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al.*

14 **IN THE UNITED STATES DISTRICT COURT**  
15 **FOR THE NORTHERN DISTRICT OF CALIFORNIA**

16 CITY AND COUNTY OF SAN FRANCISCO,  
17 Plaintiff,  
18 vs.  
19 ALEX M. AZAR II, et al.,  
Defendants.

No. C 19-02405 WHA  
*Related to*  
No. C 19-02769 WHA  
No. C 19-02916 WHA

20 STATE OF CALIFORNIA, by and through  
ATTORNEY GENERAL XAVIER BECERRA,  
21 Plaintiff,  
22 vs.  
23 ALEX M. AZAR, et al.,  
Defendants.

**DECLARATION OF DR. RANDI C.  
ETTNER, PH.D. IN SUPPORT OF  
PLAINTIFFS' MOTION FOR SUMMARY  
JUDGMENT**

24 COUNTY OF SANTA CLARA, et al.  
25 Plaintiffs,  
26 vs.  
27 U.S. DEPARTMENT OF HEALTH AND  
HUMAN SERVICES, et al.,  
28 Defendants.

1 I, Dr. Randi C. Ettner, declare as follows:

2 1. I have been retained by counsel for Plaintiffs Trust Women Seattle, Los Angeles  
3 LGBT Center, Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health, Bradbury-Sullivan  
4 LGBT Community Center, Center On Halsted, Hartford Gyn Center, Mazzone Center, Medical  
5 Students For Choice, AGLP: The Association Of LGBTQ+ Psychiatrists, American Association of  
6 Physicians for Human Rights d/b/a Glma: Health Professionals Advancing LGBTQ Equality,  
7 Colleen Mcnicholas, Robert Bolan, Ward Carpenter, Sarah Henn, and Randy Pumphrey as an  
8 expert in connection with the above-captioned matter.

9  
10 2. I submit this expert declaration based on my personal knowledge.

11 3. If called to testify in this matter, I would testify truthfully and based on my expert  
12 opinion.

13  
14 **I. BACKGROUND AND QUALIFICATIONS**

15 **Qualifications and Basis for Opinion**

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

21  
22 5. I was the chief psychologist at the Chicago Gender Center from 2005 to 2016, when  
23 it moved to Weiss Memorial Hospital. Since that time, I have held the sole psychologist position  
24 at the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. A true and accurate  
25 copy of my curriculum vitae is attached as Exhibit A to this declaration.

26 6. I have evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with  
27 gender dysphoria and mental health issues related to gender variance from 1980 to present. I have  
28

1 published four books related to the treatment of individuals with gender dysphoria, including the  
2 medical text entitled Principles of Transgender Medicine and Surgery (1st edition, co-editors  
3 Monstrey & Eyler; Rutledge 2007; and 2nd edition, coeditors Monstrey & Coleman; Routledge,  
4 June 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the  
5 provision of health care to the transgender population.  
6

7 7. I have served as a member of the University of Chicago Gender Board, and am on  
8 the editorial boards of *The International Journal of Transgenderism and Transgender Health*. I  
9 am the secretary and a member of the Board of Directors of the World Professional Association of  
10 Transgender Health (WPATH), and an author of the WPATH *Standards of Care for the Health of*  
11 *Transsexual, Transgender and Gender Nonconforming People* (7th version), published in 2011.  
12 The WPATH promulgated *Standards of Care* (“*Standards of Care*”) are the internationally  
13 recognized guidelines for the treatment of persons with gender dysphoria and serve to inform  
14 medical treatment in the United States and throughout the world.  
15

