EXHIBIT

4

(Declaration of Bernard Hudson, M.D.)

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

ROBERT L. VAZZO, LMFT, etc., et al.,)
)
Plaintiffs,)
v.) Case No. 8:17-cv-2896-T-02AAS
)
CITY OF TAMPA, FLORIDA,)
)
Defendant.)
)

DECLARATION OF BERNARD O. HUDSON MD

I, Dr. Bernard O. Hudson, hereby declare as follows:

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I. ENGAGEMENT AND QUALIFICATIONS.

1. I am over the age of 18 and am submitting this Declaration as expert testimony in support of Plaintiffs. I have been asked to offer my analysis and opinions regarding the claimed scientific justifications for City of Tampa Ordinance 2017-47, An Ordinance Of The City Of Tampa, Florida, Relating To Conversion Therapy On Patients Who Are Minors (hereinafter "Ordinance 2017-47"), specifically with respect to 'gender identity'. The facts in this Declaration are true and correct and if called upon to testify to them I would and could do so competently.

2. I have studied and practiced medical science since 1979 as a physician who specializes in psychiatry and sub-specializes in child and adolescent psychiatry, with additional expertise in psychiatric illness and treatment of juveniles in confinement. I am board certified in General Psychiatry, 1989, and Child and Adolescent Psychiatry, 1993, by the American Board of Psychiatry and Neurology; and by the National Board of Physicians and Surgeons, 2017, in General Psychiatry and Child and Adolescent Psychiatry. I have recently retired my license with the California Medical Board, having been licensed since 1985; and I am currently licensed, since 1992, with the Tennessee Health Related Board, and with the United States Drug Enforcement Agency. At the end of 2017, I retired from Los Angeles County, Department of Mental Health, Juvenile Justice Division, after 15 years. I have practiced in Wisconsin, California, Kentucky, and Tennessee. While having practiced in academic settings, I am primarily a clinician and teacher.

3. I attended the University of California, San Diego, graduating with a BS in Chemistry and serving as a teaching assistant in Biology, Chemistry, and English Literature.

4. At the Cardinal Stritch School of Medicine, Loyola University, a three-year medical school, I entered the specialty of Psychiatry. I completed my internship and residency in Psychiatry at the Medical College of Wisconsin. I completed my fellowship in Child and Adolescent Psychiatry at the University of California, Davis, School of Medicine, where I worked with Robert Dorn MD, who had been psychoanalyzed by and worked with Anna Freud MD, in London.

5. I have worked in my medical speciality, Psychiatry, and sub-speciality, Child and Adolescent Psychiatry, over the past four decades in a variety of community settings: private practice, two jails, five juvenile halls, and eight camps; two academic appointments, as a Clinical Instructor of Psychiatry, University Of California, Davis, and as an Assistant Professor of Psychiatry, Vanderbilt University School of Medicine; and with the United States Department of Justice, Civil Rights Division, Special Litigation Section, investigating juvenile detention centers in Louisiana and Georgia as an expert witness regarding local and regional community psychiatric standards of care.

6. While working for Los Angeles County, Department of Mental Health, Juvenile Justice Division, I was the designated teacher/instructor for the Department of Justice from 2005 to 2015, teaching Health Services, Mental Health Services, and Probation Services. The instruction was regarding psychiatric illness and treatment and suicide prevention strategies for juveniles in confinement.

7. Attached hereto as Exhibit A is a copy of my curriculum vitae. I have not authored any publications in the previous ten years, and I have not testified at trial or by deposition in any case during the previous four years.

8. In preparing this report, I relied on the case filings and academic, scientific, and other reference materials identified in the table of References attached hereto as Exhibit B.

9. My compensation for this engagement will be $450 per hour for deposition and trial testimony, $200 per hour for travel time, and actual expenses. I provide the remainder of my time for this engagement *pro bono*.

II. SUMMARY OF OPINIONS.

10. **My opinions regarding the lack of scientific justification for** Ordinance 2017-47 may be summarized as follows:

> **First**, biological sex is male and female, and gender is masculine and feminine.
>
> **Second**, no one can change from a male to a female or a female to a male.
>
> **Third**, a significant majority of people identifying as 'transgender' suffer from gender dysphoria, as well as significant mental illnesses such as depression, anxiety, substance-related disorders, self-harm, suicidal ideation and behaviors, and suicidal intent and attempts, etc.
>
> **Fourth**, so-called 'conversion therapy' bans such as Tampa Ordinance 2017-47, target and censor scientifically sound, evidence-based practice therapies, consisting of speech, and ethically utilized by many medical professionals with minor patients.
>
> **Fifth**, professional organizations are issuing 'affirming' therapy guidelines that disregard evidence-based practice therapies in favor of ideologically predetermined outcomes for patients suffering from gender dysphoria.
>
> **Sixth**, because the vast majority of minors who experience gender dysphoria come to accept and psychologically align with their biological sex as they age into adulthood, 'affirming' every minor who identifies as 'transgender' is poor, unscientific practice, and condemns many minors who otherwise would not persist in a 'transgender' identity in adulthood to sterilization and a future of being life-long mental health patients with the attendant costs and risks of harm.
>
> **Seventh**, there is an increasing number of ethical medical professionals who fear losing their licenses and careers by running afoul of so-called 'conversion therapy' bans and "affirming" therapy dictates.

