrimination on the basis of transgender status is subject to intermediate scrutiny.”); *Marlett v. Harrington*, No. 1:15-cv-01382, 2015 WL 6123613, at *4 (E.D. Cal. Oct. 16, 2015) (same); *Norsworthy*, 87 F. Supp. 3d at 1119 (“[D]iscrimination against transgender individuals is a form of gender-based discrimination subject to intermediate scrutiny under the Equal Protection Clause”).

Numerous district courts, including in the District of Idaho and others in the Ninth Circuit, have also held that “government discrimination based on transgender status is also discrimination based on a quasi-suspect class and thus is subject to intermediate scrutiny.” *Martin*, 286 F. Supp. 3d at 1144; *see id.* at 1145 (“[I]n Idaho . . . transgender people have no state constitutional protections from discrimination based on their transgender status in relation to employment decisions, housing, and other services. Therefore, transgender people bear all of the characteristics of a quasi-suspect class.”); *Norsworthy*, 87 F. Supp. 3d at 1119 (“Applying *Schwenk*, . . . discrimination based on transgender status independently qualifies as a suspect classification because transgender people meet the indicia of a ‘suspect’ or ‘quasi-suspect

classification.”); *Stockman*, No. 5:17-cv-01799-JGB-KK, Dkt. No. 79, at 19 (same); *Karnoski*, No. C17-1297-MJP, 2017 WL 6311305, at *7 (“The Court concludes that the policy distinguishes on the basis of transgender status, a quasi-suspect classification, and is therefore subject to intermediate scrutiny.”); *see also Stone v. Trump*, 280 F. Supp. 3d 747, 768 (D. Md. 2017); *Doe v. Trump*, 275 F. Supp. 3d 167, 208 (D.D.C. 2017); *A.H. v Minersville Area School District*, 2017 U.S. Dist. LEXIS 193622 (M.D. Pa. Nov. 22, 2017); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017); *Adkins v. City of New York*, 143 F. Supp. 3d 134, 140 (S.D.N.Y. 2015). Thus, heightened scrutiny applies to Plaintiff’s Equal Protection claim, whether regarded as a claim based on sex, or also directly based on transgender status.

Under heightened scrutiny, Defendants have the burden to show that their policy of denying sex-reassignment surgery and other medically necessary care to transgender people is substantially related to an important government interest. *See, e.g., Martin*, 286 F. Supp. 3d at 1142. The asserted governmental justification must be “exceedingly persuasive” and it must be “genuine, not hypothesized or invented *post hoc* in response to litigation.” *United States v. Virginia*, 518 U.S. 515, 533 (1996). Defendants cannot meet that burden here. There is no legitimate, much less important, governmental purpose served by denying medically necessary care to a socially disfavored group of people. *See Fields*, 653 F. 3d at 556; *Norsworthy*, 87 F. Supp. 3d at 1120 (recognizing that Defendants “articulate[d] no important governmental interest” served by denying access to sex-reassignment surgery). Gender dysphoria is a serious medical condition; when left untreated, it can result in debilitating harms, including severe depression and suicidality. Ettner Decl. ¶¶ 34, 37; Gorton Decl. ¶ 10. The treatments for gender dysphoria are well-established and effective. Ettner Decl. ¶¶ 40-58; Gorton Decl. ¶¶ 11-17. There is no legitimate government interest in denying transgender prisons access to this life-saving care.

Defendants’ policy also violates Section 1557 of the Affordable Care Act, which prohibits covered entities from discriminating based on sex in the provision of health care services. 42 U.S.C. § 18116. As a health program or activity that receives federal financial assistance, IDOC is a covered entity subject to the Affordable Care Act’s nondiscrimination

requirement. The anti-discrimination provisions of the ACA are construed consistently with those of other federal sex discrimination laws; accordingly, the ACA's prohibition of discrimination based on sex prevents differential treatment of transgender patients. *See, e.g., Prescott v. Rady Children's Hospital-San Diego*, 265 F. Supp. 3d 1090, 1099 (S.D. Cal. 2017).

III. Plaintiff Is Now Suffering and Will Continue to Suffer Irreparable Harm in the Absence of Relief

Defendants' refusal to provide Ms. Edmo with medically necessary care is causing her irreparable harm. As a result of Defendants' denial of care, Ms. Edmo has attempted suicide and twice risked her life in attempts to self-castrate. While a plaintiff seeking a preliminary injunction ordering treatment for gender dysphoria "is not required to demonstrate that she is at risk of death or imminent self-harm," *Norsworthy*, F. Supp. 3d at 1188, Ms. Edmo is at risk of these outcomes here. Ettner Decl. ¶¶ 30-33, 67; Gorton Decl. ¶ 88.

In addition to being at risk of death due to suicide or attempts to perform her own surgical care, Ms. Edmo is also suffering serious psychological harm, which the Ninth Circuit has repeatedly held constitutes irreparable injury. *See, e.g., Chalk v. U.S. Dist. Ct. Cent. Dist. of California*, 840 F. 2d 701, 709 (9th Cir. 1988) (plaintiff's "emotional stress, depression and reduced sense of well-being" constituted irreparable harm); *Thomas v. Cnty. of Los Angeles*, 978 F. 2d 504, 512 (9th Cir. 1992) ("Plaintiffs have also established irreparable harm, based on this Court's finding that the deputies' actions have resulted in irreparable physical and emotional injuries to plaintiffs and the violation of plaintiffs' civil rights."); *see also Hernandez v. Cnty. of Monterey*, 110 F. Supp. 3d 929, 956 (N.D. Cal. 2015) ("[P]ain, suffering and the risk of death constitute irreparable harm sufficient to support a preliminary injunction in prison cases.") (internal quotations omitted); *Wood v. Cnty. of Alameda*, 1995 U.S. Dist. LEXIS 17514, at *46 (N.D. Cal. Nov. 17, 1995) (finding irreparable injury where plaintiff's "declaration ma[de] clear that she has suffered feelings of guilt, depression, anxiety, and loss of self-esteem . . .").

District courts have specifically recognized that emotional pain and suffering, anxiety, and depression caused by prison officials' failure to provide adequate treatment for gender

dysphoria constitute irreparable harm warranting a preliminary injunction. *See, e.g., Hicklin*, No. 4:16-cv-02357-NCC, Dkt. No. 176 (granting permanent injunction); *Hicklin v. Precynthe*, 2018 U.S. Dist. LEXIS 21516, at *29 (concluding that plaintiff would suffer “irreparable harm in the absence of a preliminary injunction because she suffers from depression, anxiety, and intrusive thoughts of self-castration as a result of Defendants’ conduct”) (E.D. Mo. Feb. 9, 2018) (“*Hicklin I*”); *Norsworthy*, 87 F. Supp. 3d at 1192 (irreparable injury where plaintiff testified that “she suffers continued and ‘excruciating’ ‘psychological and emotional pain’ as a result of her gender dysphoria”). Evidence that an incarcerated person is at “severe risk of self-harm” through self-castration also supports a finding of irreparable injury. *Hicklin I*, 2018 U.S. Dist. LEXIS 21516, at *31 (irreparable injury where plaintiff was at “severe risk of self-harm” in light of evidence that “she has a history of suicide ideation and has indicated on more than one occasion the inclination to remove her own testicles”).

Here, the irreparable harm Ms. Edmo continues to suffer in the absence of necessary medical treatment is clear. Defendants’ refusal to provide Ms. Edmo access to qualified medical providers knowledgeable about gender dysphoria, including those who can appropriately evaluate her for and perform sex-reassignment surgery, causes Ms. Edmo extreme anguish, anxiety, depression, and stress, and places her at high risk for attempting to castrate herself again. Gorton Decl. ¶¶ 67, 69, 73, 76, 85-87; Edmo Decl. ¶¶ 27-29, 35-36. This risk is substantially heightened by the recent enlargement of Ms. Edmo’s testicles, which is a result of medically unwarranted cessation of her spironolactone. Gorton Decl. ¶ 64; Ettner Decl. ¶ 70. Ms. Edmo describes “[t]he thought of never being able to have sex-reassignment surgery” as “too stressful to imagine. I would compare it to telling a cancer patient: ‘This treatment will cure you, but you can’t have it.’ Without surgery, I feel like I am living, but dying inside.” Edmo Decl. ¶ 37. Drs. Ettner and Gordon both opine that without sex-reassignment surgery, Ms. Edmo’s symptoms of gender dysphoria will continue to worsen and the risk that she may resort to life-threatening self-castration, or another suicide attempt, is significant and “dire.” Ettner Decl. ¶¶ 67, 71; Gorton Decl. ¶ 88.

In addition to these severe emotional, psychological, and physical harms, the deprivation of Ms. Edmo’s Eighth and Fourteenth Amendment rights alone also establishes irreparable injury. “It is well established that the deprivation of constitutional rights ‘unquestionably constitutes irreparable injury.’” *Melendres v. Arpaio*, 695 F. 3d 990, 1002 (9th Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976); see also *Doe v. Harris*, 772 F. 3d 563, 583 (9th Cir. 2014); *Norsworthy*, 87 F. Supp. 3d at 1193 (“[T]he deprivation of [Plaintiff’s] constitutional rights under the Eighth Amendment is itself sufficient to establish irreparable harm.”); *Fyock v. City of Sunnyvale*, 25 F. Supp. 3d 1267, 1282 (N.D. Cal. 2014) (“[D]eprivation of constitutional rights always constitutes irreparable harm.”); accord *Stockman*, No. 5:17-cv-01799-JGB-KK, Dkt. No. 79, at 20 (finding that the stigmatic harm of transgender people being seen as “less-than” as a result of the transgender military ban constituted irreparable harm sufficient to warrant the grant of a preliminary injunction).

IV. The Balance of Equities Weighs Strongly in Plaintiff’s Favor

The balance of equities heavily favors Ms. Edmo’s requested relief. “Courts ‘must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief.’” *Winter*, 555 U.S. at 24 (quoting *Amoco Production Co.*, 480 U.S. 531, 542 (1987)).

Plaintiff has established that she suffers irreparable harm, including unnecessary physical and emotional suffering and denial of her constitutional rights, as a result of Defendants’ refusal to provide her with medically necessary treatment for gender dysphoria, including sex-reassignment surgery. This is more than sufficient to tip the balance of equities in Ms. Edmo’s favor. See, e. g., *Hicklin I*, 2018 U.S. Dist. LEXIS 21516, at *44 (finding the “balance of harms substantially weighs in favor of granting injunctive relief” because plaintiff demonstrated “she continues to face irreparable injury absent relief . . . including the denial of her constitutional rights”); *Norsworthy*, 87 F. Supp. 3d at 1193 (“The balance of the equities favors [plaintiff’s] requested relief. She has established that she is suffering and is likely to continue to suffer unnecessary pain if she is denied SRS.”); *Rhea v. Wash. Dep’t of Corr.*, 2010 U.S. Dist. LEXIS

97705, at *37 (W.D. Wash. July 2, 2010) (“In light of the medical findings of these physicians that [plaintiff] is suffering and will continue to suffer unnecessary pain, the undersigned finds that the balance of hardships is greater for Ms. Rhea if the injunction were not granted.”).

Defendants cannot cite any legitimate concerns that would outweigh the irreparable harm Ms. Edmo is suffering. *Rodde v. Bonta*, 357 F. 3d 988, 999 (9th Cir. 2004) (balance of hardships favored disabled plaintiffs, who would be deprived of necessary treatment and suffer increased pain and medical complications without relief); *Zepeda v. U.S. I.N.S.*, 753 F.2d 719, 727 (9th Cir. 1983) (defendant “cannot reasonably assert that it is harmed in any legally cognizable sense by being enjoined from constitutional violations”); *Hernandez*, 110 F. Supp. 3d at 957 (balance of equities favored inmates given Ninth Circuit law holding “that the interest in protecting individuals from physical harm outweighs monetary costs to government entities”).

V. The Public Interest Requires an Injunction

Finally, the public interest requires that Defendants be ordered to provide medically necessary treatment to Ms. Edmo, including sex-reassignment surgery. *See Melendres*, 695 F. 3d at 1002 (“[I]t is always in the public interest to prevent the violation of a party’s constitutional rights.” (citations and internal quotations omitted)); *see also United States v. Raines*, 362 U.S. 17, 27 (1960) (“[T]here is the highest public interest in the due observance of all constitutional guarantees.”). “In addition, ‘the public has a strong interest in the provision of constitutionally-adequate health care to prisoners.’” *McNearney v. Wash. Dep’t of Corr.*, 2012 U.S. Dist. LEXIS 115802, at *44 (W.D. Wash. June 15, 2012) (quoting *Flynn v. Doyle*, 630 F. Supp. 2d 987, 993 (E.D. Wis. 2009)). Conversely, there is no public interest in forcing Ms. Edmo to continue to suffer unnecessary and life-threatening harms during this litigation. *See Fields*, 653 F. 3d at 556; *Norsworthy*, 87 F. Supp. 3d at 1194.

VI. Plaintiff’s Requested Relief Complies with the Prison Litigation Reform Act

The scope of Plaintiff’s proposed injunction conforms to the Prison Litigation Reform Act’s requirement that a court “shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation

of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right.” 18 U.S.C. § 3626(a)(2). “The Court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system.” *Id.* The Ninth Circuit has clarified that the PLRA “has not substantially changed the threshold findings and standards required to justify an injunction.” *Gomez v. Vernon*, 255 F. 3d 1118, 1129 (9th Cir. 2001).

Here, an injunction granting Ms. Edmo “access to adequate medical care, including referral to a qualified surgeon for sex-reassignment surgery, is narrowly drawn, extends no further than necessary to correct the constitutional violation, and is the least intrusive means necessary to correct the violation.” *Norsworthy*, F. Supp. 3d at 1194-95. Further, “[t]here is no evidence that granting this relief will have any adverse impact on public safety or the operation of the criminal justice system.” *Id.* at 1195; *see Fields*, 653 F. 3d at 556.

CONCLUSION

For the foregoing reasons, Plaintiff requests the Court issue a preliminary injunction: 1) ordering Defendants to provide her immediate access to necessary medical treatment, including (a) sex-reassignment surgery; (b) reinstatement of spironolactone, or an equivalent type of care; (c) access to gender-appropriate underwear, clothing, and commissary items; (d) any other treatment a medical professional qualified to assess and treat gender dysphoria determines to be medically urgent; and 2) prohibiting Defendants from (a) implementing their policy and/or practice of blanket denial of access to such treatment for transgender persons incarcerated in the Idaho Department of Corrections; and (b) disciplining or retaliating against Plaintiff for expressing her gender identity, including wearing gender-appropriate underwear and clothing, and adhering to female grooming standards with regards to makeup and hair styling.

Dated: June 1, 2018

Respectfully Submitted,
NATIONAL CENTER FOR LESBIAN RIGHTS
FERGUSON DURHAM
HADSELL STORMER & RENICK LLP

By: /s/ - Lori E. Rifkin
Lori E. Rifkin
Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 1st day of June, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

ADREE EDMO (a/k/a MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF
CORRECTION; HENRY ATENCIO, in his
official capacity; JEFF ZMUDA, in his
official capacity; HOWARD KEITH
YORDY, in his official and individual
capacities; CORIZON, INC.; SCOTT
ELIASON; MURRAY YOUNG; RICHARD
CRAIG; RONA SIEGERT; CATHERINE
WHINNERY; and DOES 1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

**DECLARATION OF LORI RIFKIN AND
EXHIBITS IN SUPPORT OF PLAINTIFF'S
MOTION FOR PRELIMINARY INJUNCTION**

Complaint Filed: April 6, 2017
Discovery Cut-Off: None Set
Motion Cut-Off: None Set
Trial Date: None Set

DECLARATION OF LORI E. RIFKIN

I, Lori E. Rifkin, hereby declare and state:

1. I am a partner at the law firm of Hadsell Stormer & Renick, LLP. I am an attorney licensed to practice law in the state of California and am admitted *pro hac vice* before this Court, and am counsel of record for plaintiffs in this action. The information contained herein is based on my personal knowledge, or upon review of files and documents generated or received and regularly maintained by my office in connection with this case. If called upon, I could testify in a court of law to the accuracy of the matters set forth herein.

2. After filing Plaintiff's Second Amended Complaint on September 1, 2017, Plaintiff's counsel sought Ms. Edmo's medical records from Defendants. I communicated about this request with IDOC's counsel several times, but Defendants refused to provide these records until initial disclosures are required after the Court's ruling on Defendants' Motion for Dispositive Relief. In May 2018, I again requested Ms. Edmo's medical records based on learning of an IDOC Directive permitting release of medical records to an incarcerated person's attorney. Defendants then agreed to provide the records and did provide them on May 30, 2018.

3. Because of the gravity of Ms. Edmo's medical condition, Plaintiff's counsel retained two highly qualified medical experts, Drs. Randi Ettner and Nicholas Gorton, to evaluate her and review the incomplete medical records accessible by Ms. Edmo.

4. Attached hereto as **Exhibit 1** is the Declaration of Dr. Randi Ettner, an expert retained on behalf of Plaintiff in this matter. Dr. Ettner is a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. She was chief psychologist at the Chicago Gender Center from 2005 to 2016, and is now the sole psychologist for the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. Dr. Ettner is one of the foremost experts in the United States on treatment of individuals with gender dysphoria and is the secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH) and chairs the WPATH Committee for Institutionalized Persons.

5. Attached hereto as **Exhibit 2** is the Declaration of Dr. Nicholas Gorton, an expert retained on behalf of Plaintiff in this matter. Dr. Gorton is a physician who works in emergency medicine, and provides primary care and transition-related care to transgender patients. Dr. Gorton is an Emergency Medicine physician at Sutter Davis Hospital and a primary care physician at Lyon-Martin Health Services in San Francisco, and also serves as a clinician consultant for TransLine, a national transgender medical consultation service for clinicians needing expert advice about the care of their patients. Dr. Gorton is a preeminent expert on treatment of transgender health issues and is a member of WPATH and serves on the WPATH transgender medicine and research committee and the WPATH committee for institutionalized persons.

6. During a visit with Ms. Edmo on June 1, 2018, Plaintiff's counsel learned that Ms. Edmo has recently been told by her Unit Sergeant and another custody officer that if she wears her hair in a feminine manner and uses makeup before an attorney-client visit, she will not be permitted to attend the visit with her attorneys. Such harassment of Ms. Edmo for expressing her female identity and impermissible threat to interfere with her First Amendment right to access legal counsel further evidences the need for preliminary injunctive relief.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct. Executed June 1, 2018 in Emeryville, California.