16 8. I chair the WPATH Committee for Institutionalized Persons, and provide training  
17 to medical professionals on healthcare for transgender inmates. I have lectured throughout North  
18 America, South America, Europe, and Asia on topics related to gender dysphoria and present grand  
19 rounds on gender dysphoria at university hospitals. I am the honoree of the externally-funded Randi  
20 and Fred Ettner Fellowship in Transgender Health at the University of Minnesota. I have been an  
21 invited guest at the National Institute of Health to participate in developing a strategic research plan  
22 to advance the health of sexual and gender minorities, and in November 2017 was invited to address  
23 the Director of the Office of Civil Rights of the United States Department of Health and Human  
24 Services regarding the medical treatment of gender dysphoria. I received a commendation from  
25 the United States Congress House of Representatives on February 5, 2019 recognizing my work  
26 for WPATH and GD in Illinois.  
27  
28



1 Immig. Rev. 2017); *Broussard v. First Tower Loan, LLC*, 135 F. Supp. 3d 540 (E.D. La. 2016);  
2 *Faiella v. American Medical Response of Connecticut, Inc.*, No. HHD-CV15-6061263-S (Conn.  
3 Super. Ct.); *Kothmann v. Rosario*, 558 F. App'x 907 (11th Cir. 2014).

## 4 **II. EXPERT OPINIONS**

### 5 **Gender Identity and Gender Dysphoria**

6  
7 13. A person's sex is comprised of a number of components including, *inter alia*:  
8 chromosomal composition (detectable through karyotyping); gonads and internal reproductive  
9 organs (detectable by ultrasound, and occasionally by a physical pelvic exam); external genitalia  
10 (which are visible at birth); sexual differentiations in brain development and structure (detectible  
11 by functional magnetic resonance imaging studies and autopsy); and gender identity.

12  
13 14. Gender identity is a well-established concept in medicine. Gender identity refers to  
14 a person's inner sense of belonging to a particular sex, such as male or female. It is a deeply felt  
15 and core component of human identity. All human beings develop this elemental internal view:  
16 the conviction of belonging to a particular gender, such as male or female. Gender identity is innate,  
17 has biological underpinnings, and is firmly established early in life.

18  
19 15. When there is divergence between anatomy and identity, one's gender identity is  
20 paramount and the primary determinant of an individual's sex designation. Developmentally, it is  
21 the overarching determinant of the self-system, influencing personality, a sense of mastery,  
22 relatedness, and emotional reactivity, across the life span. It is also the foremost predictor of  
23 satisfaction and quality of life. Efforts to change an individual's gender identity are harmful, futile,  
24 and unethical.

25  
26 16. At birth, individuals are assigned a sex, typically male or female, based solely on  
27 the appearance of their external genitalia. For most people, that assignment turns out to be accurate,  
28

1 and their birth-assigned sex matches that person’s actual sex. However, for transgender individuals,  
2 this is not the case.

3 17. For transgender individuals, the sense of one’s self—one’s gender identity—differs  
4 from the sex they were assigned at birth, giving rise to a sense of being “wrongly embodied.”

5  
6 18. The medical diagnosis for that feeling of incongruence and accompanying distress  
7 is gender dysphoria, a serious medical condition, formerly known as gender identity disorder  
8 (“GID”). Gender Dysphoria is a diagnosis codified in the fifth edition of the *Diagnostic and*  
9 *Statistical Manual of Mental Disorders* (“DSM-5”). The critical element of the Gender Dysphoria  
10 diagnosis is the presence of symptoms that meet the threshold for clinical impairment. This  
11 represents a change from GID, which focused on an individual’s *identity* being disordered. This  
12 new diagnostic term, Gender Dysphoria, is also an acknowledgment that gender incongruence, in  
13 and of itself, does not constitute a mental disorder. As recently as June 16, 2018, the World Health  
14 Organization (“WHO”) likewise announced it was reclassifying the gender incongruence diagnosis  
15 in the forthcoming International Classification of Diseases-11 (“ICD-11”). This is significant  
16 because it removes “gender identity disorder” from the chapter on mental and behavioral disorders,  
17 recognizing that gender incongruence is not a mental illness, and instead incorporates it within a  
18 new chapter dedicated to sexual health.