III. ANALYSIS AND OPINIONS.

A. Preliminary Scientific Considerations.

i. Science and the Scientific Method or Principles.

11. Science is the systematic structuring of knowledge regarding the natural world that can be tested, explained, and predicted, assessing the interior and exterior universe. Empirical knowledge is based on that which is verified from experience, observation, and testing. Science does not answer the question "why?" but rather "how?"

12. The scientific method—or scientific principles—consists of an instrumental injunction, an accepted apprehension, and a common verity. This method can be used to describe causal relations (e.g., biology), or phenomenological/experiential events or connections (e.g., psychology). While many methods are described, the ongoing, continuous observations of the natural world involve characterizations, conjecturing or hypothesis, measurements, inductive and deductive reasoned predictions, experiments, and peer review; and rigorous, assiduous, replicated retesting of all the steps are of necessity.

ii. The Scientific Basis for Sex.

13. In taxonomy, Homo sapiens is the only living human species. Homo sapiens are male and female; there is no other. All of medical science regarding the diagnosis and treatment of humans is based on this understanding. Any abnormal change in the causal biological development of a male or female human being is considered a state of disease.

14. A natal male has sex chromosomes X and Y. A natal female has X and X, and given the redundancy of genetic information in a cell with two X's, in all somatic cells in a female one X is randomly inactivated, according to the Lyon hypothesis, becoming a Barr body. In men with Klinefelter's Syndrome, chromosomal XXY karyotype, there is one Barr body, and in females with chromosomal XXX karyotype, trisomy X, two Barr bodies are noted in the nucleus. Females with Turner Syndrome, chromosomal XO karyotype, do not have a Barr body, as inactivation of the only X chromosome would render the cell without DNA.

15. Gene mutations do occur, biochemical reactions do go wrong, and substances may interfere with normal development, but there has never been a description in all of human medical science describing anyone changing into the opposite sex, changing his or her sex chromosomes, or being a natal male and having a Barr body in the nucleus of his somatic cells.

16. In short, there is no **causal** science to the claim that a man can become a woman or a woman can become a man. Hence, from the genes in the DNA, to the nucleus in a cell, to the cell, to the tissue, to the organs throughout, to the organ system, and to the organism: a male is a male and cannot become a female, and a female is a female and cannot become a male. No causal science exists in the medical literature to refute this fact.

17. Males and females have a biological place that is not reversible. The propagation and mixing of genes to provide an organism with new living opportunities in its environment, is only possible in humans when a sperm, from a male, and an egg, from a female, combine to bring

together varied genotypes and ensuing phenotypes to produce a human being. During four decades of medical practice, no patient of mine has ever provided evidence that he or she had changed from one sex to the opposite sex. Some have identified as the opposite sex based on subjective thoughts and feelings, but none has ever provided objective or causal evidence that his or her DNA is now composed of genes of the opposite sex.

iii. The Recent Division of Gender and 'Gender Identity' from Sex.

18. The definition of gender has traditionally referred to the sex-related categories of masculinity or femininity. The history of the terminology of 'gender identity' has only varied over the last half century. The idea that gender is unrelated to biological sex came from John Money's concept of gender role, made public in the late 1950's. He conceived of a gender distinct from biological sex. He offered the idea, but with no evidence except in those rare individuals who suffered from abnormal development. (Money, 1955; Money, Hampson, & Hampson, 1957). Haig (2004) describes the evolution of the change in definition of gender in the article, "The Inexorable Rise in Gender and the Decline of Sex: Social Change in Academic Titles." As Haig describes, the loss of the definition of gender did not become a widespread issue until early feminist's began to use the term in the 1970's to differentiate themselves socially from males. (Lindsey, 2010).

19. The World Health Organization (WHO) (2017) recently stated on its website that sex categories are male and female while gender refers to masculine and feminine. 'Gender identity' is related to characteristics that are more or less masculine or feminine, but sex is differentiated, for example, by males with testes and females with ovaries; males have heavier bones, and females can menstruate. Thus, 'gender identity' is considered variable in individuals, but sex is immutable in all individuals. (WHO, 2017).

iv. Evidence-Based Practice Therapies.