/s/ - Lori E. Rifkin
Lori E. Rifkin

Rifkin Decl in Supp Pltf's Mtn for Preliminary Injunction

Exh. 1

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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

ADREE EDMO (a/k/a MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF
CORRECTION; HENRY ATENCIO, in
his official capacity; JEFF ZMUDA, in
his official capacity; HOWARD KEITH
YORDY, in his official and individual
capacities; CORIZON, INC.; SCOTT
ELIASON; MURRAY YOUNG;
RICHARD CRAIG; RONA SIEGERT;
CATHERINE WHINNERY; and DOES
1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

**DECLARATION OF RANDI
ETTNER, PhD, IN SUPPORT OF
PLAINTIFF'S MOTION FOR
PRELIMINARY INJUNCTION**

Complaint Filed: April 6, 2017
Discovery Cut-Off: None Set
Motion Cut-Off: None Set
Trial Date: None Set

I, Randi C. Ettner, have been retained by counsel for Adree Edmo as an expert in connection with the above-captioned matter.

1. I have actual knowledge of the matters stated and would so testify if called as a witness. I reserve the right to supplement or amend this report based on any future information that is provided to me.

2. This report contains my opinions and conclusions, including (i) scientific information regarding gender dysphoria and its impact on health and well-being of individuals afflicted; (ii) information regarding best practices and the accepted standards of care for individuals with gender dysphoria, including the efficacy of gender confirmation surgery (previously referred to as sex reassignment surgery), and (iii) the results of my evaluation of Ms. Edmo and recommendations with regard to her treatment.

My Relevant Background and Qualifications

3. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of gender dysphoric individuals. I received my doctorate in psychology (with honors) from Northwestern University. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder.

4. I was the chief psychologist at the Chicago Gender Center from 2005 to 2016, when it moved to Weiss Memorial Hospital. Since that time, I have held the sole psychologist position at the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. A true and accurate copy of my curriculum vitae is attached as **Exhibit A** to this declaration.

5. I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance from 1980 to present. I have published four books related to the treatment of individuals with gender dysphoria, including the medical text entitled Principles of Transgender Medicine and Surgery (1st edition, co-editors Monstrey & Eyler; Rutledge 2007; and 2nd edition, co-editors Monstrey & Coleman; Routledge, June 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population.

6. I have served as a member of the University of Chicago Gender Board, and am on the editorial boards of *The International Journal of Transgenderism* and *Transgender Health*. I am the secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH), and an author of the WPATH *Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People (7th version)*, published in 2011. The WPATH promulgated Standards of Care (“Standards of Care”) are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

7. I chair the WPATH Committee for Institutionalized Persons, and provide training to medical professionals on healthcare for transgender inmates. I have lectured throughout North America, Europe, and Asia on topics related to gender dysphoria and present grand rounds on gender dysphoria at university hospitals. I am the honoree of the externally-funded Randi and Fred Ettner Fellowship in Transgender Health at the

University of Minnesota. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of gender dysphoria.

8. I have been retained as an expert regarding gender dysphoria and the treatment of gender dysphoria in multiple court cases in both state and federal courts as well as administrative proceedings. I have also been a consultant to policy makers regarding appropriate care for transgender inmates.

9. Attached hereto as **Exhibit B** is a bibliography of relevant medical and scientific materials related to transgender people and gender dysphoria. I generally rely on these materials when I provide expert testimony, in addition to the documents specifically cited as supportive examples in particular sections of this declaration. I have also relied on my years of experience in this field, as set out in my curriculum vitae (**Exhibit A**), and on the materials listed therein. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

My Evaluation of Ms. Edmo

10. I reviewed the following documents for this report:

- *Diagnostic and Statistical Manual of Mental Disorders, fifth revision (DSM-5)* (2013)
- *The World Professional Organization for Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Seventh Version*, 2011

- Medical and mental health records for Adree Edmo, provided
- Ettner, Monstrey & Coleman (eds.) *Principles of Transgender Medicine and Surgery*, Routledge, New York: 2016

11. I administered the following psychodiagnostic tests to Ms. Edmo:

- *Beck Anxiety Inventory*
- *Beck Depression Inventory-II*
- *Beck Hopelessness Scale*
- *Traumatic-Symptom Inventory-2*

12. At the request of counsel, I met with Ms. Edmo at the Idaho Department of Correction (IDOC) in Boise, Idaho on March 19, 2018. The interview took place in a private visitors' area equipped with a table and chairs, and I was afforded all the necessary courtesies by staff.

Ms. Edmo's Relevant Background Information

13. Ms. Edmo was born in Pocatello, Idaho. She is one of five children; two of whom are half-siblings. Ms. Edmo spent her first two years in Texas, and then the family returned to Idaho to live on the Shoshone Bannock Native American reservation. She attended public elementary and high school and one year of college at Idaho State University, majoring in business administration. She received a paralegal certificate from the state university. Prior to her incarceration, Ms. Edmo was employed as a secretary.

14. At age 15, Ms. Edmo began abusing alcohol, and by age 20 she was using intravenous drugs. She was sentenced for her criminal conviction in 2011, and in 2012 she was incarcerated at the Idaho facility where she remains to date.

15. As a very young child, Ms. Edmo believed she was a girl, and assumed she

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would grow up to be as feminine as her two older sisters. She states her female gender identity was something she “never questioned...it’s always been this way as long as I can remember.” Ms. Edmo’s father was “absent” during her childhood and her mother was accepting of the child’s female behavior and display. Ms. Edmo describes her older brother as feeling “protective” of her, lest she be bullied for her gender non-conformity, but that never came to pass. Ms. Edmo played exclusively with girls as a youngster, and as she matured, she continued to associate exclusively with female peers.

16. By the age of 21, Ms. Edmo began to present as a female full time—she dressed in women’s clothing, and wore make-up and nail polish. She was experiencing depression and was treated by the Native American health service providers with sertraline and fluoxetine.

17. In 2012, prison mental health professionals diagnosed Ms. Edmo with gender dysphoria (302.6), and appropriately prescribed cross sex hormonal therapy. She has a well consolidated female identity and has, to the best of her ability, made a successful social role transition, given the restrictions of presenting as a woman in the male prison where she resides.

18. Ms. Edmo is exclusively attracted to men and has a committed relationship with a male inmate whom she considers a life partner.

19. She has no paraphilic fantasies, and like all severely gender dysphoric individuals, she despises her genitals, “tucks” them and does not use them as a vehicle for sensuality. She refers to her genitals as “something attached that I hate...I feel deformed in some way and get nauseous.” Ms. Edmo has attempted auto-castration on two occasions.

Relevant Medical History

20. Ms. Edmo has no chronic illnesses, save overweight/borderline obesity, with a BMI of 29.75. She has been substance free for seven years. She currently takes 450 mg venlafaxine, 8 mg estradiol, 5 mg finasteride, 5 mg medroxyprogesterone, calcium carbonate, vitamin D and vitamin B complex. In 2018, her laboratory results indicated elevated liver enzymes (ALT and AST) and spironolactone was discontinued from her hormone protocol.

Ms. Edmo's History of Suicidality

21. Ms. Edmo has a history of suicide ideation and multiple suicide attempts. At the behest of the Surgeon General, a plan for identifying populations at risk for suicide, and advancement of scientific methods to assess risk, has resulted in recent abundant scientific investigation. Several lines of research suggest that single suicide attempters differ significantly from multiple suicide attempters. Multiple attempters, and those who engage in method switching, as Ms. Edmo has, are far more likely to die by suicide than are single attempters. Ms. Edmo has attempted suicide by overdosing on pills, attempted hanging, and cutting her arms with a box cutter.

Mental Status Exam

22. Ms. Edmo appeared well groomed, wearing prison-issued garments. At 5 feet, seven inches and 190 pounds, with long hair, and minimal make-up, she makes an authentic and decidedly female presentation. Ms. Edmo was alert, cooperative, and oriented in all spheres. She was able to sit comfortably throughout the lengthy interview without a break, and with no agitation or restlessness. There are no disorders of thought,

and thought processes were logical, goal directed and without distortion. Thought content is within normal limits. Judgment and insight are adequate. Mood was calm, and affect was appropriate to context. Ms. Edmo maintained eye contact throughout, and rapport was easily established. Speech is well modulated and in a female range; language is fluent. Memory and abstract reasoning are well within normal limits. Intelligence (by estimation) is above average.

Cluster Analysis of Clinical Data

23. Anxiety and depression are symptoms that are present in many mental disorders. Like pain or fatigue, their mere presence does not provide sufficient information to be clinically useful. For example, an individual will experience pain from a head injury or a blockage in the ureter. The diagnosis and therapeutic interventions will differ in these two presentations.

24. Similarly, anxiety and depression are multi-faceted constructs, and clinicians endeavor to disentangle the affective, behavioral and somatic symptoms of these phenomena. This is critical in determining the nature of a disorder, its severity and appropriate treatment. Patterns of anxiety symptoms are often diagnostically relevant. Indeed, statistical analysis reveals four distinct symptom clusters that assist in making a differential diagnosis and inform treatment. These clusters reflect neurophysiological, subjective, panic and autonomic symptoms of anxiety. The inter-correlations of the four clusters are statistically significant (beyond the .001 level). Similarly, it is useful for clinicians to examine the overall pattern of depressive symptoms. Depressive symptoms are not only cognitive and affective, but also somatic and vegetative. Each patient displays

a unique depressive syndrome.

25. The administration of psychometric tests to measure various aspects of anxiety and depression in adult populations greatly assists with differential diagnosis, allowing the clinician to respond with a full range of appropriate therapeutic interventions.

Psychological Test Results

26. Four standardized psychometric indices with high levels of reliability and validity were administered to corroborate the clinical assessment: *The Beck Anxiety Inventory*, *The Beck Depression Inventory-II*, *The Beck Hopelessness Scale* and *The Traumatic Symptom Inventory-2*. The *Traumatic Symptom Inventory-2* includes extensive validity measures, which detect malingering, random response patterns, exaggeration of symptoms, or “faking good” i.e. an attempt to present oneself as overly virtuous. Ms. Edmo produced valid test protocols, demonstrating an honest and self-disclosing response style. I am confident, to a reasonable degree of medical certainty, that the data generated regarding her current status is valid and reliable.

27. The Beck Anxiety Inventory (BAI): Ms. Edmo experiences severe anxiety symptoms, including “feeling scared;” “fear of the worst happening;” “heart pounding;” “difficulty breathing;” etc. Most of these symptoms are somatic (physical sensations), and not subject to cognitive reappraisal (logical reinterpretation). In other words, because these symptoms are physiological, they are not within her conscious control. Ms. Edmo meets the diagnostic criteria for an anxiety disorder.

28. The Beck Depression Inventory-II (BDI-II): The BDI-II measures both the symptoms and severity of depression in twenty-one domains, with scores that range from

0-63. Ms. Edmo experiences severe depressive symptoms. These include changes in appetite and sleep, irritability, loss of energy, feelings of worthlessness, fatigue, and agitation. These symptoms represent somatic, affective and cognitive symptoms of depression.

29. Ms. Edmo scored a 36 on the *Beck Depression Inventory*. To put this in context, one study demonstrated that scores of 23 and above were predictive of patients who ultimately committed suicide. Ms. Edmo meets the diagnostic criteria for a depressive disorder.

30. The Beck Hopelessness Scale (BHS): Ms. Edmo scored moderately high on scales measuring the extent of hopelessness. Hopelessness is a psychological condition that underlies a variety of mental health disorders. Hopeless individuals believe that their important goals cannot be attained and that their worst problems cannot be solved. The BHS has utility as an indirect indicator of suicidal risk, and hopelessness has been repeatedly found to be a better predictor of suicide than depression. Ms. Edmo scored 11 on this instrument. A study of 1,969 outpatients who were administered the BHS found that of those who ultimately committed suicide, 93.8% had scores of 9 or higher.

31. The Traumatic Symptom Inventory-2 (TSI-2): The TSI-2 is a test that measures acute and chronic symptomatology, and is used to evaluate adults in a variety of clinical settings. It measures trauma at any point in an individual's lifespan, and assesses a wide range of potentially complex symptomatology (a set of symptoms), ranging from posttraumatic stress, dissociation, somatization, insecure attachment styles, impaired self-capacities and dysfunctional behaviors.

32. A respondent's level of symptomatology is interpreted based on *T*-scores, which are linear transformations of raw scale scores, similar to percentages. Higher *T*-scores indicate greater symptomatology. *T*-scores in the range of 60-64 are considered problematic, and those at or above 65 are considered clinically elevated (sufficiently extreme to represent significant clinical concern).

33. Ms. Edmo has clinically elevated scores on several scales. Consistent with a diagnosis of a depressive disorder and Gender Dysphoria, her most substantially elevated scores are on scales that tap depression (D) and suicidality (SUI). Ms. Edmo scored a 100—the highest score possible—on the scale that measures suicide ideation and suicide behavior. Elevated scores on the suicidality scale are especially problematic, as they indicate a potential threat to life or the hopelessness of individuals in inescapable, highly adverse circumstances. Suicide is a particular concern in this case, as it is accompanied by Ms. Edmo's high scores on externalizing behavior (EXT) and tension reduction behavior (TRB) and her previous history of suicide attempts. This is alarming, given that Ms. Edmo is currently receiving the maximum dose of anti-depressant medication.

Gender Dysphoria

34. Gender dysphoria, formerly known as gender identity disorder (GID), is a serious medical condition codified in the *International Classification of Diseases* (ICD10th revision: World Health Organization) and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders-5th edition* (DSM-5).

35. The condition is characterized by incongruence between one's experienced/expressed gender and assigned sex at birth, and clinically significant distress

or impairment of functioning that results. The suffering that arises from this condition has often been described as “being trapped in the wrong body.” Gender dysphoria is also the psychiatric term used to describe the severe and unremitting pain associated with the condition.

36. The diagnostic criteria for gender dysphoria in adults are as follows:

A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 month’s duration, as manifested by at least two of the following:

- i. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics.
- ii. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender.
- iii. A strong desire for the primary and/or secondary sex characteristics of the other gender.
- iv. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender).
- v. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender).
- vi. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

37. Gender dysphoria is a highly treatable condition. Without treatment, however, individuals with gender dysphoria experience anxiety, depression, suicidality, and other attendant mental health issues. They are also frequently isolated because they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently “defective.” This leads to stigmatization, and over time, ravages healthy personality development and interpersonal relationships. As a result, without treatment many such

individuals are unable to function effectively in daily life. Studies show a 41%-43% rate of suicide attempts among this population, far above the baseline for North America (Haas et al., 2014).

38. Gender dysphoric patients who are assigned a male sex at birth but identify as female and lack access to appropriate care, particularly those who are imprisoned, are often so desperate for relief that they resort to life-threatening attempts at auto-castration—removal of the testicles—in the hopes of eliminating the major source of testosterone that kindles the distress (Brown, 2010; Brown & McDuffie, 2009).

39. Gender dysphoria intensifies with age. As gender dysphoric individuals approach middle age, they experience an exacerbation of symptoms (Ettner, 2013; Ettner & Wiley, 2013).

Treatment of Gender Dysphoria

40. The standards of care for treating gender dysphoria are set forth in the WPATH Standards of Care. The *American Medical Association*, the *Endocrine Society*, the *American Psychological Association* the *American Psychiatric Association*, the *World Health Organization*, the *American Academy of Family Physicians*, the *American Public Health Association*, the *National Association of Social Workers*, the *American College of Obstetrics and Gynecology* and the *American Society of Plastic Surgeons* all endorse protocols in accordance with the WPATH standards. *See, e.g.*, American Medical Association (2008) Resolution 122 n(A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2017); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression

Nondiscrimination (2009).

41. The standards of care identify the following evidence-based protocols for the treatment of individuals with gender dysphoria:

- Changes in gender expression and role, consistent with one's gender identity (social role transition)
- Psychotherapy for purposes such as addressing the negative impact of stigma, alleviating internalized transphobia, enhancing social and peer support, improving body image, promoting resiliency, etc.
- Hormone therapy to feminize the body
- Surgery to alter primary and/or secondary sex characteristics (e.g. breasts, external genitalia, facial features, body contouring)

42. Once a diagnosis is established, a treatment plan should be developed based on the individualized assessment of the medical needs of the patient. WPATH specifies that treatment plans and provision of care must be undertaken by qualified professionals, with established competencies in the treatment of gender dysphoria (Section VIII). Regimens tendered by providers lacking the requisite experience can place patients at significant medical risk.

43. Like protocols for the treatment of diabetes or other medical conditions, medical management of gender dysphoria for incarcerated individuals does not differ from protocols for non-institutionalized persons. For this reason, the WPATH Standards of Care expressly state that all elements of the prescribed assessment and treatment are equally applicable to patients who are institutionalized or incarcerated in prisons (Section XIV), and the standards of care have also been recognized by the National Commission on Correctional Health Care (NCCHC) as the clinically accepted standards for the care of inmates with gender dysphoria. (NCCHC Policy Statement, Transgender Health Care in

Correctional Settings (October 18, 2009; reaffirmed with revision April, 2015), available at <http://www.ncchc.org/transgender-health-care-in-correctional-settings>.)

44. **Psychotherapy**: Psychotherapy can provide support and help with many issues that arise in tandem with gender dysphoria. However, psychotherapy alone is not a substitute for medical intervention when medical interventions are required, nor is it a precondition for medically indicated treatment. By analogy, counseling can be useful for patients with diabetes by providing psychoeducation about living with chronic illness and nutritional information, but counseling does not obviate the need for insulin.

45. **Social Role Transition**: The Standards of Care establish the therapeutic importance of changes in gender expression and presentation—the ability to feminize one’s appearance— as a critical component of treatment. Known as the “real life experience,” it requires dressing, grooming, and otherwise conveying, via social signifiers, a public face and role consistent with one’s gender identity. This is an appropriate and essential part of identity consolidation. Through this experience, the shame of growing up living as a “false self” and the grief of being born in the “wrong body” can be ameliorated. (Greenberg and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007.)

46. The Standards of Care also specifically provide that permanent facial and body hair removal, which eliminates a visible secondary sex characteristic, is significant in alleviating gender dysphoria (Section V).