19  
20 19. The condition is characterized by incongruence between one’s  
21 experienced/expressed gender and assigned sex at birth, and clinically significant distress or  
22 impairment of functioning that results. Gender dysphoria is manifested by symptoms such as  
23 preoccupation with ridding oneself of the primary and/or secondary sex characteristics associated  
24 with one’s birth- assigned sex. Untreated gender dysphoria can result in significant clinical distress,  
25 debilitating depression, and suicidality.

26  
27 20. The diagnostic criteria for gender dysphoria in adults are as follows:  
28

- 1 a. A marked incongruence between one's experienced/expressed gender and  
 2 assigned gender, of at least 6 month's duration, as manifested by at least two of  
 3 the following:
- 4 i. A marked incongruence between one's experienced/expressed gender  
 and primary and/or secondary sex characteristics.
  - 5 ii. A strong desire to be rid of one's primary and/or secondary sex  
 characteristics.
  - 6 iii. A strong desire for the primary and/or secondary sex characteristics of  
 the other gender.
  - 7 iv. A strong desire to be of the other gender.
  - 8 v. A strong desire to be treated as the other gender.
  - 9 vi. A strong conviction that one has the typical feelings and reactions of the  
 other gender.
- 10 b. The condition is associated with clinically significant distress or impairment in  
 11 social, occupational, or other important areas of functioning.

12 21. Gender dysphoria is a highly treatable condition. Without treatment, however,  
 13 individuals with gender dysphoria experience anxiety, depression, suicidality, and other attendant  
 14 mental health issues. They are also frequently isolated because they carry a burden of shame and  
 15 low self-esteem, attributable to the feeling of being inherently "defective." This leads to  
 16 stigmatization, and over time, ravages healthy personality development and interpersonal  
 17 relationships. As a result, without treatment many such individuals are unable to function  
 18 effectively in daily life. Studies show a 41%-43% rate of suicide attempts among this population,  
 19 far above the baseline for North America (Haas et al., 2014).

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

24 23. Gender dysphoria generally intensifies with age. As gender dysphoric individuals  
 25 approach middle age, they experience an exacerbation of symptoms (Ettner, 2013; Ettner & Wiley,  
 26 2013).  
 27  
 28

## Treatment of Gender Dysphoria

1  
2 24. The standards of care for treating gender dysphoria are set forth in the WPATH  
3 *Standards of Care*, first published in 1979. The *Standards of Care* are the internationally  
4 recognized guidelines for the treatment of persons with gender dysphoria, and inform medical  
5 treatment throughout the world, and in this country. The American Medical Association, the  
6 Endocrine Society, the American Psychological Association the American Psychiatric Association,  
7 the World Health Organization, the American Academy of Family Physicians, the American Public  
8 Health Association, the National Association of Social Workers, the American College of  
9 Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse protocols in  
10 accordance with the WPATH standards. See, e.g., American Medical Association (2008)  
11 Resolution 122 (A-08); *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons:*  
12 *An Endocrine Society Clinical Practice Guideline* (2017); American Psychological Association  
13 Policy Statement on Transgender, Gender Identity & Gender Expression Non-discrimination  
14 (2008).

15  
16  
17 25. The Standards of Care identify the following evidence-based protocols for the  
18 treatment of individuals with gender dysphoria:

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

27 26. The ability to live in a manner consistent with one's gender identity is critical to a  
28 person's health and well-being and is a key aspect in the treatment of gender dysphoria. The  
process by which transgender people come to live in a manner consistent with their gender identity,  
rather than the sex they were assigned at birth, is known as transition. The steps that each

1 transgender person takes to transition are not identical. Whether any particular treatment is  
2 medically necessary or even appropriate depends on the medical needs of the individual.