20. There are various types of therapy for parents and children/adolescents, including cognitive behavioral, dialectical behavioral, interpersonal, psychodynamic, psychoanalytic, mindfulness, family, play, marriage and family, and psychotherapy. Not all therapies, however, constitute evidence-based practice. Evidence-based practice therapies adhere to psychological techniques which are scientifically based. Both the American Psychiatric Association and the American Psychological Association consider evidence-based practice therapies to be preferred approaches for symptom relief. (Emmelkamp, et al., 2014; Cook, Schwartz, & Kaslow, 2017; McNair, Woodrow, & Hare 2017; Sackett, et al.,1996; Spring, 2007; Blow & Karam, 2017; Kraus, et al., 2016; Linehan, et al., 1999; Vigerland, et al., 2016).

21. Since there are several kinds of evidence-based practice therapies, choosing the correct one is dependent on which one will best help the suffering patient. Patients with eating disorders, depression, intellectual disabilities, marital issues, etc. will require a combination of therapies as the symptoms lessen or worsen. As always, the two main goals of evidence-based practice therapy are the quality of the treatment to lessen the symptom load and the increasing accountability of the therapy by the patient to work to solve their dysfunction, aided by a qualified therapist using evidence-based practice.

22. What is not present in any literature search are evidence-based practice therapies for someone identifying as 'transgender'. There is phenomenological/experiential science that identifies a psychiatric disorder called gender dysphoria in those claiming to be 'transgender'. The use of opposite-sex hormones in those individuals with gender dysphoria does not change DNA, chromosomes, steroid/sex receptors, or Barr bodies in natal females, or add Barr bodies to natal males; nor muscle strength, bone density, organs throughout the body, or biological sex. A male may believe he is a female and vice versa, but in Homo sapiens biological sex does not change. In reality, neither opposite sex hormones nor surgical alteration of healthy tissue changes anyone into the opposite sex.

B. There Is No Scientific Justification for Banning Evidence-Based Practice Talk Therapies for Minors Who Present with Gender Dysphoria.

i. Children and Adolescents Who Identify as LGBT Are at A Substantially Higher Risk of Mental Illness Requiring Treatment.

23. Human sexuality is extraordinarily diverse. The LGBT acronym includes people who have expressed non-conventional sexual orientations or identities. Currently the state of knowledge regarding LGBT people is expected to be extended in the next few decades as society continues to become more accepting of this population. But despite this increasingly widespread social acceptance, LGBT individuals continue to suffer from a variety of mental illnesses. Many LGBT people are now 'coming out' during adolescence when developmental issues of identity, social acceptance, and strong peer-influence and opinion are most intense. Increasingly, children are claiming sexual identities at ever younger ages.

24. A study in the United States indicates that over 95% of the US population is heterosexual. (Gates, 2011). World-wide estimates of heterosexuality are essentially the same, some slightly less and some slightly more. During this period, studies have shown that past-year mental health diagnosis among youth indicate that 10% have a mood disorder, 25% an anxiety disorder, and 8.3% a substance related disorder. (Kessler, et al., 2012; Kessler, 2007; CDC, 2013). Additionally, suicide is the third leading cause of death for youth ages 10-14 and the second leading cause of death for ages 15-24. (Bostwick, et al., 2010). When LGBT individuals are included, they are at significantly greater risk of poor mental health: elevated risk for depression and mood disorders, anxiety disorders, PTSD, alcohol related disorders, and suicide ideation/intent. (Cochran, Sullivan, & Mays, 2003; Cochran, et al., 2007; Gilman, et al., 2001; Hatzenbuehler, Nolen-Hoeksema, Dovidio, 2009; Burgard, Cochran, Mays, 2005; Needham, 2012). Many studies demonstrate that severe distress, symptoms of mental illness, and behaviors related to these disorders are to be found in the LGBT population well before adulthood. (Fish & Pasley, 2015; Ueno, 2005; Eskin, Kaynak-Demir, & Demir 2005). US and international studies reveal a population with high levels of emotional distress, symptoms related to mood and anxiety disorders, self-harm, suicidal ideation and suicidal behavior compared to heterosexual youth. (Fergusson, et al., 2005; Fleming, et al., 2007; Marshal, et al., 2011).

ii. So-Called "Conversion Therapy" Bans Unscientifically Target and Censor Sound, Evidence-Based Practice Therapies Delivered Through Speech.