47. **Hormone Therapy**: For individuals with persistent, well-documented gender dysphoria, hormone therapy is an essential, medically indicated treatment to alleviate the distress of the condition. Cross sex hormone administration is a well-

established and effective treatment modality for gender dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association and the American Psychological Association all concur that hormone therapy, provided in accordance with the WPATH Standards of Care, is the medically necessary, evidence-based, best practice care for most patients with gender dysphoria.

48. The goals of hormone therapy are (1) to significantly reduce hormone production associated with the person's birth sex, causing the unwanted secondary sex characteristics to recede, and (2) to replace the natal, circulating sex hormones with feminizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (*i.e.* those born with insufficient sex steroid hormones). (*See* Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline; 2009).

49. The therapeutic effects of hormone therapy are twofold: (1) with endocrine treatment, the patient acquires congruent secondary sex characteristics, *i.e.* breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (2) hormones act directly on the brain, via receptor sites, attenuating the dysphoria and attendant psychiatric symptoms, and promoting a sense of well-being.

50. **Surgical Treatment:** For individuals with severe gender dysphoria, hormone therapy alone is insufficient. In these cases, dysphoria does not abate without surgical intervention. Genital confirmation surgery has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains body congruence resulting from the normal appearing and functioning

female uro-genital structures. Both outcomes are crucial in attenuating or eliminating gender dysphoria.

51. Decades of methodologically sound and rigorous scientific research have demonstrated that gender confirmation surgery is a safe and effective treatment for severe gender dysphoria and, indeed, for many, it is the only effective treatment. The American Medical Association, the Endocrine Society, the American Psychological Association, and the American Psychiatric Association all endorse surgical therapy, in accordance with the WPATH Standards of Care, as medically necessary treatment for individuals with severe gender dysphoria. *See* American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009) (“For many transsexual adults, genital sex reassignment surgery may be the necessary step towards achieving their ultimate goal of living successfully in their desired gender role.”); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009) (recognizing “the efficacy, benefit and medical necessity of gender transition treatments” and referencing studies demonstrating the effectiveness of sex-reassignment surgeries).

52. Surgeries are considered “effective” from a medical perspective, if they “have a therapeutic effect” (Monstrey et al. 2007). More than three decades of research confirms that gender confirmation surgery is therapeutic and therefore an effective treatment for gender dysphoria. Indeed, for many patients with severe gender dysphoria, gender confirmation surgery is the *only* effective treatment.

53. In a 1998 meta-analysis, Pfafflin and Junge reviewed data from 80 studies,

from 12 countries, spanning 30 years. They concluded that “reassignment procedures were effective in relieving gender dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes” (Pfafflin & Junge 1998).

54. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in the Netherlands concluded that after surgery there was “a virtual absence of gender dysphoria” in the cohort and “results substantiate previous conclusions that sex reassignment is effective” (Smith et al. 2005). Indeed, the authors of the study concluded that the surgery “appeared therapeutic and beneficial” across a wide spectrum of factors and “[t]he main symptom for which the patients had requested treatment, gender dysphoria, had decreased to such a degree that it had disappeared.”

55. Given the decades of extensive experience and research supporting the effectiveness of gender confirmation surgery, it is clear that reconstructive surgery is a medically necessary, not experimental, treatment for gender dysphoria. Therefore, it is included as a medically necessary treatment in the WPATH Standards of Care.

56. In 2008, WPATH issued a “Medical Necessity Statement” expressly stating: “These medical procedures and treatment protocols are not experimental: decades of both clinical and medical research show they are essential to achieving well-being for the transsexual patient.”

57. Similarly, Resolution 122 (A-08) of the American Medical Association states: “Health experts in GID, including WPATH, have rejected the myth that these

treatments are ‘cosmetic’ or ‘experimental’ and have recognized that these treatments can provide safe and effective treatment for a serious health condition.”

58. On May 30, 2014, the Appellate Division of the Departmental Appeals Board of the United States Department of Health and Human Services issued decision number 2576, in which the Board determined that Medicare’s policy barring coverage for transition-related surgeries was not valid under the “reasonableness standard.” The Board found that the ban “was based principally on” a report from 1981 that has been rendered obsolete by numerous “medical studies published in the more than 32 years since issuance of the 1981 report.” The Board specifically concluded that transition-related surgeries are “safe and effective and not experimental.” As a result, Medicare’s exclusion was struck down and Medicare was directed to consider surgeries on a case-by-case basis.

Assessment and Treatment Recommendations

59. Adree Edmo has persistent, well-documented and severe gender dysphoria. She has been receiving hormone therapy since 2012. As a result of ongoing endocrine treatment, she has been *hormonally confirmed*. In other words, she has the same circulating sex hormones and secondary sex characteristics as a typical adult female.

60. Ms. Edmo successfully consolidated her female identity long ago, as she never was socialized as a male. Rather, her mother and the Shoshone Bannock tribal community accepted her female identity at a young age and Ms. Edmo has always identified as female. She has also changed her name, and has relentlessly advocated for medical and surgical care. Ms. Edmo’s intractable determination to live authentically and reduce her dysphoria is the impetus to wear facial make-up, despite disciplinary

consequences. There are instances in her file documenting that prison officials have disciplined her for expressing her gender identity.

61. Despite years of feminizing hormone therapy, Ms. Edmo continues to suffer from severe gender dysphoria and attendant depression. The long-term hormonal treatment she has undergone has served to intensify Ms. Edmo's anatomical dysphoria. Having a female appearance and male genitalia generates profound distress. Her inability to reduce or modulate this internal anguish is very likely to result in emotional decompensation and self-harm.

62. Ms. Edmo has twice resorted to attempting auto-castration. This is not an act of mutilation, but rather "surgical self-treatment" (SST). Auto-castration is not uncommon in prison settings, but it is a desperate act that occurs only in the absence of appropriate or adequate medical care. Unfortunately, most individuals who attempt to remove the testicles are unaware of the amount of blood that is generated and the elasticity of the vas deferens neuro-vascular bundle, which can retract into the body cavity. As a result, people often do not succeed with these surgeries given the extreme amounts of blood, or they can end up bleeding out and dying. Because of the amount of blood involved, it is not uncommon for individuals to be caught in an attempt and sent to a hospital where their condition is stabilized.

63. The WPATH Standards of Care establish the following requirements for a patient in need of gender confirmation surgery:

- Persistent, well-documented gender dysphoria.
- Capacity to make a fully-informed decision and to consent for treatment.

- Age of majority in a given country.
- If significant medical or mental health concerns are present, they must be well controlled.
- Twelve months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual).
- Twelve continuous months of living in an identity-congruent gender role.

64. Despite the obvious severity of her gender dysphoria, the Idaho Department of Corrections has failed to provide the necessary care or to demonstrate an understanding of the severity of this medical condition. In May of 2016, a prison provider, Scott Eliason, told Ms. Edmo that sex-reassignment surgery was “not medically indicated.” In January of 2017, following an attempt at auto-castration, a note in Ms. Edmo's chart states that she cut her scrotum “as she was confused about her gender... confusion happens a couple of times a year.” These notes suggest that these providers are not qualified to provide appropriate care to Ms. Edmo and that they do not understand gender dysphoria generally or the severity of Ms. Edmo's medical issues in particular.

65. In fact, Ms. Edmo meets, and exceeds, the criteria for this medically necessary surgery: She has persistent, well-documented gender dysphoria. She is free of any disorders of thought or impaired reality testing, able to provide informed consent and to participate in decisions regarding her healthcare. She understands the irrevocable nature of surgery. Having been on hormonal therapy for years, irreversible anatomical changes are present. For years, Ms. Edmo has lived in her affirmed and well-consolidated female gender. She has no mental health or medical concerns that contraindicate surgery. On the contrary, surgery is the therapeutic intervention that would significantly improve her

emotional and physical health.

66. Owing to the severity of her gender dysphoria diagnosis, the ensuing clinically significant distress, and the limited efficacy of hormone therapy, gender confirmation surgery is medically indicated for Ms. Edmo and should be immediately performed. Surgery would create congruent genitalia, thereby eliminating the severe distress Ms. Edmo experiences due to her male genitalia. Moreover, removal of her testicles will eliminate 80% of androgen (male sex hormone) production. As a result, she will require lower dosages of feminizing hormones which will be particularly therapeutic given her recent history of elevated liver enzymes.

67. Gender dysphoria intensifies with age. If Ms. Edmo does not receive gender confirmation surgery, she is at great risk of succumbing to feelings of hopelessness and despair, leading to emotional destabilization and suicide.

68. While inexperienced providers might cite the administration of psychotropic drugs—anti-depressants and/or anti-anxiolytics—as treatment, these medications are not effective, and not the evidence-based treatment protocol for gender dysphoria. Merely giving psychotropic medications to a severely gender dysphoric patient is analogous to treating a cancer patient with anti-anxiety medication rather than chemotherapy. Likewise, placing gender dysphoric inmates in segregation in an attempt to prevent suicide or self-surgery is medically inadvisable, as it serves to kindle gender dysphoria and exacerbate symptoms.

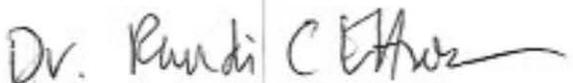
69. The treatment Ms. Edmo is receiving falls far short of the Standards of Care. Ms. Edmo should have access to canteen items that are available to female inmates and a

means of safe and effective hair removal. These treatments are necessary to ameliorate her gender dysphoria.

70. Her hormonal regimen should be closely monitored, due to recent liver function test abnormalities. According to the Endocrine Society guidelines, Ms. Edmo should not be receiving medroxyprogesterone, which may have an androgenizing effect and increase cardiovascular risk, particularly given her elevated liver enzymes. She should be switched to transdermal estrogen (two 100 microgram patches per week) or parenteral estradiol valerate (5-20 mg every two weeks), or estradiol cypionate (2-10 mg weekly), with ongoing monitoring and medication adjustment, via laboratory follow-up. Although spironolactone has been discontinued, it is not known to cause an elevation of liver enzymes. Ms. Edmo may need a liver ultrasound to determine if there is hepatic injury.

71. There are no contraindications to the implementation of medically necessary surgical intervention for this inmate. The potential consequences of denying appropriate treatment however, are predictable and dire.

I declare under penalty of perjury under the laws of the United States of America and the State of Idaho that the foregoing is true and correct. Executed this 2nd day of May, 2018 in Evanston, Illinois.



Dr. Randi C. Ettner

Exhibit A

RANDI ETTNER, PHD
1214 Lake Street
Evanston, Illinois 60201
847-328-3433

POSITIONS HELD

Clinical Psychologist
Forensic Psychologist
Fellow and Diplomate in Clinical Evaluation, American Board of
Psychological Specialties
Fellow and Diplomate in Trauma/PTSD
President, New Health Foundation Worldwide
Secretary, World Professional Association of Transgender Healthcare
(WPATH)
Chair, Committee for Incarcerated Persons, WPATH
Global Education Initiative Committee
University of Minnesota Medical Foundation: Leadership Council
Psychologist, Center for Gender Confirmation Surgery, Weiss Memorial
Hospital
Adjunct Faculty, Prescott College
Editorial Board, *International Journal of Transgenderism*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international
appearances)
Internationally syndicated columnist
Private practitioner
Medical staff Weiss Memorial Hospital, Chicago IL

EDUCATION

| | |
|-------------|--|
| PhD, 1979 | Northwestern University (with honors) Evanston, Illinois |
| MA, 1976 | Roosevelt University (with honors) Chicago, Illinois |
| BA, 1969-73 | Indiana University Bloomington, Indiana Cum Laude Major: Clinical Psychology; Minor: Sociology |
| 1972 | Moray College of Education Edinburgh, Scotland International Education Program |
| 1970 | Harvard University Cambridge, Massachusetts Social Relations Undergraduate Summer Study Program in Group Dynamics and Processes |

CLINICAL AND PROFESSIONAL EXPERIENCE

- 2016-present Psychologist: Chicago Gender Center
Consultant: Walgreens; Tawani Enterprises
Private practitioner
- 2011 Instructor, Prescott College: Gender-A multidimensional approach
- 2000 Instructor, Illinois Professional School of Psychology
- 1995-present Supervision of clinicians in counseling gender non conforming clients
- 1993 Post-doctoral continuing education with Dr. James Butcher in MMPI-2 Interpretation, University of Minnesota
- 1992 Continuing advanced tutorial with Dr. Leah Schaefer in psychotherapy
- 1983-1984 Staff psychologist, Women's Health Center, St. Francis Hospital, Evanston, Illinois
- 1981-1984 Instructor, Roosevelt University, Department of Psychology: Psychology of Women, Tests and Measurements, Clinical Psychology, Personal Growth, Personality Theories, Abnormal Psychology
- 1976-1978 Research Associate, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
- 1975-1977 Clinical Internship, Cook County Hospital, Chicago, Illinois, Department of Psychiatry
- 1971 Research Associate, Department of Psychology, Indiana University
- 1970-1972 Teaching Assistant in Experimental and Introductory Psychology
Department of Psychology, Indiana University
- 1969-1971 Experimental Psychology Laboratory Assistant, Department of Psychology, Indiana University

LECTURES AND HOSPITAL GRAND ROUNDS PRESENTATIONS

The role of the mental health professional in gender confirmation surgeries, Mt. Sinai Hospital, New York City, NY, 2018

Mental health evaluation for gender confirmation surgery, Gender Confirmation Surgical Team, Weiss Memorial Hospital, Chicago, IL 2018

Transitioning; Bathrooms are only the beginning, American College of Legal Medicine, Charleston, SC, 2018

Gender Dysphoria: A medical perspective, Department of Health and Human Services, Office for Civil Rights, Washington, D.C, 2017

Multi-disciplinary health care for transgender patients, James A. Lovell Federal Health Care Center, North Chicago, IL, 2017

Psychological and Social Issues in the Aging Transgender Person, Weiss Memorial Hospital, Chicago, 2017.

Psychiatric and Legal Issues for Transgender Inmates, USPATH, Los Angeles, 2017

Transgender 101 for Surgeons, American Society of Plastic Surgeons, 2017.

Healthcare for transgender inmates in the US, Erasmus Medical Center, Rotterdam, Netherlands, 2016.

Tomboys Revisited: Replication and Implication; Models of Care; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment: WPATH global education initiative, Chicago, 2015; Atlanta, 2016; Ft. Lauderdale, 2016; Washington, D.C., 2016, Los Angeles, 2017, Minneapolis, 2017, Chicago, 2017; Columbus, Ohio, 2017

Pre-operative evaluation in gender-affirming surgery-American Society of Plastic Surgeons, 2015

Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care- Fenway Health Clinic, Boston, 2015

Gender reassignment surgery- Midwestern Association of Plastic Surgeons, 2015

Adult development and quality of life in transgender healthcare- Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2015

Healthcare for transgender inmates- American Academy of Psychiatry and the Law, 2014

Supporting transgender students: best school practices for success- American Civil Liberties Union of Illinois and Illinois Safe School Alliance, 2014

Addressing the needs of transgender students on campus- Prescott College, 2014

The role of the behavioral psychologist in transgender healthcare – Gay and Lesbian Medical Association, 2013

Understanding transgender- Nielsen Corporation, Chicago, Illinois, 2013

Role of the forensic psychologist in transgender care; Care of the aging transgender patient- University of California San Francisco, Center for Excellence, 2013

Evidence-based care of transgendered patients- North Shore University Health Systems, University of Chicago, Illinois, 2011; Roosevelt-St. Vincent Hospital, New York; Columbia Presbyterian Hospital, Columbia University, New York, 2011

*Children of Transsexuals-*International Association of Sex Researchers, Ottawa, Canada, 2005; Chicago School of Professional Psychology, 2005

Gender and the Law- DePaul University College of Law, Chicago, Illinois, 2003; American Bar Association annual meeting, New York, 2000

*Gender Identity, Gender Dysphoria and Clinical Issues –*WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools, Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

Psychosocial Assessment of Risk and Intervention Strategies in Prenatal Patients- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984; Purdue University School of Nursing, West Layette, Indiana, 1980

Psychoneuroimmunology and Cancer Treatment- St. Francis Hospital, Evanston, Illinois, 1984

Psychosexual Factors in Women's Health- St. Francis Hospital, Center for Women's Health, Evanston, Illinois, 1984

Sexual Dysfunction in Medical Practice- St. Francis Hospital, Dept. of OB/GYN, Evanston, Illinois, 1980

Sleep Apnea - St. Francis Hospital, Evanston, Illinois, 1996; Lincolnwood Public Library, Lincolnwood, Illinois, 1996

The Role of Denial in Dialysis Patients - Cook County Hospital, Department of Psychiatry, Chicago, Illinois, 1977

PUBLICATIONS

Ettner, R., White, T., Ettner, F., Friese, T., Schechter, L. (2018) Tomboys revisited: A retrospective comparison of childhood behaviors in lesbians and transment. *Journal of Child and Adolescent Psychiatry*, in press.

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Berli, J., Kudnson, G., Fraser, L., Tangpricha, V., Ettner, R., et al. Gender Confirmation Surgery: what surgeons need to know when providing care for transgender individuals. *JAMA Surgery*; 2017.

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Ettner, R. Care of the elderly transgender patient. *Current Opinion in Endocrinology and Diabetes*, 2013, Vol. 20(6), 580-584.

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Ettner, R., Ettner, F. and White, T. Secrecy and the pathophysiology of hypertension. *International Journal of Family Medicine* 2012, Vol. 2012.

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Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., Adler, R., Brown, G., Devor, A., Ehrbar, R., Ettner, R., et.al. Standards of Care for the health of transsexual, transgender, and gender-nonconforming people. World Professional Association for Transgender Health (WPATH). 2012.

Ettner, R., White, T., and Brown, G. Family and systems aggression towards therapists. *International Journal of Transgenderism*, Vol. 12, 2010.

Ettner, R. The etiology of transsexualism in Principles of Transgender Medicine and Surgery. Ettner, R., Monstrey, S., and Eyler, E. (Eds.). Routledge Press, 2007.

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Monstrey, S. De Cuypere, G. and Ettner, R. Surgery: General principles in Principles of Transgender Medicine and Surgery, Ettner, R., Monstrey, S., and Eyler, E. (Eds.) Routledge Press, 2007.

Schechter, L., Boffa, J., Ettner, R., and Ettner, F. Revision vaginoplasty with sigmoid interposition: A reliable solution for a difficult problem. The World Professional Association for Transgender Health (WPATH), 2007, *XX Biennial Symposium*, 31-32.

Ettner, R. Transsexual Couples: A qualitative evaluation of atypical partner preferences. *International Journal of Transgenderism*, Vol. 10, 2007.

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White, T. and Ettner, R. Disclosure, risks, and protective factors for children whose parents are undergoing a gender transition. *Journal of Gay and Lesbian Psychotherapy*, Vol. 8, 2004.

Witten, T., Benestad, L., Berger, L., Ekins, R., Ettner, R., Harima, K. Transgender and Transsexuality. Encyclopeida of Sex and Gender. Springer, Ember, & Ember (Eds.) Stonewall, Scotland, 2004.

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"Social and Psychological Issues of Aging in Transsexuals," proceedings, Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, 2005.

"The Role of Psychological Tests in Forensic Settings," *Chicago Daily Law Bulletin*, 1997.

Confessions of a Gender Defender: A Psychologist's Reflections on Life amongst the Transgendered. Chicago Spectrum Press. 1996.

"Post-traumatic Stress Disorder," *Chicago Daily Law Bulletin*, 1995.

"Compensation for Mental Injury," *Chicago Daily Law Bulletin*, 1994.

"Workshop Model for the Inclusion and Treatment of the Families of Transsexuals," Proceedings of the Harry Benjamin International Gender Dysphoria Symposium; Bavaria, Germany, 1995.

“Transsexualism- The Phenotypic Variable,” Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.

“The Work of Worrying: Emotional Preparation for Labor,” Pregnancy as Healing. A Holistic Philosophy for Prenatal Care, Peterson, G. and Mehl, L. Vol. II. Chapter 13, Mindbody Press, 1985.

PROFESSIONAL AFFILIATIONS

University of Minnesota Medical School–Leadership Council
American College of Forensic Psychologists
World Professional Association for Transgender Health
World Health Organization (WHO) Global Access Practice Network
TransNet national network for transgender research
American Psychological Association
American College of Forensic Examiners
Society for the Scientific Study of Sexuality
Screenwriters and Actors Guild
Phi Beta Kappa

AWARDS AND HONORS

The Randi and Fred Ettner Transgender Health Fellowship-Program in Human Sexuality, University of Minnesota, 2016
Phi Beta Kappa, 1971
Indiana University Women’s Honor Society, 1969-1972
Indiana University Honors Program, 9-1972
Merit Scholarship Recipient, 1970-1972
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972
Representative, Student Governing Commission, Indiana University, 1970

LICENSE

Clinical Psychologist, State of Illinois, 1980

Exhibit B

BIBLIOGRAPHY OF RELEVANT SOURCES

Ainsworth, T. & Spiegel, J. (2010) Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. *Quality of Life Research* 19(7): 1019-1024.

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Ettner, R., Ettner, F. & White, T. (2012). Secrecy and the pathophysiology of hypertension. *International Journal of Family Medicine*: 2012.

Ettner, R., and Wylie, K. (2013) Psychological and social adjustment in older transsexual people. *Maturitas*, March, Vol. 74, (3), 226-229.

Ettner, R. (2015). Etiopathogenetic hypothesis on transsexualism. In Trombetta, Luguori & Bertolotto (eds) Management of Gender Identity Dysphoria: A Multidimensional Approach to Transsexualism. Italy: Springer.

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Ettner, R., Monstrey, S., & Eyler, A. (Eds.), Principles of Transgender Medicine and Surgery. New York, NY: Haworth Press. (2007).

Ettner, R. Monstrey, S., & Coleman, E. (Eds.)(2017). Principles of Transgender Medicine and Surgery, 2nd edition, New York: Taylor and Francis.

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Rifkin Decl in Supp Pltf's Mtn for Preliminary Injunction
Exh. 2

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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

ADREE EDMO (a/k/a MASON EDMO),

Case No.: 1:17-cv-00151-BLW

Plaintiff,

v.

**DECLARATION OF RYAN
NICHOLAS GORTON, MD, IN
SUPPORT OF PLAINTIFF'S
MOTION FOR PRELIMINARY
INJUNCTION**

IDAHO DEPARTMENT OF
CORRECTION; HENRY ATENCIO, in
his official capacity; JEFF ZMUDA, in
his official capacity; HOWARD KEITH
YORDY, in his official and individual
capacities; CORIZON, INC.; SCOTT
ELIASON; MURRAY YOUNG;
RICHARD CRAIG; RONA SIEGERT;
CATHERINE WHINNERY; and DOES
1-15;

Complaint Filed: April 6, 2017
Discovery Cut-Off: None Set
Motion Cut-Off: None Set
Trial Date: None Set

Defendants.

I, Ryan Nicholas Gorton, have been retained by counsel for Adree Edmo as an expert in connection with the above-captioned matter.

1. I have actual knowledge of the matters stated and would so testify if called as a witness. I reserve the right to supplement or amend this report based on any future information that is provided to me.

2. The purpose of my retention in this matter is to evaluate Ms. Edmo and offer my expert opinion as to what treatment is medically necessary to address her Gender Dysphoria, including whether she has a medical need to undergo genital sex reassignment surgery (SRS). SRS is also sometimes referred to as Gender Affirming Surgery and these terms can be used interchangeably.

My Relevant Background and Qualifications

3. I am a physician licensed in California. I received my medical degree from the University of North Carolina School of Medicine in 1998 and completed my residency and chief residency in emergency medicine at Kings County Hospital in Brooklyn, New York.

4. In addition to working as an Emergency Medicine physician at Sutter Davis Hospital, for over a decade I have also served as a primary care physician at Lyon-Martin Health Services (“Lyon-Martin”) in San Francisco since 2005 where I have provided primary care and transition-related care to more than 400 transgender patients. I provide medical assessments including the diagnosis of Gender Dysphoria, initiate and monitor hormonal treatment, and refer for mental health treatments. I also determine whether and when patients are appropriate for referral for sex reassignment surgeries, provide pre-

operative preparation and clearance, and provide post-operative care in consultation with the appropriate surgeon. I also provide supervision to Nurse Practitioners, Nurse Practitioner Residents, and Physician Assistants treating transgender patients at Lyon-Martin. Lyon-Martin is an historically LGBT clinic that has been serving transgender patients for over 30 years. Lyon-Martin is also one of just a handful of sites in the United States that trains medical students, residents, and fellows to provide transgender primary care, and I have been a primary clinical instructor for these trainees including the 1 year Nurse Practitioner Residency that Lyon-Martin provides. I have provided extensive clinical instruction to over 100 trainees during this time.

5. I also serve as a clinician consultant for TransLine,¹ a national transgender medical consultation service for clinicians needing expert advice about the care of their individual patients. I am a member of the World Professional Association for Transgender Health (WPATH) and serve on their transgender medicine and research committee and institutionalized persons committee.

6. I have presented lectures and grand rounds on transgender health issues at numerous medical school and residency programs throughout the United States as well as national and international conferences. I have also co-authored numerous publications addressing transgender health, including professional journal articles and chapters and sections in professional texts, and publications aimed at the transgender community itself.

7. A copy of my *Curriculum Vitae* is attached to the declaration as **Exhibit A**.

¹ <http://project-health.org/transline/>.

Gender Dysphoria

8. Gender Dysphoria (GD) is a medical condition in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (“DSM-V”). Individuals with Gender Dysphoria experience incongruence between their gender identity and birth-assigned sex and distress as a result.

9. The diagnostic criteria for Gender Dysphoria in the DSM-V for adults and adolescents are:

A) A marked incongruence between one's experiences/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in younger adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in younger adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B) The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

10. Individuals with Gender Dysphoria, if not treated, often suffer clinically significant emotional distress, including depression or suicidal thoughts, and/or impairment of functioning in their daily lives. Untreated, a significant proportion (30-40%)

become suicidal, with many attempting and completing suicide. In studies in European populations who have appropriate access to comprehensive transgender healthcare, suicidality rates are similar pre-treatment but decrease after treatment. For example, in a long term follow-up study of Belgian transgender people, suicide attempt rates declined from 29% to 5% after treatment.

11. The accepted medical protocols for treatment of people with Gender Dysphoria involve interventions to assist patients to live in accordance with their gender identity. The widely accepted standards of care in the U.S. and internationally are published by the World Professional Association for Transgender Health (WPATH SOC).

12. Medically necessary treatment for Gender Dysphoria often includes social transition, hormone therapy (medical transition), gender affirming surgeries (sex reassignment surgeries), and mental health care. Treatment plans are individualized based on the needs of the patient. For most patients who meet the clinical criteria, however, and unless contraindications exist, treatment plans generally include all four types of treatment.

13. Social transition is the process by which the patient lives their life in the gender role that corresponds with their gender identity. This typically involves adopting a new name, changing name and gender markers on identity documents, dressing and grooming appropriate to the patient's gender identity, using pronouns and other markers of their gender, and using restrooms and other sex-segregated spaces congruent with their gender identity.

14. Hormonal transition (generally called hormonal replacement therapy, or HRT) in transgender women results in development of female secondary sex characteristics

such as breast development, redistribution of body fat to a more female distribution, decreased muscle mass, decreased density and speed of growth of body hair, softening of skin and changes in sebum production and odor, changes in mood, decreased testicular size and decreased sperm production, emotional and some subtle neuropsychological changes.

15. Surgical transition with gender affirming surgeries is individualized, and the surgeries needed are dependent on individual patient needs and how well gender dysphoria is addressed with other treatments. While it is common for gender dysphoria to improve with social and hormonal transitions and with supportive mental health care, most often, surgery is needed to adequately and sufficiently address the dysphoria. In transgender women, surgery can include genital reconstructions (generally vaginoplasty which is the construction of a vagina, labia, and clitoris using the penis and scrotum, along with removal of the testicles), mammoplasty, facial and neck feminization surgery, vocal surgery, and other surgeries aimed at feminizing the body. In my experience, genital reconstruction (almost always by vaginoplasty) is the most often necessary surgery for transgender women and can dramatically improve gender dysphoria.

16. Mental health care can include individual or group counseling. This often focuses on two broad categories. First, a focus on the direct management of gender dysphoria, the primary symptom as well as name of the condition. Second, it can focus on supporting the patient throughout the medical, social, and surgical transitions.

17. These accepted medical protocols apply to incarcerated persons. *See* WPATH SOC at 67.

Terminology

18. In this report I will use a number of terms that are important to understand for an accurate depiction of my evaluation. These include the following:

Gender Dysphoria (GD), like Depression is both a diagnosis and the predominant symptoms of that diagnosis. The symptom of gender dysphoria is the psychological distress one feels when there is a conflict between one's internal gender identity and both one's physical body and how one is perceived and treated by others in society. Like depression, this can range from being mild to severe emotional distress.

Gender Identity is the hard-wired, internal sense of one's gender.

Sex Reassignment Surgery (SRS), A/K/A Gender Affirming Surgery is a class of surgical procedures performed for transgender patients to align their physical bodies with their Gender Identity. When used alone, I refer to the broad category. When speaking of specific subsets of procedures in that category I will provide a specifier. For example "Genital SRS" would refer to all procedures on the genitals of transgender patients (which itself is a category). I will also refer to specific surgeries by name.

Vaginoplasty is the surgical creation of a vagina in transgender women. In the vast majority of cases, this will be a penile inversion vaginoplasty which uses the skin of the penis to line the new vagina, head of penis as the new clitoris, and the scrotum to create labia majora.

Hormone Replacement Therapy (HRT) is the provision of sex hormones (and sometimes sex hormone antagonists) to change the body of transgender people to better reflect their gender identity.

Non-Suicidal Self Injury (NSSI) is intentionally harming one's physical body and is generally intended to get psychological relief from a painful emotional state by converting the emotional pain into physical pain. This is the classic "cutting" to relieve emotional distress and is best compared to a coping mechanism (albeit a poor one). Patients exhibiting this behavior have no intent to commit suicide by their self-harm although NSSI and suicidal behavior can be found in the same individual.

Self-Surgery, like NSSI, also does not involve any intent to end one's life. The motivation is distinctly different from NSSI, however. With self-surgery, the individual is attempting to provide a necessary surgical treatment to themselves that is otherwise unobtainable. Examples of this include Inés Ramírez Pérez, who performed her own cesarean section in

a remote region of Mexico,² and Aron Ralston (whose story was popularized in the movie “127 Hours”) who amputated his own arm to free himself from a dislodged boulder that trapped him in Canyonland National Park. Self-surgery has been well documented in transgender women in prison and is a serious risk to these women when they are not provided medically necessary treatment. Self-surgery can also be distinguished from NSSI by the greater care and planning that patients put into these actions. While patients with NSSI may think a lot about the action and may even take steps to minimize the harm, the act and the pain it causes and the relief from emotional stress they provide is the ultimate goal of persons engaging in NSSI. In the case of self-surgery, thinking about the act often involves planning to perform it in the least harmful way possible and to diminish the risks associated with the procedure. Moreover the end goal of self-surgery is to achieve an appropriate surgical result rather than to directly cope with emotional distress. Suicidality, NSSI, and self-surgery can manifest in the same individual at different times, but have entirely different motivations and planned results.

Physical Examination of Ms. Edmo

19. Ms. Edmo is a 30 year old transgender woman who appears her stated age. She was dressed in a prison uniform, which was clean and well kept, but tight across her chest because of the male cut. She exhibited good hygiene. Her hair was kept in a feminine style. She had feminine mannerisms and speech pattern. She is of overweight but not obese build. Her breast development is small for her frame but is apparent through clothing. She has multiple tattoos on her distal upper extremities and neck. She has cutting scars on both forearms which while healed appear between 1-12 months old.

20. Ms. Edmo was pleasant and cooperative during the exam. She was alert and oriented to date and time. Her thought process was linear, clear, and well-ordered. Ms. Edmo was polite and attentive throughout the interview and requested only a brief bathroom break. She was provided a lunch by the COs as her visit with me ran through lunch.

² www.ncbi.nlm.nih.gov/pubmed/15001385.

21. She denied any active suicidal or homicidal ideations, and while she does report some vague thoughts of NSSI (explained below), she denies a concrete plan at present. She had no paranoid thinking and did not appear to be responding to any internal stimuli. She had no abnormal psychomotor behaviors. When asked to rate her symptoms on a 0-10 scale (with 0 being none and 10 being the worst possible symptoms she could imagine), she rated her current anxiety as 3/10, depression 4/10, and her gender dysphoria as 7/10 this morning. Her affect was full and appropriate to the situation, but multiple times she was tearful when discussing difficult topics.

22. When asked to list her current medications, Ms. Edmo was able to provide from memory without prompting, “Estrogen 4 mg twice daily, Medroxyprogesterone 5 or 10 mg daily, I’m not sure, 5 mg of Proscar, Vitamin D and calcium, Effexor 450 mg every morning” and notes “they stopped my spironolactone February 18th.”

23. Her rate, flow, and intensity of speech were normal. She gave consistent and at times insightful answers to my questions. She appears to be of average to slightly above average intelligence and exhibited an average vocabulary and fair grammar, although her vocabulary when discussing mental health issues including her gender dysphoria was above average to superior for her level of education and intelligence. When we discussed aspects of her hormone treatment and surgical treatments, she asked appropriate and sometimes insightful questions. Her posture was good and her gait was normal. She had no gross motor deficits.

Ms. Edmo’s Childhood and Adolescence

24. Ms. Edmo grew up in Pocatello Idaho. She was the youngest of 5 children

with two older sisters and two older brothers. Throughout her childhood and adolescence, she “identified mostly with my sisters” and is currently closest to her sister who is next closest in age to Ms. Edmo. Both parents were involved, although Ms. Edmo’s father was in prison during her early to middle adolescence and both parents have had substance abuse problems. Ms. Edmo reported that growing up (and now) her belief system is both Native American and Catholic.

25. Ms. Edmo first had a sense that she was a girl at around age 5 or 6. She recalls seeing her sisters go through puberty and thinking “hey, I’m going to go through the same things.” She had overall a good and supportive relationship with all of her siblings, but was closer to her sisters. They would allow Ms. Edmo to play with their Barbies and other traditionally girls' toys. They frequently played and would dress up Ms. Edmo (at her request) as a girl and apply makeup. She reports her sisters enjoyed this because it was like dressing a doll, and Ms. Edmo liked to do it because she could “be a girl” with them. She did report some mild teasing from her brothers who thought her feminine play was inappropriate. They would tell her to “quit being a sissy” and that “people are going to think you’re gay” but there was never any physical abuse and generally all her siblings got on well. Ms. Edmo recalls that her mother asked her around age 11 or 12 “Do you like boys or girls?” Ms. Edmo responded asking her if it would matter if she liked boys, to which her mother replied “No, not at all.” She reports hearing from her sisters that her mother had inquired if Ms. Edmo was “gay,” to which her sister replied “it wouldn’t matter if he [sic] was.” While this was not specifically addressing Ms. Edmo's female gender identity, she already knew that her sexual/affectional preference was for boys. So while Ms. Edmo's

sexual orientation is heterosexual (a woman who has a sexual/affectional preference for men) she reports that knowing her family would accept her if she were a gay man was nonetheless very reassuring and important to her.

26. She also reports that she encountered only rare bullying at school. She reports that she had mostly female friends throughout her school years. They treated her “like one of the girls” and she would even use the girls’ rest room sometimes in grade school. She reports this being unnoticed or overlooked by teachers but that a few students questioned her about it.

27. While Ms. Edmo was not openly transgender (and did not even know that word as a child), she was relatively happy and her feminine behaviors, dress, and play received little negative repercussions, and significant positive reactions from her sisters and some peers through most of school. She knew she was a girl inside and was allowed to express that fairly publicly. She attributes this in part to being Native American, which corresponds with the experiences of other Native American transgender people with whom I have worked who report greater acceptance by Native American communities of gender non-conforming people.

28. However in early adolescence, Ms. Edmo began having significant difficulties. A male family member began sexually assaulting her, which generally took the form of anal penetration. Ms. Edmo reported he would tell her “I’m going to show you what happens to girls” during those assaults.

29. Ms. Edmo also reported that at the onset of puberty and noticeable physical changes, her previous mild to moderate gender dysphoria became severe. Although she did

not have the words to describe her dysphoria at the time, she understands now that this is the term for what she was feeling. At about age 11-12 she began noticing changes in her voice, as well as hair growth on and enlargement of her genitals. As she saw her sisters' breasts develop at age 12 she "realized that my body isn't going to do the same as theirs." She reports holding out hope when she daydreamed that she was "just a late bloomer" and would develop like her sisters. This feeling was strong even after intellectually accepting this was not likely to happen. She also reports that at this age her understanding of herself as a girl in a boy's body was fully formed (although she didn't at the time have a word to describe this and was unaware of others being the same way). She states that when she had more significant pubertal development she finally "let go" of this daydream and "realized it's not going to happen" which caused a dramatic increase in her gender dysphoria. She also reports this is when she first became significantly depressed.