25. In my experience as a psychiatrist who sub-specializes in child and adolescent psychiatry, the population identifying as LGBT is at significantly greater risk of psychiatric illness and requires treatment—not predetermined goals of "affirmation" or "conversion." Laws that keep patients away from treatment harm these individuals. Laws that purport to ban "conversion" therapies and impose "affirming" therapies are such laws. Many of the youth I have encountered who claim LGBT status are confused, depressed, anxious, isolated, using substances, experiencing poor sleep, complain of physical symptoms, and can be self-harming and/or suicidal. They ruminate about peers and what parents will say and do. Highly distressed and uncertain, they seem relieved when I state that they are free to discuss whatever comes into their minds. Some are so anxious they admit to panic attacks when in public and with their peers in school. They remark that there is no one to talk to privately and brood about what to do. Distressed by thoughts that they cannot process, many resign to a distressed LGBT identity. Conversely, I have encountered minors who appear comfortable with being part of the LGBT group and understand that their peer group may be a source of stress and aggression. In this situation, the discussion centers on how best to handle such instances of stress and bullying or aggression, who to talk with, and how best to organize the therapy to meet their needs as the therapeutic process unfolds.

26. I have diagnosed and treated many individuals suffering from gender dysphoria and sexual instincts that disturb them and cause them significant discomfort. While diagnosing and treating a patient, I will offer educational observations based on my scientific understandings in psychiatry and child and adolescent psychiatry. As with all those who seek relief from pain and suffering, the type of therapy applied depends not on their sexual non-conformity or orientation, but rather on the needs of the patients to alleviate their pain and suffering. As a child and adolescent psychiatrist, I use no therapy that attempts to 'affirm' or 'convert', but rather I attempt to **restore** physical, mental, and civil functioning; a sense of gratitude; improved self-esteem; and an ability to observe oneself and make adjustments and adapt to varying situations. Evidence-based practice therapy for people suffering from gender dysphoria does not harm the patient but aims to help them explore root causes, alleviate their pain and suffering, and assist them with their dysphoria.

27. I and others who ethically practice psychiatry and child and adolescent psychiatry **never engage in physically aversive or verbally coercive treatments, as this kind of treatment is reprehensible, and is lacking in any evidence-based science.** Practices that knowingly attempt to coerce or harm patients have been repudiated by myself and others in my profession for several decades. I have taken the Hippocratic Oath and I have stated publicly that "I will use treatment to help the sick according to my ability and judgement, but never with a view to injury and wrong-doing." My therapy is a combination of evidence-based practice, both in terms of therapy through speech and psychopharmacology; and the objective is to heal. I do not harm patients, although therapy can be painful and pharmacologic treatment may have distressing side effects. Apart from occasional court-ordered therapy sessions, therapy is voluntary.

28. In my experience, children and adolescents suffering from gender dysphoria and identifying as 'transgender' presented with varying expectations for therapy. Some presented with a preconceived notion that I must identify as 'gay' in order to help them, and they preconditioned

therapy on my answering that inquiry. Some, though fewer, demanded full affirmation of their 'transgender' identity and/or expression as a precondition to my treating them. The minors I was most able to help, however, presented without preconditions, actively engaged in therapy, came to realize important issues about themselves, experienced a diminishment of their symptoms, admitted they had a better sense of how they became the persons they were, and were grateful for the therapy. In addition to speech-based therapy, this group usually also required pharmacologic treatment for a variety of psychiatric illnesses.

29. Within the group I have tried to help, however, some indicated reticence or doubt about my being able to help them because of California's law against so-called "conversion therapy." I allowed the patients within this group to talk and wonder freely, and the therapy approaches I used, as with all patients, depended on the symptoms presented and the character of the person. Their initial reticence caused by such 'conversion' bans, however, impacted the duration and initial effectiveness of treatment. I also have been told by many patients that they have friends who are afraid to seek help for their distress due to "the law" that prevents any therapist or physician from attempting to "convert them."

30. I am not aware of any evidence-based practice therapy that 'converts' someone from being 'transgender', and 'conversion' is never a therapeutic goal. But California's law, like Tampa's Ordinance 2017-47 banned any therapy approach that might lead to a person's changing from legal definitions of sexual orientation or from a 'transgender' identity. Thus, laws like Tampa's Ordinance 2017-47 negatively impact both practitioners and patients. Practitioners are afraid to provide, or have discontinued providing, psychiatric treatment for psychological pain and suffering related to gender dysphoria and identity because such treatment either violates or could be construed to violate the law against 'conversion therapy'. Patients are afraid to seek, or forego seeking, such therapy for the same reasons. While it was never clear to me how such a ban could ethically or fairly be enforced, or who would be qualified to enforce it, I apprehended that the California Medical Board would withdraw my license if I was found to be afoul of the law.