30. However, puberty, while difficult, was not entirely negative. Ms. Edmo had numerous female friends in junior high school and high school. She began wearing makeup to school - chiefly mascara and foundation. She reports this is when she started wearing more feminine clothing - sometimes girls pants and blouses and reports that she was "very picky" about the clothes that she wore - wanting even the boy's clothes she had to look feminine. She reports she was supported in this and that "all my friends who were girls liked it," and that they would trade makeup and tips. She felt she bonded with her female friends and felt like "one of them." Ms. Edmo reports that even before she learned that being transgender was "a thing," around mid-adolescence she contemplated getting breast implants as an adult.

Early Adulthood

31. Ms. Edmo reports she completed high school and some college. She also did a “correspondence course” to get a certificate to be a paralegal. After this, she worked as a receptionist in the Tribal Attorney’s Office for the Shoshone Bannock Tribe in 2007-2008, followed by working in Tribal Gaming at a tribal owned casino.

32. By early adulthood, she had learned that there were other transgender people and that she could obtain a diagnosis regarding her gender dysphoria and obtain medical and surgical treatments to alter her body to better reflect her gender identity. She reports wanting to get HRT and SRS but that “I knew that was a lengthy process,” and her intent to transition was interrupted both by her difficulty organizing herself due to concurrent substance abuse as well as eventually being imprisoned. She does report that a psychiatrist she had seen through the Indian Health Service mentioned the possibility of getting a diagnosis related to gender dysphoria and said that if she wanted treatment, they would have to send her to a specialist.

33. Even pre-treatment, as a young adult Ms. Edmo was more free to live as a woman. She reports wearing women’s underwear almost exclusively and wearing either women’s clothes or feminine men’s clothes. She reports that she dressed most feminine when she would go out with friends or to parties—dressing fully in women’s clothes including a bra stuffed to simulate breasts.

34. Ms. Edmo was incarcerated in July 2011 and arrived to the prison where she currently resides in April 2012.

35. In 2011, Ms. Edmo told her family that she was planning on being evaluated

for treatment of her gender dysphoria while in prison with the goal of transitioning to female. She reports that her mother was very supportive and told her, “If that’s what you need to move on in life, then I’m right behind you.” She also reports that one sister was very supportive. She is not in frequent contact with her other siblings and father, but her sister told her that they are generally supportive. Ms. Edmo finally spoke to her father in 2012 who she reports as being generally accepting: “You’re still my child.”

Ms. Edmo’s Experiences in Prison

36. We discussed in some depth Ms. Edmo’s ability to live authentically as a female while in prison. Clothing is a significant source of dysphoria—especially underwear. Ms. Edmo is allowed prison-issued bras as well as ones she has purchased from the commissary. In addition to being necessary support for her breast growth, she also reports bras help her dysphoria to some extent because “it makes me feel more female.” However she is not allowed to use prison-issued women’s underwear or to purchase women’s underwear from the commissary. Similarly she is only allowed to wear men’s outerwear (despite this being poorly fitting given the breast growth and change in body shape she’s achieved with HRT). She reports that wearing men’s clothes “makes me feel less of who I am, I don’t get to consolidate my identity,” and that “I don’t get to display what I feel like inside.” She reports the lack of women’s underwear and a “gaff” significantly exacerbates her dysphoria but that having to wear men’s outerwear, while still mildly exacerbating her dysphoria, is more of an “irritation.” A “gaff” is an undergarment often used by transgender women who have not had genital SRS which keeps the penis and testes firmly against the pubis and perineum so that they do not bulge out and give a

feminine look to pants worn over them. Many transgender women (including Ms. Edmo) also find keeping their genitals from moving and being noticed lessens their dysphoria about their genitals.

37. Despite restrictions on her gender presentation, Ms. Edmo has managed, like many transgender women in prison, to alter or obtain clothing that is more feminine. She reports that she has two pairs of women's underwear. She has also several times fashioned a gaff from her prison issued clothing. She has received a number of DORs for this and other conduct she has engaged in to achieve more appropriate gender presentations. She received several DORs for destruction of property under \$25, all of which were for making changes to her prison issued clothing to make it resemble women's clothing. This includes altering her underwear to resemble a gaff or women's panties. She has also received DORs for wearing homemade makeup and on 9/27/15 for having a bottle of mascara.

38. When asked about the rules that limit her ability to present herself as a woman, Ms. Edmo reported that she's been told that the prison's "PREA policy says male offenders are not to present as women or appear feminine in any manner. No jewelry clothing, or makeup." She states that this is because if male inmates dressed that way, it would make them more likely to be raped because they would be "asking for it." PREA stands for the federal Rape Elimination Act.

39. In addition to DORs, Ms. Edmo has had medical complications of using homemade gaffs. She has had several episodes where she gets redness, swelling, and sometimes extreme pain from the gaff, though she reports this has diminished somewhat as she has had testicular volume decrease on HRT. Dr. Alviso documented this swelling

and redness in a note dated 1/4/18, as did RN Buckles on 9/30/17: “TWO AREAS OF SLIGHT REDNESS/SWELLING ON UPPER SIDES OF TESTICLES- VERY TENDER TO TOUCH, NO TEMPERATURE DIFFERENCE. PT STATES ‘I WAS SEEN FOR THIS IN FEBRUARY AND NOW ITS BACK.’” With Ms. Edmo’s recent discontinuation of her anti-androgen (discussed below), her testicular size is likely to increase, which in turn is likely to exacerbate her dysphoria.

40. In addition to clothes, Ms. Edmo has managed to wear some makeup. She reports extensive use of makeup before prison and that her female role models growing up (mother, grandmother, and sisters) always wore makeup “from the start to the end of the day.” She reports when she cannot wear makeup, she feels “naked” and “like I’m missing something” and that “people are not seeing the real me.” She feels that wearing makeup “signifies I’m a woman” and communicates this to others. Unfortunately while Ms. Edmo does wear makeup, she has experienced negative repercussion for it including several DORs as well as harassment—mostly from Corrections Officers (CO). She reports that she does the most she can do without drawing too much negative attention.

41. By wearing the clothes she’s been given in the most feminine way possible, wearing makeup, and fashioning underwear, Ms. Edmo is trying to treat her dysphoria and notes that when she is dressed more femininely, she is “treated more like a female” by others (inmates to a greater extent than medical/mental health staff and COs).

The Prison’s Failure to Treat Ms. Edmo’s Gender Dysphoria

42. Ms. Edmo reports that her first formal diagnosis was in prison. She reports that she has attended a “GD group” periodically during prison, which she reports is

“basically a process group where we process feelings and that’s the extent of it.” When I asked if there were educational resources provided or discussions of specific treatment options or resources, she reported that these topics were addressed rarely or never. She noted specifically that the mental health staff’s advice regarding Ms. Edmo living as a woman in a men’s prison was simply not to do so until released because it was in violation of prison policy and PREA.

43. Ms. Edmo reports that she has specifically recommended that the mental health staff utilize the “APA Transgender Model,” in which she seems to be describing the APA Guidelines for Psychological Practice With Transgender and Gender Nonconforming People.³ She has also requested that she have more frequent individual therapy appointments that address her actual GD “with CBT, but nothing has come of it.” When I asked what she understood CBT (cognitive behavioral therapy) to be, she understood the concept in layperson’s terms. While she does not receive anything resembling CBT, she reports receiving therapy about every 90-120 days, but that her therapists focus on her depression and anxiety. When she brings up gender dysphoria, they talk about “coping in a men’s prison,” and uniformly tell her not to live as a woman and that she needs “to figure out a way to deal with [her] dysphoria that doesn’t involve wearing makeup or violating policy.”

44. Ms. Edmo’s medical records confirm these statements and issues. Indeed, the medical records show that mental health staff have failed to address Ms. Edmo’s gender

³ <https://www.apa.org/practice/guidelines/transgender.pdf>.

dysphoria in any meaningful way, which has put her life at significant risk. Even if mental health providers wanted to provide appropriate and medically necessary treatment, prison policies and rules prevent them from doing so. A 12/17/15 note from Laura Watson, LCSW for instance, suggests she was prevented by policy from recommending medically necessary treatments for gender dysphoria such as wearing makeup and women's clothing: "Edmo continued to state if Edmo gets a DOR, Edmo wants the hearing officer to know it was part of the [treatment] plan and that it plays a role in Edmo's dysphoria. We spoke at length about ways in which Edmo could feel feminine though going against policy but Edmo seemed resistant to this. I was honest with Edmo that I could not write a [treatment] goal that goes against policy." A note from Ms. Watson dated 11/28/17 was similar: "Edmo then stated a clinician stated that it was clinically recommended that Edmo wear makeup and even called unit 15 to verbalize the approval. I told Edmo I would look into this but if this was what was communicated, this was inaccurate as the current policy indicates this. Edmo states it is not clear in policy but we discussed 'not dressing in a feminine manner' as part of the PREA policy." Ms. Edmo reported to me that Dr. Aviso similarly told her that he was not allowed to recommend certain things for her, such as surgery, and that he can only "suggest" that she have access to women's clothing and commissary items. Other mental health and medical providers have also told Ms. Edmo that "if it was up to me I'd call you 'she' but we get memos telling us we can't."

45. As is apparent from Ms. Edmo's records and history of self-surgery, she experiences significant dysphoria that is focused on her genitals. When she requested women's underwear and other items to help conceal her genitalia, however, prison staff

offered her a jockstrap and ABD (Army Battle Dressing) pads to place in the jockstrap to provide “pressure” on her genitals. Ms. Edmo reports this did not help because the jockstrap was looser than even men’s underwear. She was able to fashion underwear and a gaff from the jockstraps that provided more of what she needed, but she was penalized by staff when this was discovered and advised by her mental health providers to stop doing this. Because she has had to utilize makeshift gaffs from what she’s been able to cobble together, she’s had several episodes where she’s developed redness, swelling, and pain to her genitals, which were documented at least once in her medical record but was not specifically treated. When this happens, Ms. Edmo faces the choice of continuing to “tuck,” which causes pain and swelling, or stopping that practice, which exacerbates her dysphoria.

46. Ms. Edmo was also eventually provided with hormone replacement therapy (HRT) which has been modestly effective. Since starting HRT, she has experienced fairly typical results: breast growth, change in muscle and fat distribution to a more feminine body habitus, decreased testicular volume, decrease speed of growth and thickness of facial hair, and diminished libido—all of which she notes as positive effects. She denies any significant adverse effects from the HRT when administered properly.

47. Prior to Ms. Edmo’s first appointment with Dr. Alviso in 2016, her medical records contain no real transgender history. The whole of the history section in the record reflecting her initial diagnosis states: “Hoping to be a GID treatment—never been on it. No hx of blood clots, no hx of bleeding [illegible word] etc. Generally healthy except above.” The reference to “above” appears to be checkboxes on the form. I saw no notes prior to Dr. Alviso's 12/14/16 evaluation that had anything resembling a transgender

history. Without knowing Ms. Edmo's history (e.g. how long she has experienced dysphoria, the focus and severity of her dysphoria, exacerbating and mitigating effects, whether she has social support, how she manages stress, the steps she has taken to transition, further medical and family history, etc.), it would be impossible to provide safe and effective care. It is also possible, however, that prison officials failed to assess this history because, even if they had it, they are precluded by prison policy from providing adequate care (such as surgery and access to female commissary items).

48. Ms. Edmo has had enough time on HRT to realize physical changes, particularly after receiving HRT under the care of Dr. Alviso. While some of these could regress if HRT is stopped or diminished (as happened with the cessation of her anti-androgen medication this year, discussed below), Ms. Edmo understands that there is unlikely to be any further changes: "I've gotten the most out of what I've been prescribed. I know there's not really much more that can change" via HRT.

49. I agree that Ms. Edmo has likely seen the extent of the physical changes from HRT. I am alarmed, however, by the wholly insufficient and even dangerous monitoring and management of her medications, hormone levels and blood tests.

50. Indeed, before Ms. Edmo began seeing Dr. Alviso, her treatment was obviously provided by clinicians who are wholly unfamiliar with medical treatment for gender dysphoria. For example, an 8/31/15 note by a provider I cannot identify states, "testosterone well suppressed" and that "spironolactone is at max dose." Adequate suppression of testosterone means it is in the normal female range (15-70), while Ms. Edmo's level was 107. Moreover her spironolactone was only at 100 mg twice daily—a

fairly average dose for transgender women, but certainly not the maximum (200 mg twice daily). Ms. Edmo was in fact very poorly hormonally controlled. Reviewing her labs from 9/16/12 until her initial appointment with Dr. Alviso on 12/14/16, her testosterone level was checked 13 times. Of those times, only twice was her testosterone in the normal female range. It is not even apparent that all of her providers were aware of what a normal female level of testosterone is. On 9/4/15, a provider I cannot identify wrote, “Normal female testosterone ranges from 230-189 in healthy 30 year old nonsmoker, moderate exercise. Your testosterone level is well below these values!” Normal female testosterone values are actually 15-70 ng/dL (with some slight lab variation). While testosterone levels may be mildly higher among women who smoke, given Ms. Edmo is a non-smoker, any testosterone level above 70 would be considered elevated. Normal male levels of testosterone are 280-1100 ng/dL (with some slight lab variation).

51. Notably, medical staff did not recognize when Ms. Edmo’s hormones were in the appropriate ranges. In a Chronic Disease Note on 3/16/16, Dr. Agler noted that her testosterone result “imply estrogen dose is too high. May also be associated with timing of meds. Change pills to pill call only to assist with timing (per pt request). No med dose change yet. If labs same next time will need to decrease estrogen.” Dosage timing would not substantially affect testosterone levels, but what is most surprising is that despite this being one of only two times between 9/16/12 and 12/14/16 when Ms. Edmo’s testosterone was finally at a reasonable level, Dr. Agler did not recognize this and believed her estrogen dosage should be lowered.

52. In addition to inadequate dosing, staff also failed to provide HRT even as

prescribed. For example, Ms. Edmo's Health Service Request on 11/22/15 states: "My GID meds still have not been given to me on a consistent basis. This is causing me to have heightened depression, anxiety, and extreme gender dysphoria. Specifically proscar and spironolactone." Ms. Edmo reported to me this was often a problem, though in the past year she has been getting her prescribed medications more regularly and with less difficulty.

53. Medical staff also failed to recognize obvious problematic health issues. In a Chronic Disease Note dated 9/8/16 by David Agler MD, he recorded "RRR" under Ms. Edmo's cardiac exam despite her heart rate being significantly elevated at 124. "RRR" stands for Regular Rate and Rhythm, which contradicts this significantly elevated heart rate. A 2/16/17 Chronic Disease note by "D Dics, PA" similarly reported "RRR" despite Ms. Edmo's elevated heart rate of 112. According to the records, medical staff never addressed Ms. Edmo's frequent tachycardia (abnormally rapid heart rate). At a minimum, this should have warranted a check of her thyroid function and inquiry into any signs or symptoms of a pulmonary embolism (blood clot in the lungs), which transgender women are at increased risk for because of taking estrogen.

54. In the interests of brevity, I will not detail every one of the following Chronic Disease Notes I reviewed dated 2/16/17, 11/29/2016, 9/8/16, 6/16/16, 3/16/16, 12/23/15, 6/26/15, 9/23/15, 4/6/15, 1/8/15, 10/8/14, 7/3/14, 3/6/14, 1/3/14, 9/13/13, 7/1/13, 9/13/13, 7/1/13, 3/26/13, and 12/3/12. There was one illegible note I did not review. In all of these notes specifically addressing her GD, there was not a single time that a psychiatric examination was included in the physical examination. This is significant because as

primary care doctors filling out Chronic Disease Notes, it is imperative to assess not only the physical efficacy of the hormones (hormone levels, side effects), but also whether HRT is ameliorating her gender dysphoria. As detailed above, the IDOC and Corizon clinicians utterly failed to monitor her labs in any effective way and, as these notes show, also failed to monitor the effect of HRT on her underlying condition. These failures placed Ms. Edmo at substantial risk of harm. In addition, four notes made the error I described above as showing a heart rate that was abnormally elevated but improperly noting “RRR” (with no indication that her abnormal vital signs were addressed in any way). None adequately assessed her gender dysphoria. Some actually suggested that her gender dysphoria is not a significant psychological issue for Ms. Edmo which, based on my evaluation and review of her medical records, has been a serious and ever present issue. In most of these notes, her disease control was listed as “good” or “fair,” with a notable exception of 9/23/15 which listed it as “poor.” That 9/23/15 note, however, fails to detail any issues except for a decrease in her blood estrogen levels. There is no assessment of her dysphoria or psychiatric examination. Six days later, Ms. Edmo made her first attempt at self-surgery. Had medical and mental health provided the requisite care detailed above, it is likely her self-surgery attempt could have been prevented by acute intervention.

55. One particularly egregious error in her medical care, which negatively affected her HRT and her overall health, began in December 2017. On 12/20/17 her labs were drawn and the initial report was received 12/22/17. Her labs showed new abnormalities: ALT 179 (elevated), AST 84 (elevated), Bicarbonate = 10 (low). The AST and ALT are tests of liver inflammation (which are included in what is called Liver

Function Tests or LFTs and in a Comprehensive Metabolic Panel or CMP). AST and ALT elevations can occur from viral infections (including hepatitis A, B, and C as well as other viruses), exposure to toxins (including medications), metabolic conditions, autoimmune disease, and other problems that cause injury to the cells in the liver. The bicarbonate also stood out as particularly low indicating her blood was significantly more acidic than usual. This “acidosis” merits calculation of the “anion gap” which is a way to determine what type of acidosis this was—which in Ms. Edmo’s case was a “high anion gap metabolic acidosis” which implies that there may have been a toxin or chemical in her blood which was causing the acidosis and, given this was associated temporally, may have been related to the elevated AST/ALT. Causes of this type of acidosis include overdose on tylenol or aspirin, Lactic acidosis (which can be from low blood flow states, low oxygen, heart failure, infections and sepsis, thiamine deficiency, alcohols, and the side effects of many drugs and toxins).

56. When patients have elevated AST/ALT, it is important to promptly perform an adequate history and physical examination to help determine the cause. Particularly in Ms. Edmo’s case because of the high anion gap metabolic acidosis, it was extremely important that she have a good history and examination performed promptly after the results were obtained, followed by additional focused labs based on this history and examination. I found no such evidence of an evaluation in her records and when asked, Ms. Edmo confirmed that this did not occur.

57. On 12/27/17, Ms. Edmo reported to sick call for cough and wheezing. This was her first clinical contact after the labs were obtained. She was seen by Danielle Young,

RN. There is no note that her abnormal labs were noted or addressed. She was instructed by Ms. Young to “CONTACT MEDICAL STAFF IF SYMPTOMS WORSEN OR DO NOT RESOLVE.”

58. On 1/3/18, Ms. Edmo was seen in consultation by Dr. Marvin Alviso. I see no indication that Dr. Alviso either noted the labs or performed any focused history or examination relevant to a patient with the lab abnormalities that she had. In fact, he increased her estradiol from a total of 6 mg daily to 8 mg daily and continued her spironolactone and progesterone doses. It would be quite unusual to increase her estradiol if he was aware of the labs, as estradiol can infrequently cause elevated LFTs. In the context of these labs being abnormal, one would not increase a potentially hepatotoxic medicine. During this visit he did request repeat labs “Please Check BMP in 1 week. If normal, can increase spironolactone to 200 mg BID, Check BMP again In 1 week to make sure electrolytes are still normal.” A BMP (basic metabolic panel) contains some of the labs that were done on 12/20/17, but do not include LFTs. A BMP plus LFTs is essentially what is contained in a CMP (Comprehensive Metabolic Panel) which was what was drawn on 12/20/17. Thus I do not believe Dr. Alviso had these results when he saw Ms. Edmo.

59. On 1/5/18, Dr. Emily Hutchison ordered an increase in Ms. Edmo’s venlafaxine extended release dose from the maximum recommended dose of 375 mg daily to 450 mg daily. Venlafaxine is a medication to treat depression. On that same date, there was a notation: “Will increase venlafaxine to 450 mg po qam. RTC 3 months” and “side effects, access to mh.” I could not find any indication that Dr. Hutchison took note of Ms. Edmo’s labs from two weeks prior before she increased the dose of venlafaxine. Ms. Edmo

also could not recall Dr. Hutchinson questioning her about this. This medication change is extremely concerning since venlafaxine is the most likely medicine prescribed to Ms. Edmo that would cause elevations in LFTs.

60. On 1/13/18, Ms. Edmo had additional labs drawn. Her liver tests had jumped to significantly worrisome levels of ALT 1782 and AST 742, though her bicarbonate (indicative of the acidosis) had normalized.

61. A note entered on 1/17/18 is the first one that indicates any action on Ms. Edmo's abnormal labs. Nicolas Wise entered a verbal order "VO per Alviso/Eldredge. Stop Spironolactone for 5 days. Repeat state CMP to eval LFTs. Send Alviso labs, If normal then restart same dose 1/23/18. If not get new orders from Alviso." While Ms. Edmo's December LFTs were elevated and should have prompted further evaluation, the 1/13/18 levels are much more worrisome and suggest significant damage to the liver. Moreover, the fact that ALT was elevated higher than AST suggests a possible infectious cause—such as hepatitis A, B, or C. Lack of any evaluation at this point—at a minimum, a history and examination—is far below the standard of care. In my other practice as an emergency medicine physician I have had patients sent by their primary care provider for emergent evaluation based on acutely elevated LFTs that are far lower than this.

62. On 1/21/18, a nurse reviewed the chart and noted "Please review Effexor order, max daily dose is 375mg, prescribed 450mg." Effexor is the brand name for venlafaxine—the medication Dr. Hutchison increased beyond the recommended maximum dose prior to the dramatic increase in Ms. Edmo's LFTs. I see no indication that the risk of the increased venlafaxine dose was reconsidered or considered a possible cause of the

elevated LFTs.

63. Of the medications that Ms. Edmo takes, the one most likely to cause elevated AST/ALT is venlafaxine (which causes this complication in about 1% of those who take the medicine at normal doses of 37.5 - 375 mg daily). Oral estrogen and progesterone can rarely cause elevated AST/ALT. By contrast, elevated LFTs are extremely rare with Spironolactone. Spironolactone is a medicine that blocks the effects of testosterone and aldosterone, which Ms. Edmo was taking as part of her HRT regimen.

64. The unnecessary withdrawal of Ms. Edmo's spironolactone has caused significant problems. In addition to transient leg swelling, Ms. Edmo reports worsened gender dysphoria due to recurrent masculinization. She reports that she submitted a request on April 5, 2018 for a different antiandrogen to be started. As of the date of our meeting, she still did not have an antiandrogen prescribed.

65. If I had been Ms. Edmo's treating doctor on January 18, 2018 (when Dr. Alviso saw Ms. Edmo), I would have immediately discontinued her venlafaxine, halved her estrogen and left the spironolactone alone. I would have performed a focused history and examination, requested appropriate lab testing, and ordered tests for acute viral hepatitis infection (specifically hepatitis A and C, as she has immunity from B per her prior labs), as well as a liver ultrasound. Moreover since she is non-immune to hepatitis A as demonstrated by prior labs, I would have offered that vaccine (which Ms. Edmo reports she's never been offered) if this was not the cause of her symptoms. Based on my review of Ms. Edmo's medical records and my interview with her, the prison's medical response to her potentially life-threatening liver issues was to stop the HRT medication that was the

least likely to be the problem and increase the depression medication that was the mostly likely to be the problem (beyond even its maximum recommended dosage).

Ms. Edmo's Self-Surgery and Suicide Attempts

66. Self-surgery is performed by patients who are in desperate medical need. The purpose is to obtain, through self-treatment, the medical care a person needs but cannot access. Ms. Edmo has made two attempts at self-surgery with her goal being removing her testicles. She has also had thoughts of, but never attempted, self-surgery to amputate her penis. When asked why she wanted to remove her testicles, she said it was because they produce testosterone and "I had to stop it. It's not me and it's not supposed to be in me." Her first attempt was in September of 2015 and involved a relatively shallow incision which was repaired with steri-strips by prison medical staff. This was referred to as "Nonsuicidal self-injury" (NSSI)⁴ in the chart, but staff placed Ms. Edmo on suicide watch. Ms. Edmo reports that this was neither suicidal ideation nor NSSI. Her intent was to remove her testicles (not to inflict pain or kill herself), but the excessive blood made her seek help. This is congruent with her statements as recorded in her medical record of 9/29/15: "Pt reports he 'hates it' referring to his penis/scrotum. 'When I saw so much blood I stopped.'" The record describes her as being "covered in blood." Ms. Edmo differentiates this self-surgery from NSSI in that her goal was not to inflict physical pain. In fact, it was the pain in addition to heavy bleeding that stopped her. She reports that her thoughts before doing

⁴ NSSI refers to behaviors such as cutting, burning, scraping skin, or biting oneself, primarily to cause bleeding, bruising, or pain. People who engage in these behaviors find some emotional relief from the pain they inflict, but do not have any intent to end their life.

the self-surgery were: “It was making me sick in my body. It could kill me if I do this [removal of her testicles], but it’s killing me slowly anyway.”

67. The fact that medical staff do not appear to be able to distinguish between suicidality, NSSI, and self-surgery has placed Ms. Edmo at increased risk of harm. Her self-surgery attempts are assessed variously as either NSSI or suicidality, neither of which apply. For example, after her first attempt, she was placed on suicide watch even though there is no indication she was suicidal. A 10/1/15 “Suicide Risk Assessment” by T. Ruth states, “Inmate Edmo was placed on suicide watch 9/29/15 after Edmo attempted to remove Edmo’s testicles.” The note continues: “Edmo denied plan or intent to harm self,” which is congruent with what is expected in an attempt at self-surgery. Unlike NSSI or suicidality, self-surgery is a desperate “health-seeking” action—in Ms. Edmo’s case, disposing of the source of testosterone in her body.

68. The day after her self-surgery attempt, she was also seen by Laura Watson, LCSW. It appears that Ms. Watson met with Ms. Edmo for an extended period but that she also has no training in, or understanding of, gender dysphoria. Ms. Watson’s note states, for example, “We discussed ways Edmo could begin to work more on Edmo’s self and the issues Edmo has had throughout Edmo’s life rather than only focusing on the outside. Explored insecurities that all men and women have and how fixing things on the outside, don’t fix things on the inside the way we expect them to.” In fact, gender dysphoria is a highly treatable condition. Research from the past four decades establishes that “fixing things on the outside” has dramatically beneficial effects on a person’s mental health, including through HRT and surgery. Moreover, it is beyond dispute that all issues amenable

to treatment should be addressed in clinically appropriate ways. Rather than avoid treating Ms. Edmo's severe gender dysphoria, as Ms. Watson and other clinicians repeatedly have done, they should have treated that condition first. This is particularly true since Ms. Edmo's gender dysphoria has been persistent and well-documented throughout her life. Indeed, once appropriate care is provided for her gender dysphoria, there is every reason to believe that Ms. Edmo's ability to address other mental health issues will be substantially improved.

69. Because medical staff do not understand gender dysphoria or the standards of care, they missed obvious medical signs that portended Ms. Edmo's first attempt at self-surgery. A mental health note dated 10/5/15 (after that attempt) states: "Met with Edmo today...Spent quite a bit of time discussing Edmo's reported need to "feminize..." Edmo expressed frustration at medical stating Edmo knows Edmo's own body and knows the meds are not where they should be. Edmo states this is partly why Edmo decided Edmo would take things into Edmo's own hands by attempting to castrate Edmo's self." In fact, Ms. Edmo's last testosterone level prior to this attempt was double the maximum female level (70) at 153. Ms. Edmo was thus correct that her medication was not at the appropriate level.

70. It is apparent from Ms. Edmo's medical file that medical and mental health staff were well aware of her risk for self-surgery. Various medical professionals repeatedly documented her nearly constant thoughts of self-castration, including on 7/21/15, 8/20/15, 8/26/15, 12/3/15, 12/17/15, 12/28/15, 1/1/16, 1/2/16, 1/25/16, 1/27/16, 3/24/16, 5/20/16, 11/2/16, 12/27/16. For example, a treatment plan from 11/2/16, about two months before

her second self-surgery attempt, notes persistent risk for self-surgery and a goal that this will be decreased: “Edmo reports struggling with attempts/desire to self-castrate on average 4 days per week. Edmo will report a decrease in average frequency of thoughts of self-castration from 4 days/wk to 3 days/wk.”

71. Another example is a treatment plan from 5/20/16, which reports, “Edmo reports some struggles with attempting to self-castrate or desires to self-castrate. Edmo struggles with dealing with the Dysphoria of Edmo’s diagnosis and the limitations of feminizing.” The plan continues: “Edmo will identify at least two ways Edmo could feel more feminine (within IDOC policy) and engage in these prior to giving into impulsive, self-harming thoughts,” that “Edmo will use coping skills when struggling to manage symptoms and will notify staff if feeling suicidal wanting to engage in self-injurious behaviors.” This plan fails to address the core and immediate issue of self-surgery. Self surgery is a health-seeking behavior; not a self-harming one. Asking Ms. Edmo to only report suicidal thoughts or self-harming thoughts thus fails to address her risk of self-surgery. The medically appropriate (and required) care at this point was to provide surgical intervention—a treatment that could not only significantly decrease, but potentially eliminate her gender dysphoria. Requiring Ms. Edmo to identify further ways to “feminize” in a prison environment that targets and punishes her for that behavior is also futile and even potentially dangerous since it exposes her to discipline, including solitary confinement.

72. The advice in the 5/20/16 note also conflicted with the counseling Ms. Edmo received in December of 2016 because she was reporting thoughts of self-surgery. A note

from Elizabeth Adkisson on 12/27/16, just *four days* before Ms. Edmo's second self-surgery attempt, states: "Edmo reports wanting panties because Edmo is tired of feeling the male genitalia between Edmo's legs. Edmo reports Dr. Alviso prescribed 'panties' for Edmo as a means of encouraging Edmo to identify with Edmo's 'authentic gender.' We discussed living as a female and how clothes nor make-up define who we are as women. We discussed living authentically, gender biology, sense of self, and the dimensions of being a trans-gender [sic] person in a male prison. ...We discussed gender as a binary concept beyond anatomy and Edmo expressed frustration at not being allowed to tuck. Edmo was encouraged to journal about Edmo's experience of becoming transgendered [sic] while incarcerated and how Edmo identifies gender norms within a male dominant culture."

73. A therapist who has training and experience with transgender clients would never minimize the importance of presenting consistently with one's gender identity. This note demonstrates a serious lack of understanding of transgender medical issues. There are significant and well-documented negative health outcomes for transgender women who are not allowed to present as women. Moreover, Ms. Adkisson's suggestion of journaling as a solution for a patient contemplating self-surgery is not only wrong, but likely directly contributed to Ms. Edmo's self-surgery attempt days later. Had Ms. Edmo been allowed a gaff and other necessities to present as a woman, her self-surgery attempt may have been prevented. At a minimum, her mental health provider should have provided supportive therapy acknowledging Ms. Edmo's gender dysphoria as well as a close mental health follow up appointment. Instead, mental health staff provided wholly deficient and

conflicting care in the run-up to Ms. Edmo's second-self surgery attempt, thereby placing Ms. Edmo at serious risk of the very self-surgery that triggered the appointment in the first instance.

74. As is somewhat typical in patients who attempt self-surgery, Ms. Edmo learned from her first attempt. For her subsequent attempt on 12/31/16, she had prepared for weeks before engaging in self-surgery. She accessed a medical reference guide in the prison's computer lab. She studied the anatomy of the scrotum and chose her incision site based on having the best chance to get to the testicle without injuring the epididymis (a term she used with me while questioning her pronunciation). She obtained gauze and alcohol swabs which she used to clean the area. She boiled the razor blade she used immediately before the procedure and scrubbed her hands with soap, so she would diminish the chance of infection. She also enlisted the help of another inmate in case she lost too much blood and was unable to call for help. She reports losing less blood and this time was able to exteriorize the testicle through the incision she made. She eventually had to abandon this attempt not due to pain (which she was this time prepared for) or a fear of bleeding out, but because the blood prevented her from seeing the proper anatomy: "It was bleeding too much and I couldn't see what I was doing anymore." She had made much more surgical headway during this attempt, which required transport to a hospital where a urologist was called to perform the repair. When asked about her hospital visit, I inquired if she had been informed of the risks, benefits, and alternatives for treatment, or asked to sign consent. She reports she signed nothing, and when staff started asking her about consent for the procedure, the correctional officer (CO) told the physician not to discuss consent with Ms.

Edmo and to instead speak with the Nurse Practitioner at the prison. She had not been told anything about risks, benefits, or alternatives to treatment.

75. Ms. Edmo was not placed in segregation after this attempt and reports she was provided medical treatments in the infirmary, but not acute mental health care. She cannot recall any mental health provider raising this issue since her self-surgery attempt.

76. While her providers conflate self-surgery with NSSI and suicidality, Ms. Edmo seems to be able to readily distinguish between the three. In a note dated 1/1/16 (which I believe from timing and placement in her chart was really 1/1/2017, or the day after her second self-surgery attempt), a clinician wrote: “When addressing the recent cutting of testicles, Edmo reported that Edmo wanted to get rid of the testes because they are neither wanted or needed. Edmo denied this as a suicide attempt and associated this with an increase in dysphoria due to a lack of support and treatment.” I agree with this assessment that the lack of support and treatment for her GD resulted in increased dysphoria, which prompted her to attempt self-surgery. Another note that same day (1/1/17) states something similar “...the night previous (12/31/2016), Edmo attempted to castrate Edmo’s self. Edmo stated that Edmo’s actions were related to feeling angry/frustrated that Edmo was not receiving the help desired related to Edmo’s gender dysphoria. Inmate Edmo’s actions were reported as a method to stop/cease testosterone production in Edmo’s body. Edmo denied suicidal Intention or any current plan. Inmate Edmo reported baseline depression symptoms related to Edmo’s gender dysphoria diagnosis. Edmo was unwilling to discuss Edmo’s depression apart from gender dysphoria symptoms.” From a clinical perspective, I agree with Ms. Edmo that it made little sense at

that time to discuss her depression exclusive of her gender dysphoria, which was and is her primary, largely untreated medical issue.

77. In addition to these two distinct episodes of self-surgery, Ms. Edmo has had suicidal ideations and attempts, as well as NSSI (manifested as cutting her wrists). While the suicidal ideation with prior attempts (the first in 2009 and second in 2010) has been an issue in the past, Ms. Edmo denies any current significant suicidal ideations. She reported that her suicide attempts and ideation always involved her gender dysphoria. The most significant suicidality she reports was in 2014 when she submitted a request to have SRS and was told “we're never giving you that ever.” She was placed in segregation on suicide watch. She describes this as significantly exacerbating her symptoms and for 4 days, she was stripped of most of her clothes and left in the cell with only a smock. Her only contact with anyone else was “a clinician [who] checked on me every 24 hours.” Like many transgender patients, especially those like Ms. Edmo who have been denied access to medically necessary care, having to see her body unclothed is a significant trigger for her dysphoria. Thus, in addition to failing to provide any specific care to address her acute mental health condition and its origin (gender dysphoria), staff placed her in an isolation environment that would exacerbate nearly any mental health issue and was specifically detrimental to Ms. Edmo in that it forced her to confront the source of her mental anguish constantly.

78. Ms. Edmo reports that she has not had significant suicidal ideations in the past 2-3 years; however, she started resorting to NSSI more recently (in December 2017 or January 2018) on her forearms. She describes her motivation for this as distinct from her

motivation when she attempted self-surgery, although it does appear to be related to her dysphoria in that she is using it as a coping mechanism for her dysphoria. She describes feeling her genitals between her legs as “torment” and that when she cuts, she experiences “a relief of mental anguish, like slashing a tire and the negative emotions flow out of me like a tire going flat.”

79. When we discussed the differences between suicidality, NSSI, and self-surgery, Ms. Edmo readily distinguished which was operative at the time of specific events. When I asked her about her mental health providers distinguishing between these, she reported that “they always lump it into suicide,” which is congruent with my review of her records.

Ms. Edmo’s Ongoing Risk of Harm

80. When I asked Ms. Edmo about the idea, raised by her therapist in her medical file, that gender is more about what is inside, she replied, “In a perfect world, I guess makeup and clothes wouldn’t matter, but we’re not in a perfect world, so it does.” Unprompted, she made a correlation between this and racism—that her brown skin should not matter, but has a significant effect on how people treat her (both inside and outside of prison), which can have both mental health consequences and real world negative effects. In response to whether, if given the choice, she would eliminate racism or transphobia (for her personally rather than in the broader society), she immediately responded “transphobia” without hesitation.