31. 'Conversion therapy' bans like Tampa's Ordinance 2017-47 impose de facto speech codes that subject practitioners to fear that they could be disciplined for saying the wrong thing. Although ethical practitioners in jurisdictions with such bans desire to provide psychiatric treatment to individuals suffering from gender dysphoria, they are increasingly concerned that treating such patients who identify as 'transgender' would jeopardize their careers.

32. I had a personal experience justifying these fears when an individual who came to a community clinic for treatment became extremely and publicly upset that I used the individual's legal name—for legal and ethical reasons—instead of the individual's preferred name which apparently was attached to the individual's cross-gender identity. This person filed an accusation of misconduct against me with the medical board and, although the case was dismissed and the records destroyed, I sensed how quickly my career could be derailed by simply using someone's legal name in apparent violation of 'affirming' principles.

33. Although the science of treating individuals who identify as 'transgender' is in the early stages of discovery, there are many evidence-based practice therapies that could be used to relieve the distress of gender dysphoria, whatever the direction of change that could occur for any particular patient. But practitioners are reluctant to treat such individuals, or have discontinued

treating such individuals, for fear of actually helping someone who may later a claim a violation of a 'conversion therapy' ban.

iii. So-Called 'Affirming' Therapy Is Not an Evidence-Based Practice and Imposes an Outcome Predetermined by Therapists.

34. So-called "affirmative" therapy, which is promoted by Ordinance 2017-47, is actually not therapy for the patient, but an instruction manual for the therapist to follow to declare and affirm, and how to understand those who identify as 'transgender' or among the gender nonconforming group. But simply affirming people are who they say they are is not diagnosing and not providing treatment or therapy but is instead 'reality nodding'. I have had countless patients inform me of their self-diagnoses, only to discover after further inquiry that their correct diagnoses are different from what they had believed. Hundreds of patients have told me what they believe to be causing their problems, and through therapy they discover that the etiology of their problems is distinctly different from what they had believed. Therapy is for the patient; and most patients drop out of therapy because therapy requires an inward-looking ability, and many will stop due to the difficulty with examining themselves. There is no evidence-based practice therapy specifically for LGBT people, only guidelines for the 'affirming' therapist to be informative, knowledgeable, understanding, sympathetic, and agreeable. But these guidelines are merely a baseline for how any psychiatrist or therapist should interact with anyone who seeks alleviation from pain and suffering. They do not, however, provide evidence-based practice therapy guidance that is needed by the patient to relieve their suffering.

35. Many publications purport to provide guidelines or standards for the therapy of those identifying as 'transgender', but there is no evidence-based practice therapy described in those same publications. The American Psychological Association (APA) published in 2015 its "Guidelines for Psychological Practice with Transgender and Gender Nonconforming People" ("APA, 2015"). However, guidelines are not evidence-based practice therapy. The World Professional Association for Transgender Health (WPATH) in 2011 published its "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Seventh Version" ("WPATH, 2011"). However, standards of care are not evidence-based practice therapy. What is discussed are social stressors, being culturally sensitive, stigma, psychiatric co-morbidities, suicidal ideations and/or suicidal intent, sexually transmitted diseases (STDs), and substance abuse. Busa & Lakshman (2018) authored the article, "A Review of Evidence Based Treatments for Transgender Youth Diagnosed with Social Anxiety Disorder." Contrary to its title, however, this article is not a review of evidence-based practice therapy for those identifying as 'transgender'; rather, it is a look into evidence-based practice for anxiety disorders. But the authors recommend that therapists "modify and adapt" their therapeutic approach with 'transgender' youth, which risks invalidating the evidence-based practice justification for the therapy. Another article characteristic of many of this type was authored by Hope, et al. (2016), "Culturally Competent Evidence-Based Behavioral Health Services for the Transgender Community: Progress and Challenges." This article title makes it appear that evidence-based practice therapy is taking place, but what the article actually describes is educating a therapist about how to understand the culture of being a 'transgender' and in "affirming" and "helping to transition."

36. The APA, 2015 guidelines are an explicit attempt to dictate a therapist's affirmation of a client's 'gender identity', irrespective of the science that reveals no one can become the

opposite sex. The article describes sixteen guidelines, the express purpose of which is for a psychologist to become a "trans-affirmative" psychologist. While the article states that guidelines are different from standards, in my experience, guidelines can quickly become standards. And given the possibility that the goals and self-chosen identity of a person who is asking a therapist for help may change over time, and given that no one can yet determine if change will occur in any particular individual, following the guidelines places a client in a situation where the outcome is already determined by the psychologist. To the extent the goal of therapy is 'know thyself', the 'thyself' is already preconceived by the guideline-following psychologist. People come to a mental health provider for many reasons, known and unknown, and to foreclose the possibility that change can occur in a direction not of the provider's choosing limits the person's freedom and autonomy, stalls therapeutic progress, and interferes with the natural course of healing.