81. Ms. Edmo estimates that her gender dysphoria has decreased 10-20 percent as a result of HRT and her ability (albeit heavily restricted) to present as a female in prison.

She reports that “about 90 percent” of her dysphoria is focused on her genitals. When asked about any mitigating factors for her gender dysphoria, she noted that her legal case has been helpful because it provides some hope that she will get the care she needs. When I posed the hypothetical of what she would do if she lost her lawsuit, or if the prison began more strictly enforcing rules about clothing, hair, and makeup, or if she lost access to hormones, she became visibly upset. She eventually answered that she would likely commit suicide.

Surgery is Medically Necessary to Treat Ms. Edmo’s Gender Dysphoria

82. The World Professional Association for Transgender Health (WPATH) promulgates standards of care for transgender individuals. These are internationally recognized and the single most commonly used standards for the treatment of transgender people. In my experience as a provider, almost all insurance plans rely on WPATH’s criteria or a variation for genital surgery in transgender patients in their coverage decisions.

The criteria for vaginoplasty in transgender women are:

- i. Persistent, well documented gender dysphoria;
- ii. Capacity to make a fully informed decision and to consent for treatment;
- iii. Age of majority in a given country;
- iv. If significant medical or mental health concerns are present, they must be well controlled;
- v. 12 continuous months of hormone therapy as appropriate to the patient’s gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
- vi. 12 continuous months of living in a gender role that is congruent with their gender identity.

83. In addition, WPATH notes that “[a]lthough not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other

medical professional.”

84. Applying these criteria to Ms. Edmo’s case, it is abundantly clear that she both needs and qualifies for surgery. Ms. Edmo reports a history of persistent gender dysphoria since childhood and has legally changed her name to a traditionally female name. Indeed, prison medical staff have themselves diagnosed her with GID. She is an adult and has mental capacity to consent to surgery. She has an above average understanding of the surgery and is able to speak about it in knowledgeable terms. In addition, Ms. Edmo does not appear to have any uncontrolled medical problem that would preclude surgery. In particular, I note she has had a substantial weight loss (from a peak of 260 obese, almost morbid obesity, to a current reported weight of 195, overweight but not obese) and attributes this to “getting on hormones and really understanding I also need to take care of my body” in addition to knowing that significant obesity can be an impediment to getting genital SRS. Her mental health issues are also reasonably well controlled. Finally, she has had multiple years of continuous HRT and has been living as a woman for many years. This is despite the fact that she has suffered frequent harassment, punishment as severe as solitary confinement, and multiple DORs for living authentically as a woman. As for the additional recommended criteria of “regular visits with a mental health or other medical professional,” Ms. Edmo has availed herself of the mental health services offered and has advocated for more, such as requesting a clinician with broader experience in transgender medical treatments and requesting additional therapy sessions to focus on her GD. She has had over the years far more mental health and medical visits related to her GD than many transgender patients referred for this surgery.

85. Despite Ms. Edmo's obvious and urgent need for surgery, medical staff at the prison have denied this care. A note in her chart by Scott Eliason MD on 4/20/16 provides information about this decision. In this note, Dr. Eliason acknowledges that Ms. Edmo is suffering negative consequences, including potentially failing to get parole in order to live authentically as a woman in prison: "Is eligible for parole but this has not been granted due to multiple DORs related to use of makeup and feminine appearance." He notes that Ms. Edmo, "[c]ites an improvement in gender dysphoria on hormone replacement, though has ongoing frustrations stemming from current anatomy. Cites that she made attempts to mutilate her genitalia this past fall because of the severity of distress. ...emphasizes need for intact genitalia for successful SRS as a deterrent to self-mutilation. I spoke to prison staff about the inmate's behavior; which is notable for animated affect and no observed distress. I have also personally observed the inmate in these settings and did not observe significant dysphoria." Based on this note, Dr. Eliason either does not understand that gender dysphoria is, like depression or anxiety, a symptom that cannot be directly observed, or he believes that he can observe internal emotions accurately from behavior. Both of these conclusions are medically incorrect and, in Ms. Edmo's case, have placed her at significant risk of harm. Thus, while affect and behavior can be externally observed, mood must be assessed by questioning the patient.

86. Dr. Eliason's note concludes: "A: 27 year old male to female with Gender Dysphoria, Alcohol Use disorder, and Depression. Will continue current medications. Inmate has been observed to be functioning well in the correctional setting. Does not meet criteria for medical necessity for sex reassignment surgery. I staffed this case with Dr.

Jeremy Stoddart, Dr. Murray Young, Jeremy Clark LCPC (clinical supervisor and WPATH member) and they agreed with my assessment. That being said I will continue to monitor and assess this inmate for the medical necessity of SRS throughout there [sic] stay here- For the time being it is my opinion that the combination of hormonal treatment and supportive counseling is sufficient for her gender dysphoria. Medical Necessity for Sexual Reassignment Surgery is not very well defined and is constantly shifting but the following situations could meet medical necessity: 1) Congenital malformations or ambiguous genitalia would likely require sexual reassignment or reparative surgery. 2) Severe and devastating dysphoria that is primarily due to genitals could potentially meet criteria for gender reassignment surgery as well. 3) Some type of medical problem in which endogenous sexual hormones were causing severe physiological damage. There may also be other situations which could be determine as medically necessary as more information becomes available. This inmate does not meet any of those above criteria.”

87. In fact, as detailed above, the medical necessity and criteria for sex affirming surgery is well-established and there is no question that Ms. Edmo meets it. Indeed, in her case, it may very well be life-saving care. In contrast, Dr. Eliason’s examples of “medical necessity” are far afield from the medical standards. Although his third example seems to recognize that surgery stops the production of sex hormones, I cannot conceive of a situation where the endogenous hormone could cause “severe physiological damage” warranting surgery. His second example, which is most applicable to Ms. Edmo, is the most problematic. The standard for surgery is not “severe and devastating gender dysphoria that is primarily due to the genitals,” as Dr. Eliason contends. Rather, as noted above, the

standard is “persistent, well documented gender dysphoria,” among other criteria. A doctor would never, for instance, recommend surgery only for “severe and devastating” cancer. Required and medically necessary treatments are those that will alleviate and address the underlying medical condition. In short, Dr. Eliason’s standard for surgery is wholly unsupported.

Medically Necessary Treatment Recommendations

88. Ms. Edmo has well established and persistent gender dysphoria, a substantial portion of which is related to her male genitalia. She meets criteria for genital SRS and is stable enough to undergo surgery. It is medically necessary that she be immediately referred to an appropriate surgeon skilled in performing penile inversion vaginoplasty as soon as possible, but at a minimum within the next 6 months. This is particularly important since Ms. Edmo remains at substantial risk for self-surgery or suicide if she is denied this medically necessary care.

89. Medical staff should ensure that Ms. Edmo’s HRT achieves hormone levels within the appropriate ranges. It is apparent that Ms. Edmo’s chronically inadequate HRT contributed to her first and possibly second attempt at self-surgery.

90. The prison should restart her spironolactone since there is virtually no chance this medication caused her elevated LFTs. Published medical studies on spironolactone show that Ms. Edmo’s LFT elevations are far beyond those ever associated with that medication.⁵ Staff should also monitor her LFTs every 2 months for 6 months then every

⁵ <https://livertox.nih.gov/Spironolactone.htm>.

6 months for a year.

91. Regarding her elevated liver function tests, fortunately they have finally normalized as of the last labs that I have available. In order to prevent potential permanent liver damage, however, the prison should at a minimum order hepatitis A and C serologies and provide appropriate care in light of those results.

92. Given her heightened risk for self-surgery, Ms. Edmo should have immediate access to appropriate female underwear, female clothing, and female grooming standards, especially with regards to makeup and hair styling. She should be allowed to purchase women's commissary items and be allowed to utilize these items without reprisals, including DORs.

93. Any DORs that Ms. Edmo accumulated for the health-seeking behavior of expressing her gender identity should be reconsidered and at a minimum, should not negatively influence her chance for parole.

I declare under penalty of perjury under the laws of the United States of America and the State of Idaho that the foregoing is true and correct. Executed this 29th day of May, 2018 in Davis, California.



Dr. Ryan Nicholas Gorton

Exhibit A

Ryan Nicholas Gorton, MD, DABEM

901 Douglass Ave, Davis CA 95616
(504) 261-8379 (mobile)
nickgorton@gmail.com

Professional Practice

February 2005 – Current Emergency Medicine Physician
Sutter Davis Hospital
Davis, CA

July 2002 – February 2005 Emergency Medicine Physician
St Tammany Parish Hospital
Covington, LA

Professional Practice: Volunteer Activities

March 2005 – Current Primary Care Provider and Clinical Instructor
Lyon-Martin Health Services
San Francisco, CA.

August 2005 – February 2006 Acting Medical Director
Lyon-Martin Health Services
San Francisco, CA.

September 2008 – Current Executive Committee Member and Lecturer
Project HEALTH <http://www.project-health.org/>
San Francisco, CA.

January 2011 – Current Consultant TransLine National Clinical Consultation Line

Medical-Legal Consultant: Sylvia Rivera Law Project, New York, NY
Lambda Legal Defense and Education Fund, Inc., New York, NY
Transgender Law Center, San Francisco, CA
National Center for Lesbian Rights. San Francisco, CA
Northwest Justice Project, Seattle, WA
The Legal Aid Society, New York, NY
National Center for Transgender Equality, Washington, DC
TGI Justice Project, Oakland, CA.
ACLU Florida

Post Graduate Training

June 2001 – June 2002 Chief Resident, Department of Emergency Medicine
Kings County Hospital Center/SUNY Downstate
Brooklyn, NY

July 1998 – June 2002 Emergency Medicine Residency
Kings County Hospital Center/SUNY Downstate
Brooklyn, NY

Education

August 1994 – May 1998 Doctor of Medicine
University of North Carolina School of Medicine
Chapel Hill, NC

August 1988 – August 1991 Bachelor of Science in Biochemistry, Summa Cum Laude
North Carolina State University
Raleigh, NC

Professional Affiliations

World Professional Association for Transgender Health (formerly HBGDA)

- ◆ Transgender Medicine and Research Committee
- ◆ Institutionalized Persons Committee

University of California at San Francisco Center of Excellence for Transgender Health

- ◆ Medical Advisory Board 2010-2013 (during development of original Primary Care Protocols)

American Medical Association

- ◆ GLBT Advisory Committee 2009-2011

Gay and Lesbian Medical Association

- ◆ LGBT Medical Experts Panel

Licensure/Certification

Nov 2003 – Present Diplomate American Board of Emergency Medicine
Nov 2004 – Present CA State Medical License A89440
Feb 2002 – 2009 LA State Medical License 14466R
June 2001 – 2010 NY State Medical License 221808

Publications and Papers

Gorton, R, and Berdahl, C. *Improving the Quality of Emergency Care for Transgender Patients. Annals of emergency medicine.* 71(2): 189-192. 2018.

Gorton, R, and Erickson-Schroth, L. *Hormonal and Surgical Treatment Options for FTMs.* Psychiatric Clinics of North America. Psychiatric Clinics of North America. 40(1): 79-97. 2017.

Ingram, N., Pratt V., and Gorton, R. *Counting trans* patients: A Community Health Center Case Study.* TSQ: Transgender Studies Quarterly. 2(1): 136-147. 2015.

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Gorton R. Transgender as Mental Illness: Nosology, Social Justice, and the Tarnished Golden Mean. In Stryker S and Aizura A (Eds.), *The Transgender Studies Reader, Vol 2*. New York, NY Taylor and Francis. 2013.

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Ehrbar R, and Gorton R. *Exploring Provider Treatment Models in Interpreting the Standards of Care*. International Journal of Transgenderism, 12(4):198-210. 2010.

Pittsburgh Transgender Health Research Summer Institute: *A Review and Guidance for Future Research—Proceedings from the Summer Institute at the Center for Research on Health and Sexual Orientation, University of Pittsburgh t*. International Journal of Transgenderism, 12(4):211-229. 2010.

Haraldsen I, Ehrbar R, Gorton R, and Menvielle E. *Recommendations for Revision of the DSM Diagnosis of Gender Identity Disorder in Adolescents*. International Journal of Transgenderism, 12(2):75-79. 2010.

Gorton R. *Transgender Health Benefits: Collateral Damage in the Resolution of the National Health Care Financing Dilemma*. Sexuality Research and Social Policy: Journal of NSRC. 4(4):81-91. Dec 2007.

Gorton R. *Health Care and Insurance Issues for Transgender Persons*. American Family Practitioner. 74(12):2022. December 2006.
<http://www.aafp.org/afp/20061215/letters.html>

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Gorton R, Buth J, and Spade D. *Medical Therapy and Health Maintenance for Transgender Men: A Guide For Health Care Providers*. Lyon-Martin Women's Health Services. San Francisco, CA. 2005. ISBN 0-9773250-0-8 (www.nickgorton.org)

Gorton R. *A Critical Analysis of the Hayes Report: "Sex Reassignment Surgery and*

Associated Therapies for Treatment of GID. Report prepared for the Lambda Legal Defense Fund. May 2005.

Greenberg's Text Atlas of Emergency Medicine, Michael Greenberg Ed. Lippincott Williams & Wilkins. ISBN 0-7817-4586-1 2004. Contributing Author: Chapter 4 – Eyes/Ophthalmic.

Gorton R. “Toward a Resolution of GID, the Model of Disease, and the Transgender Community.” MAKE. March 2005.
<http://www.makezine.org/giddisease.htm>

Sinnert R, et al, Gorton R. “The ratio of ionized calcium to magnesium modifies the bronchodilatory effects of magnesium therapy in acute asthma.” *Acad Emerg Med* 2002 9(5) 436-437.

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Rosamond W, Gorton R, Hinn A, Hohenhaus S, Morris D. “Rapid response to stroke symptoms: the Delay in Accessing Stroke Healthcare (DASH) study.” *Acad Emerg Med* 1998 Jan; 5(1) 45-51.

Selected Conference Presentations and Invited Talks

Gorton, R. “Acute and Long Term Complications of Silicone Pumping: Primary, Secondary, and Tertiary Prevention”. WPATH Symposium. Amsterdam, The Netherlands. June, 2016.

Gorton, R, Ettner, R, Brown, G, Bermudez, F, Orthwein, J and Mazur, T. “Orange isn’t the New Black (Yet)”. WPATH Symposium. Amsterdam, The Netherlands. June, 2016.

Gorton R. “Transgender Patient Care in the Emergency Department”. American Academy of Emergency Medicine Scientific Assembly. Las Vegas, Nevada. February 2016.

Gorton R. “Transgender Patients in the Emergency Department”. Stanford University Department of Emergency Medicine SimWars. Stanford, CA. February 2016.

Gorton R. “History of Transgender Medicine”. UCSF School of Medicine Transgender Health elective. San Francisco, CA. February 2016.

Gorton R. “Free Silicone Complications and Management”. National Transgender Health Summit. Oakland, CA. April 2015.

- Gorton R. "History of Transgender Medicine". UCSF School of Medicine Transgender Health elective. San Francisco, CA. March 2015.
- Gorton R. "Transgender Healthcare". UC Davis School of Medicine. Sacramento, CA. December 2015.
- Gorton R. "Engaging and Retaining Transgender Patients in Ongoing Primary Care". National Association of Community Health Centers Health Institute and Expo. San Diego, CA. August 2014.
- Gorton R. "Sexual and Reproductive Health: A Focus on Transgender Patients". California Family Health Council. Webinar. March 2014.
- Gorton, R, Green, J and Tescher, J. "California Dreaming: Two Decades of Change in Health Insurance Law and Policy". WPATH Symposium. Bangkok, Thailand. February, 2014.
- Gorton, R and Chung, C. "From Grassroots Health Advocacy to Expanding Clinician Competency: Project HEALTH (Harnessing Education, Advocacy & Leadership for Transgender Health)". WPATH Symposium. Bangkok, Thailand. February, 2014.
- Gorton, R and Tescher, J. "Minding the Gap: Development and Implementation of a Clinical Rotation in Transgender Health". WPATH Symposium. Bangkok, Thailand. February, 2014.
- Gorton R and Keenan C. "LGBT Sexual and Reproductive Health Issues". California Family Health Council Women's Health Update. San Francisco, CA. April, 2013.
- Gorton R. "Transgender Medicine". California AHEC Webinar. San Francisco, CA. April, 2013.
- Gorton R. "Transgender Aging Issues". Institute on Aging Conference on LGBT Aging. San Francisco, CA. November, 2012.
- Gorton R and Branning N. "Transgender Primary Care". California Academy of Physician Assistants Annual Conference. Palm Springs, CA. October, 2012.
- Gorton R. "Primary care and Hormonal Treatment for Transgender Clients". Samuel Merritt University. Oakland, CA. June 2012.
- Gorton R. "Primary care and Hormonal Treatment for Transgender Clients" Grand

Rounds for the VA Medical Center. San Francisco, CA. June 2012.

Gorton R and Wertz K. "Transgender Health Care" Webinar for the California Family Health Council. San Francisco, CA. June, 2012.

Eichenbaum J, Gorton R and May A. "Transgender Health, the VA, and Barriers to Care." San Francisco Veterans Administration Mental Health Services Grand Rounds. San Francisco, CA. May, 2012.

Gorton R and Wertz K. "Working With GLBT Clients" California Family Health Council Webinar. Los Angeles, CA. May, 2011.

Gorton R. "Improving Access to Transgender Health Care: Outcomes from Project HEALTH" World Professional Association for Transgender Health. Atlanta, GA. September, 2011.

Gorton R and Wertz K. "Trailblazing for Transgender Health" Southern Comfort Conference. Atlanta, GA. September, 2011.

Gorton R. "Nuts and Bolts of Transgender Primary Care" Gay and Lesbian Medical Association Annual Conference. Atlanta, GA. September, 2011.

Gorton R. "Transgender Medicine and Cultural Competency" Kaiser Department of OB/Gyn Grand Rounds. San Francisco, CA. April, 2011.

Gorton R. "Evidence Based Transgender Medicine" Opening Plenary UCSF National Transgender Health Summit. San Francisco, CA. January, 2011.