37. Those in my profession know that many children will not retain a 'transgender' identity as adults, and that a significant majority will come to accept and psychologically align with their biological sex. (See Meyer-Bahlburg, 2002). Who can say with scientific certainty which child will become a 'transgender' adult and which will not? Banning evidence-based practice therapy is a harm to people seeking help with psychiatric illness; and it is perverse to ban a possible therapy that will for a majority of children help them reharmonize with their biological sex. (See, e.g., Meyer-Bahlburg, 2002, p. 360 (commending "treatment approach that speeds up the fading" of cross-gender behavior in children)). Additionally, there is no currently accepted evidence-based practice therapy for children who claim to be 'transgender'. I spend a significant amount of time working with parents to help them understand what is happening to their children; and this is important for the family to comprehend the diagnosis and the recommended treatment. Automatically affirming a child's claimed identity is not evidence-based practice, but rather a declaration of a future of being a life-long patient, cross-sex hormones, surgical destruction of healthy tissue and surgical side effects, life-long medical costs, and a life-long diagnosis of gender dysphoria with accompanying health problems such as sterility and loss of sexual pleasure. (Cretella, 2018). Any discussion of risk of harm resulting from therapy must include the mounting evidence of life-long potential harms from "affirming" therapy.

38. To affirm patients in denying the realities of their sex and the substantial likelihood of later psychological alignment with that sex is to withhold effective and holistic psychiatric care. This is reality: The practice of psychology and psychiatry is the art of assisting clients/patients with being able to live in the real world, in harmony with the circumstances they find themselves in, and to enjoin with the world in a manner that will allow them to live freely, in a civil way, and to associate with others to the benefit of themselves and society. The guidelines that are put forth by many professional organizations, simply to affirm a patient's denial of reality, is to withhold effective evidence-based practice and individual holistic psychiatric care. But the practice of psychiatry and psychology, at its essence, is the art of assisting patients and clients to live in harmony with reality.

I declare under penalty of perjury under the laws of the United States that the foregoing statements are true and accurate.

Executed this May 7, 2019.

Bernard Hudson MD
Bernard O. Hudson, M.D.

BERNARD O HUDSON MD

CURRICULUM VITAE

OFFICE TELEPHONE: PRIVATE

DATE AND PLACE OF BIRTH: MARCH 30, 1952
SACRAMENTO, CALIFORNIA

PERSONAL DATA: MARITAL STATUS MARRIED 05-31-1980
SPOUSE'S NAME MARSHA R HUDSON BS RN
CHILDREN'S DATA KARRIS R HUDSON 10-27-1980
TORRY S HUDSON 02-22-1987
*BRANDON J HUDSON 05-13-1988
*Deceased 07-18-2015

EDUCATION:

UNIVERSITY OF CALIFORNIA, SAN DIEGO
LA JOLLA CALIFORNIA 1975-1979
BACHELOR OF SCIENCE CHEMISTRY

LOYOLA UNIVERSITY
CARDINAL STRITCH SCHOOL OF MEDICINE
CHICAGO ILLINOIS 1979-1982

MEDICAL COLLEGE OF WISCONSIN
MILWAUKEE WISCONSIN 1982-1985
INTERNSHIP/RESIDENCY PSYCHIATRY

UNIVERSITY OF CALIFORNIA, DAVIS
SCHOOL OF MEDICINE
SACRAMENTO CALIFORNIA 1985-1987
C/A PSYCHIATRY FELLOWSHIP

CURRENT CME:

UNIVERSITY OF ARIZONA
COLLEGE OF MEDICINE 09-17, 3 CME

NEUROSCIENCE EDUCATION INSTITUTE
DEPARTMENT OF CONTINUING EDUCATION
11-17, 36 CME

TENNESSEE HEALTH RELATED BOARDS
TRAUMATIC BRAIN INJURY 10-17, 6 CME

EXHIBIT A

PROFESSIONAL EXPERIENCE:

Yolo County Day Treatment Program April 1986-December 1988
Broderick, California
Outpatient program for 8-10 adolescents
Provided psychiatric consultation to administration and clinical staff and diagnosis and treatment to adolescents.

California Youth Authority April 1987-October 1990
DeWitt Nelson School
Stockton, California
Provided psychiatric evaluations for Parole Board and emergency psychiatric evaluation.

Omnibus Mental Health Group June 1897-September 1991
Davis and Sacramento, California
Clinical practice involving diagnosis and treatment of children, adolescents, and adults. Provided supervision for Psychiatrists; Psychologists; Licensed Clinical Social Workers; Marriage, Family, And Child Counselors; and Master of Social Work Interns.

California Youth Authority April 1987-October 1990
DeWitt Nelson School
Stockton, California
Provided psychiatric evaluations for Parole Board and emergency psychiatric evaluation.

St. Patrick's Home for Children June 1987-September 1991
Sacramento, California
Residential Treatment Facility, 44 Bed
Provided clinical consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Sacramento Children's Home July 1987-July 1991
Sacramento, California
Residential Treatment Facility, 60 bed
Provided psychiatric emergency call and emergency consultation to clinical staff.

Regional Adolescent Treatment Program July 1988-July 1990
Stockton, California
Residential Treatment Facility, 42 bed
Provided clinical consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Serendipity Diagnostic and Treatment Center March 1988-Aug 1988
Citrus Heights, California
Residential Treatment Facility, 38 bed
Provided psychiatric consultation to administration and clinical staff and diagnosis and treatment to residents.

Regional Adolescent Treatment Program July 1988-July 1990
Stockton, California
Residential Treatment Facility, 42 bed
Provided clinical consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Sacramento County Juvenile Hall Sept 1988-Sept 1991
Sacramento, California
300 Bed Juvenile Detention Center
Provided psychiatric consultation to juvenile detention center administration and clinical staff and diagnosis and treatment to detainees.

F.O.R.M. School December 1988-October 1990
Nevada City, California
Residential Treatment Facility, 48 bed
Provided psychiatric consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Families First January 1989-October 1989
Davis, California
Residential Treatment Facility, 24 bed
Provided psychiatric consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Pine Point, Center, Inc. October 1993-October 1995
Jackson, Tennessee
Juvenile Sexual Offender Program
Medical Director
Residential Treatment Facility, 32 bed
Provided psychiatric consultation to residential administration and clinical staff and diagnosis and treatment to residents.

Pine Point, Center, Inc. February 1994-October 1995
Jackson, Tennessee
Juvenile Sexual Offender Program
Medical Director
Residential Treatment Facility, 16 bed
Provided medical oversight for nursing and clinical staff, quality assurance and improvement for medical services, and diagnosis and treatment for residents.

Hermitage Hall, Inc. October 1996-October 1999
Nashville, Tennessee
Juvenile Sexual Offenders Program
Medical Director
Residential Treatment Program, 95 bed
Provided medical oversight for nursing and clinical staff, quality assurance and improvement for medical services, and diagnosis and treatment for residents.

Dede Wallace School April 1998-January 1999
Nashville, Tennessee
Community Outpatient Clinic
Provided part-time psychiatric diagnosis and treatment to children and adolescents.

Jackson Academy September 1998-March 1999
Dickson, Tennessee
Residential Treatment Facility, 75 bed
Provided psychiatric consultation to administration and clinical staff and diagnosis and treatment to residents.

Camelot Care Centers, Inc. May 1999-December 1999
Nashville, Tennessee
Consulting Corporate Medical Director
Provided psychiatric consultation to administration regarding medical and mental health standards of practice.

Juvenile Justice Center April 2000-October 2000
Nashville, Tennessee
95 Bed Juvenile Detention Facility
Provided psychiatric consultation to administration, clinical training to probation staff and diagnosis and treatment to detainees.

Los Angeles County Nov 2000-Dec 2002
Department of Mental Health
Juvenile Justice Division
Locum Tenens – Staff Care, Inc.
Provided psychiatric diagnosis and treatment to juvenile hall and camp detainees.

Clinical Counseling Services July 2002-Aug 2004
Los Angeles, California
Community Mental Health Clinic
Provided psychiatric diagnosis and treatment to outpatients.

Los Angeles County January 2003-December 2017 **(RETIRED)**
Department of Mental Health
Juvenile Justice Division
Staff Psychiatrist
Provided psychiatric diagnosis and treatment to juvenile hall and camp detainees.

Centerstone of Tennessee January 2018- December 2018
Frank Luton Center
Staff Psychiatrist
Provided psychiatric diagnosis and treatment to outpatients.

ADULT PSYCHIATRY:

Sacramento County Jail April 1986-September 1988
Sacramento, California
Provided psychiatric diagnosis and treatment to jail inmates on the Forensic Inpatient Unit, a 20 bed acute care setting.

Criminal Justice Center April 2000-December 2000
Nashville, Tennessee
Davidson County Jail
Provided psychiatric diagnosis and treatment to jail inmates.