Green J and Members of the Center of Excellence for Transgender Health Medical Advisory Board. "Primary Care Protocols" Morning Plenary UCSF National Transgender Health Summit. San Francisco, CA. January, 2011.

Freshel K, Gorton R, Hansom C and Barnes A. "Communities Working Together to Become Culturally Competent" California State Rural Health Association Conference. Sacramento, CA. November, 2010.

Gorton R, Spade D and Wilkinson W. "Transposium: Healthcare Access and Quality For Transgender Individuals" Shaking the Foundations: The West Coast Conference on Progressive Lawyering, Primary Care Associate Program, Stanford School of Law. Stanford CA. October, 2010.

Gorton R. "Improving Access to Transgender Healthcare: Outcomes from Project HEALTH (Harnessing Education, Advocacy, and Leadership for

Transgender Health)" Gay and Lesbian Medical Association Annual Conference. San Diego, CA. September 2010.

Gorton R, Gould D and Wertz K. "Trailblazing for Transgender Health" National Gay and Lesbian Task Force Creating Change Conference. March 2010.

Gorton R. "Grand Rounds: Transgender Medicine" Highland General Hospital Department of Internal Medicine. Oakland, CA. January, 2010.

Gorton R. "Grand Rounds: Transgender Medicine" Kaiser Permanente Department of Internal Medicine. San Francisco, CA. December, 2009.

Keatley J and Gorton R. "Transgender Health Care Issues in California Today" Equality California and the California LGBT Legislative Caucus Briefing on LGBTI Health Care Issues. Sacramento, CA. December 2009.

Ehrbar R, Winters K, and Gorton R. "Revision Suggestions for Gender Related Diagnoses in the DSM and ICD" WPATH XXI Biennial Symposium. Oslo, Norway. June, 2009.

Gorton R. "A Place at the Table" American College Health Association Annual Meeting. San Francisco, CA. May, 2009.

Famula M, Hall A, Pardo S, Gorton R. "Providing Trans-Specific Health Care to Transgender Students in the College Setting." American College Health Association Annual Meeting. San Francisco, CA. May, 2009.

Gorton R. "Transgender Health" American Medical Student Association: Regional Conference. Lubbock, TX. March, 2009.

Gorton R. "Medical Ethics and Evidence Based Transgender Medicine" Equality and Parity II: A Statewide Action for Transgender HIV Prevention and Care. Los Angeles, CA, January 2009.

Gorton R. "Transgender Medicine 101" AMSA Regional Conference. Lubbock, TX. December, 2008.

Gorton R, Djordjevic M, and Brownstein M. "Female to Male (FTM) Health Update" (Provider Session) The 7th Annual Mazzoni Center Trans-Health Conference. Philadelphia, PA. May 2008.

Gorton R. "FTM Hormones 201." (Community Session) The 7th Annual Mazzoni Center Trans-Health Conference. Philadelphia, PA. May 2008.

Green J, Gorton R, Razza R, and Tamar-Mattis A, "Healthcare and Access Issues

Panel.” University of California Hastings College of the Law
Transposium Conference. April 2008.

Arkles G, Gorton R, Sanchez D, Suarez C. “Trans Issues in Health Care Panel.”
Harvard Law School Lambda Legal Advocacy Conference. February
2008.

Gorton N, Thaler C, and Keisling M. “Drawing the Curtain: An Overview of
Medical
Privacy Protections and Risks for Transgender Patients and Providers ”
WPATH Symposium, 2007, Chicago.

Gorton R. “Transgender Medicine 2007: A Medical Ethics and Evidence Based
Paradigm Shift.” (Provider Session) The 6th Annual Mazzoni Center
Trans-Health Conference. Philadelphia, PA. April 2007.

Gorton R. “FTM Hormones 201.” (Community Session) The 6th Annual Mazzoni
Center Trans-Health Conference. Philadelphia, PA. April 2007.

Gorton R. “Medical Ethics and Evidence Based Transgender Medicine.” FORGE
Forward. Milwaukee WI. March 2007.

Gorton R. “FTM Hormonal Treatment: Beyond 101.” FORGE Forward.
Milwaukee
WI. March 2007.

Gorton R. "Transgender Healthcare in 2007: Its Time to Take it Seriously."
Humboldt
State University 13th Annual Diversity Conference and Education Summit.
Arcata CA. March 2007.

Spade D, Gehi P, Arkles G, and Gorton R. “Barriers to health care access for
transpeople.” UCLA School of Law, Williams Institute Annual Update.
Los
Angeles, CA. February 2007.

Marksamer J and Gorton R. "Legal Support and Advocacy for Transgender
Youth and Their Families." Gay and Lesbian Medical Association Annual
Conference. San Francisco, CA. October 2006.

Gorton R. “Hormone Therapy 101.” FTM-Gender Odyssey 2006. Seattle, WA.
September 2006.

Gorton R. “Hormone Therapy 201.” FTM-Gender Odyssey 2006. Seattle, WA.
September 2006.

Gorton R. “Transgender Medicine.” California Department of Health Early
Intervention Program Statewide Conference. May 2006.

- Gorton R. "Primary Care and Hormonal Therapy for Transgender Males."
(Provider
Session) The 5th Annual Mazzoni Center Trans-Health Conference.
Philadelphia, PA. March 2006.
- Gorton R. "Health Maintenance for Transgender Men." (Community Session) The
5th
Annual Mazzoni Center Trans-Health Conference. Philadelphia, PA.
March
2006.
- Gorton R. "Primary Care and Hormonal Therapy for Transgender Males." The 23rd
Annual Conference of the Gay and Lesbian Medical Association. Montreal,
Canada. September, 2005.
- Spade, D, and Gorton R. "Medical-Legal Policy Update in the Quest for Trans
Health
Care and Justice." The 23rd Annual Conference of the Gay and Lesbian
Medical Association. Montreal, Canada. September, 2005.
- Arkles Z, and Gorton R. "Medical-legal Collaboration in the Quest for Trans
Health
Care and Justice" The 19th Biennial Symposium of the Harry Benjamin
International Gender Dysphoria Association. Bologna, Italy. April, 2005.

Professional Advocacy

Supported as physician member of the American Medical Association for adoption
of inclusive language for transgender people within AMA policy.
"Recommendations to Modify AMA Policy to Ensure Inclusion for
Transgender Physicians, Medical Students and Patients." Accepted
by the AMA Board of Delegates July 2007. See "AMA Meeting:
Anti-discrimination policy extended to transgendered." AMA
News July 16, 2007.
<http://www.ama-assn.org/amednews/2007/07/16/prsk0716.htm>.
Policy amendment available at:
<http://www.ama-assn.org/ama1/pub/upload/mm/467/bot11a07.doc>

Authored and proposed with Vernon A, and Maxey K. *Resolution to amend the
American College of Emergency Physicians 'Code of Ethics for
Emergency Physicians.'* Accepted as policy October 2005. Now
reads (amended language underlined): "Provision of emergency
medical treatment should not be based on gender, age, race,
socioeconomic status, sexual orientation, real or perceived gender
identity, or cultural background."

Awards

Claire Skiffington Vanguard Award. Transgender Law Center. San Francisco, CA.
2012.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 1st day of June, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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Attorneys for Plaintiff

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

ADREE EDMO (a/k/a MASON EDMO),
Plaintiff,

v.

IDAHO DEPARTMENT OF
CORRECTION; HENRY ATENCIO, in
his official capacity; JEFF ZMUDA, in
his official capacity; HOWARD KEITH
YORDY, in his official and individual
capacities; CORIZON, INC.; SCOTT
ELIASON; MURRAY YOUNG;
RICHARD CRAIG; RONA SIEGERT;
CATHERINE WHINNERY; and DOES
1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

**DECLARATION OF ADREE
EDMO IN SUPPORT OF
PLAINTIFF'S MOTION FOR
PRELIMINARY INJUNCTION**

Complaint Filed: April 6,
2017
Discovery Cut-Off: None Set
Motion Cut-Off: None Set
Trial Date: None Set

I, Adree Edmo, am the Plaintiff in the above-captioned matter. I have personal knowledge of the information set forth herein and if called upon to testify, I would testify to the truth of the following:

1. I was born on October 29, 1987 in Pocatello, Idaho and was raised as Mason Dean Edmo. I am a member of the Shoshone-Bannock Tribes, and lived at the Fort Hall Indian Reservation in Pocatello for most of my life.

2. I identify as a woman and female although I was assigned male at birth.

3. Around the age of 5 or 6, I remember first being aware of the feeling that I was a girl. At that time, I identified with my older sisters even though I was “supposed” to act like and identify with my older brothers. I wanted to be like my older sisters. I was much closer to them and shared more of their interests as compared to my older brothers. My sisters would let me play with their Barbies and other “girls’” toys. I felt accepted by my family.

4. Things became much harder when I started going through puberty. Growing up, I watched my older sisters become women and always hoped the same would happen to me. When I reached puberty, I had to come to terms with the fact that that was not how my body worked. It was a shocking and very depressing realization.

5. When I was 12 or 13, I started to feel more confident about expressing my female identity and moved towards accepting myself. At the age of 14 or 15, I started wearing girls’ jeans. I remember experimenting with my mom’s foundation and sister’s mascara, and began wearing makeup to school. Dressing this way and wearing makeup made me feel liberated and more like myself.

6. While I knew that I was different, I never thought there was something wrong with me or what I was doing. My family was generally supportive. My grade school friends, who were all female, were also very supportive of me. In high school, I would usually go into the girls' bathroom with my friends.

7. I began living full-time as a woman around the age of 20 or 21. I wore makeup, women's outerwear, underwear, and bras, and styled my long hair. I would get my nails done with my mom and my sisters. By that point, my sisters, friends, and boyfriends were referring to me as "she," so the transition into living as a woman felt comfortable and natural.

8. Living as a woman and expressing my gender freely made me feel for the first time in my life like others saw me as the real person that I am—as the woman I am.

9. I first heard of Gender Identity Disorder ("GID") during a visit with the psychiatrist at my tribal health center. The psychiatrist asked me how long I had been living as a woman and if I had ever been diagnosed with GID. After I said no, he explained GID, and said that he thought I may have GID.

10. Around this time, I met a few transgender people and learned about hormone replacement therapy and surgical procedures that could help me transition. I was interested in sex-reassignment surgery, but was unsure of where to find resources. My substance abuse issues also prevented me from making progress toward medically transitioning at that time.

11. In 2012, I began going by the name "Adree," which is based on "Adrianna." I love the name "Adrianna" and suggested it to my cousin when he found out he was going

to have a daughter. It felt good to introduce myself as “Adree” and my new name helped affirm my female identity. I decided to legally change my name in September 2013. I saw the legal name change as another step in consolidating my identity.

My Experience at ISCI

12. I have been imprisoned at Idaho State Correctional Institution (ISCI) since April 2012. I was diagnosed with GID at ISCI in July 2012. My health providers also refer to me as having a diagnosis of gender dysphoria.

13. Being a woman housed in a men’s prison causes me extreme mental pain, anxiety, and stress. Not only am I a target for sexual assault and harassment, which makes me feel perpetually unsafe, but I am also consistently denied recognition of my identity as a woman. This treatment, particularly because I was living freely as a woman before prison, feels like torture above and beyond my prison sentence.

14. I am forced to wear men’s outwear and underwear. I am restricted from purchasing and wearing women’s outerwear, underwear, and makeup. I am denied access to female commissary items. I am denied the basic items that female inmates are allowed.

15. The male clothing I am forced to wear does not accommodate my transitioning body, particularly in the chest area. In addition to being forced to wear ill-fitting and uncomfortable clothing, I am harassed by correctional officers for how my clothing fits—something I have no control over. I recall one instance in which a correctional officer said something like “men don’t wear clothes that tight.” When I tried to explain that my clothing was tight because of my hormone replacement therapy, the correctional officer said something to the effect of: “Well that’s a medical choice.”

16. Since arriving at ISCI, I experience frequent verbal harassment by prison staff who refuse to accept and treat me as a woman. The majority of the harassment consists of comments targeting my appearance, mannerisms, and transitioning body. For example, I have been told “You can’t walk like that; guys don’t walk like that.” I have also been told on several occasions that I will be treated like a man because I am housed in a male prison. The prison staff’s harassment of me encourages the same conduct by other inmates. I have noticed that other inmates often engage in verbal harassment when prison staff are also doing it. The harassment makes me feel humiliated, ashamed, degraded, and scared. It is also a constant reminder that my body does not match my feeling of being a woman and female.

17. IDOC correctional and medical staff never refer to me using female gender pronouns. They refer to me only my last name, “Edmo,” or by male gender pronouns.

18. Until recently, I was permitted to use the showers when no male inmates were in the bathrooms. That is no longer the case. I am now forced to shower when male inmates are also showering. Some of the shower stalls do not have curtains, thus exposing my entire naked body to male inmates. I feel powerless and live in constant fear of being physically harmed or raped by male inmates.

19. I have received multiple disciplinary offense reports (“DORs”) for expressing my female identity. Some of the DORs I received were for wearing makeup, modifying the prison-issued male underwear to resemble female underwear, and for my hair being “too feminine.” These DORs are considered “disobeying orders.” The discipline makes me feel dehumanized and degraded.

20. At my last parole board hearing, I was told that I am not eligible for parole because my disciplinary record was full of “disobeying orders.”

Medical and Mental Health Treatment

21. Since being incarcerated, my gender dysphoria and depression have worsened substantially.

22. The only treatment I have been provided for my gender dysphoria at ISCI is hormone replacement therapy. I began hormone replacement therapy in September or October 2012, and see it as the first medical step in my transitioning process. But by itself, it is not enough to treat my gender dysphoria.

23. The medical professionals I have seen at ISCI refuse to use female gender pronouns when referring to me. Some healthcare professionals even use male pronouns when referring to me.

24. I am seen by a nurse practitioner once every three months. I see a doctor for gender dysphoria, Dr. Alviso, once a year. Whenever I ask for changes to my hormone doses, I am told I have to wait for my yearly appointment with Dr. Alviso.

25. The mental health professionals I have seen at ISCI admit they are not familiar with gender dysphoria. They tell me to “hold onto hope” and that I will get what I need when I am out of prison.

26. Earlier this year, I was taken off one of my feminizing hormones, spironolactone. I was told that spironolactone was a possible cause of the elevated liver enzymes on my blood test, but do not know if there were any tests done to determine the actual cause. Since they have stopped my spironolactone, I have experienced painful

testicular enlargement, rapid facial hair growth, and weight gain. This is agonizing for me. I requested to be put back on spironolactone, but was informed that I had to wait for my yearly appointment with Dr. Alviso.

27. I have made multiple attempts to remedy these serious problems. I have filed numerous grievances through Corizon and IDOC for necessary medical treatment, including sex-reassignment surgery, appropriate hormone treatment, facial hair electrolysis, and treatment by medical and mental health professionals with expertise in gender dysphoria. I have also made requests to medical professionals directly during my appointments. All of my efforts have been denied or ignored.

28. I also wrote a letter to the Warden asking him to allow me these necessary medical treatments. In response, I was told that I could receive any medical treatment recommended in a medical memo. When I relayed this information to medical professionals, they told me that IDOC policy prevents them from recommending any of my medically necessary treatments. It is extremely depressing and frustrating to be consistently denied access to the medical treatments that I need.

29. I attempted suicide in February 2014 after my first request to have sex-reassignment surgery was denied. The hormone replacement therapy was not having much effect at the time and I had been struggling to get the proper estrogen doses prescribed. Once my request to have the surgery was denied, I felt hopeless. I didn't think I would ever get the treatment I needed.

30. After my attempted suicide, I was placed on suicide watch. I was placed in an isolation cell and stripped down. Being naked and in the isolation cell increased my

gender dysphoria and suicidal thoughts, given my anatomy.

31. I attempted to perform self-surgery to remove my testicles in September 2015. I felt that this was the only choice I had because I was being continually denied the surgery that I need. Before I attempted self-surgery, I placed the following note in my cell: “I do not want to die, but I am a woman, and women do not have these.” I wrote the note to make sure that correctional staff understood that I was trying to help myself, and not commit suicide. I then cut open my scrotum with a razor blade.

32. Despite my attempt to make clear that I was not suicidal, I was placed on suicide watch after I was found. This made my depression and gender dysphoria even worse. Moreover, mental health staff told me that if I tried the same thing again, I would be sent to maximum security. They did not seem to understand that this was my attempt to address my gender dysphoria. The prison’s reaction to my self-surgery made me think that if there were going to be a next attempt, I needed to be successful.

33. My second self-surgery attempt was on December 31, 2016. Once again, I felt this was the only choice I had because the prison was not helping me get the treatment I needed. In preparation, I researched the best incision point to perform the surgery. I also asked my friend to call for help if I began to lose too much blood because I did not want to die. On the second attempt, I almost severed my entire right testicle. I had to be taken to the hospital for surgery to repair my testicle. None of the medical professionals talked to me about the possibility of finishing removal of the testicle and did not give me a choice about repairing it.

34. Both times I attempted to perform self-surgery, I was at a point beyond

mental anguish. I was thinking: “If I don’t do this, I won’t be able to keep going.” I was not getting the treatment that I need to live and I felt an urgent need to take action and fix myself. When I performed self-surgery, I never intended to kill myself. I do not regret attempting self-surgery because I see self-surgery as self-treatment and self-help.

35. The first time I thought about self-surgery was in prison. I had never considered trying this to treat myself before because I had never felt that level of desperation about gender dysphoria. I had previously been able to live full time as a woman and express my gender identity freely. Being denied the treatment I need and being prohibited from living as a woman makes me feel hopeless.

36. Whenever my gender dysphoria gets worse, my urge to perform self-surgery increases. My male genitalia feels so alienated from the rest of my body and from my identity. Having that genitalia is a huge source of stress, anxiety, and depression, but it is something that can be removed. As I am getting older, my need to consolidate my female identity grows stronger.

37. The thought of never being able to have sex-reassignment surgery is too stressful to imagine. I would compare it to telling a cancer patient: “This treatment will cure you, but you can’t have it.” Without surgery, I feel like I am living, but dying inside

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38. More recently, I have started cutting my wrists as a way to deal with my mental anguish about my gender dysphoria. In those moments, I cut myself because I would rather feel physical pain than deal with the mental anguish of never receiving sex-reassignment surgery, and always being treated as someone I am not.

I declare under penalty of perjury under the laws of the United States of America and the State of Idaho that the foregoing is true and correct. Executed this 1st day of June, 2018 in Kuna, Idaho.


Ms. Adree Edmo