NATIONAL HEALTH AND SERVICE CORPS:

Bluegrass Mental Health and Mental Retardation Board, Inc. Sept 1991-January 1992
Lexington, Kentucky
Child, Adolescent, and Adult Psychiatry
Temporary Placement
Provided psychiatric consultation to mental health clinic administration and clinical staff and psychiatric diagnosis and treatment to outpatients covering four separate community mental health clinics.

Carey Counseling Center, Inc. November 1992-August 1995
Paris, Tennessee
Child, Adolescent, and Adult Psychiatry
Permanent Placement
Provided psychiatric consultation to mental health clinic administration and clinical staff and psychiatric diagnosis and mental health clinics, a residential treatment facility of 16 beds, and a therapeutic preschool of 12 children.

ACADEMIC APPOINTMENTS:

University of California, Davis School of Medicine July 1987-September 1991
Sacramento, California
Clinical Instructor of Psychiatry

Vanderbilt University School of Medicine August 1995-August 2000
Department of Psychiatry
Division of Child and Adolescent Psychiatry
Nashville, Tennessee
Assistant Professor of Psychiatry

Vanderbilt University August 1995-September 1998
School of Medicine
Department of Psychiatry
Division of Child and Adolescent Psychiatry
Psychiatric Hospital at Vanderbilt
Nashville, Tennessee
Clinical Director, Partial Hospitalization Program for Adolescents

Vanderbilt University January 1998-July 2000
School of Medicine
Vanderbilt University Children's Hospital
Department of Psychiatry
Division of Child and Adolescent Psychiatry
Nashville, Tennessee
Director, Consultation/Liaison Service

Vanderbilt University 1997-1998
School of Medicine
Department of Psychiatry
Division of Child and Adolescent Psychiatry
Nashville, Tennessee
J. E. Dozier Award: Outstanding Teacher in Child and Adolescent Psychiatry

FORENSIC PSYHIATRIC CONSULTATION:

Mississippi Protection and Advocacy, Inc. July 1997-Jan 1998
Jack Bach, JD
Investigation into psychiatric standards at East Mississippi State Hospital.

United States Department of Justice August 1997-Feb 1998
Civil Rights Division
Special Litigation Section
Kevin Russell, JD
Investigation into medical/psychiatric conditions in Georgia's juvenile detention facilities.

United States Department of Justice April 1998-January 2000
Civil Rights Division
Special Litigation Section
Kevin Russell, JD
Investigation into medical/psychiatric conditions in Louisiana juvenile detention facilities.

LICENSURE AND CERTIFICATION:

MEDICAL LICENSURE-

WISCONSIN	25297	07-01-1983	EXPIRED
CALIFORNIA	G55362	07-16-1985	RETIRED 3/31/19
KENTUCKY	TEMPORARY		EXPIRED
TENNESSEE	MD25085		CURRENT

SPECIALTY BOARD CERTIFICATION
GENERAL PSYCHIATRY (ADULT)
AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
CERTIFICATION NUMBER 31466
1989

CHILD AND ADOLESCENT PSYCHIATRY
AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
CERTIFICATION NUMBER 3269
1993

NATIONAL BOARD OF PHYSCIANS AND SURGEONS
GENERAL PSYCHIATRY (ADULT)
2017

NATIONAL BOARD OF PHYSCIANS AND SURGEONS
CHILD/ADOLESCENT PSYCHIATRY
2017

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Burgard, S.A., Cochran, S.D., Mays, V.M. (2005). Alcohol and Tobacco Use Patterns Among Heterosexually and Homosexually Experienced California Women. *Drug Alcohol Depend.*, 77, 61–70.

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City of Tampa Ordinance 2017-47, An Ordinance Of The City Of Tampa, Florida, Relating To Conversion Therapy On Patients Who Are Minors (and all publications cited therein).

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Cochran, S.D., Sullivan, J.G., Mays, V.M. (2003). Prevalence of Mental Disorders, Psychological Distress, and Mental Health Services Use Among Lesbian, Gay, and Bisexual Adults in the United States. *J. Consult. Clin. Psychol.*, 71, 53–61.

Cook, S.C., Schwartz, A.C., Kaslow, N.J. (2017). Evidence-Based Psychotherapy: Advantages and Challenges. *Neurotherapeutics*, 14 (3), 537–545. doi:10.1007/s13311-017-0549-4.

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and evidence-based psychological interventions. *International Journal of Methods in Psychiatric Research*, 23 (S1), 58–91.

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First Amended Verified Complaint for Declaratory, Preliminary and Permanent Injunctive Relief, and Damages (Doc. 78, June 12, 2018), *Vazzo, et al. v. City of Tampa, Fla.*, No. 8:17-cv-02896-CEH-AAS, U.S. Dist. Ct., M.D. Fla.

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