3 27. Once a diagnosis is established, a treatment plan should be developed based on the  
4 individualized assessment of the medical needs of the patient. WPATH specifies that treatment  
5 plans and provision of care must be undertaken by qualified professionals, with established  
6 competencies in the treatment of gender dysphoria (Section VIII).  
7

8 28. **Psychotherapy:** Psychotherapy can provide support and help with many issues that  
9 arise in tandem with gender dysphoria. However, psychotherapy alone is not a substitute for  
10 medical intervention when medical interventions are required, nor is it a precondition for medically  
11 indicated treatment. By analogy, counseling can be useful for patients with diabetes by providing  
12 psychoeducation about living with chronic illness and nutritional information, but counseling does  
13 not obviate the need for insulin.  
14

15 29. **Social Role Transition:** The *Standards of Care* establish the therapeutic  
16 importance of changes in gender expression and presentation—the ability to feminize or  
17 masculinize one’s appearance— as a critical component of treatment. Known as the “real life  
18 experience,” it requires dressing, grooming, and otherwise conveying, via social signifiers, a public  
19 face and role consistent with one’s gender identity. This is an appropriate and essential part of  
20 identity consolidation. Through this experience, the transgender individual can begin to address  
21 the shame some experience of growing up living as a “false self” and the grief of being born in the  
22 “wrong body.” (Greenberg and Laurence, 1981; Ettner, 1999; Devor, 2004; Bockting, 2007.)  
23

24 30. **Hormone Therapy:** For individuals with persistent, well-documented gender  
25 dysphoria, hormone therapy is an essential, medically indicated treatment to alleviate the distress  
26 of the condition. Cross sex hormone administration is a well-established and effective treatment  
27 modality for gender dysphoria. The American Medical Association, the Endocrine Society, the  
28

1 American Psychiatric Association and the American Psychological Association all concur that  
2 hormone therapy, provided in accordance with the WPATH *Standards of Care*, is the medically  
3 necessary, evidence-based, best practice care for most patients with gender dysphoria.

4         31. The goals of hormone therapy are (1) to significantly reduce hormone production  
5 associated with the person's birth sex, causing the unwanted secondary sex characteristics to  
6 recede, and (2) to replace the natal, circulating sex hormones with either feminizing or  
7 masculinizing hormones, using the principles of hormone replacement treatment developed for  
8 hypogonadal patients (i.e. those born with insufficient sex steroid hormones). *See Endocrine*  
9 *Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical*  
10 *Practice Guideline* (2017); *Endocrine Treatment of Transsexual Persons: An Endocrine Society*  
11 *Clinical Practice Guideline* (2009).

12  
13  
14         32. The therapeutic effects of hormone therapy are twofold: (1) with endocrine  
15 treatment, the patient acquires congruent secondary sex characteristics, i.e., breast development,  
16 redistribution of body fat, cessation of male pattern baldness, and reduction of body hair; and (2)  
17 hormones act directly on the brain, via receptor sites, attenuating the dysphoria and attendant  
18 psychiatric symptoms, and promoting a sense of well-being.

19         33. For many patients, hormones alone will not provide sufficient breast development  
20 to approximate the female torso. For these patients, breast augmentation has a dramatic,  
21 irreplaceable, and permanent effect on reducing gender dysphoria, and thus unquestionable  
22 therapeutic results.

23  
24         34. **Surgical Treatment:** For individuals with severe gender dysphoria, hormone  
25 therapy alone is insufficient. In these cases, dysphoria does not abate without surgical intervention.  
26 For transgender women, genital confirmation surgery has two therapeutic purposes. First, removal  
27 of the testicles eliminates the major source of testosterone in the body. Second, the patient attains  
28

1 body congruence resulting from the normal appearing and functioning female uro-genital  
2 structures. Both outcomes are crucial in attenuating or eliminating gender dysphoria. Additionally,  
3 breast augmentation procedures play the critical role in treatment mentioned in the paragraph  
4 immediately above.

5  
6 35. Decades of methodologically sound and rigorous scientific research have  
7 demonstrated that gender confirmation surgery is a safe and effective treatment for severe gender  
8 dysphoria and, indeed, for many, it is the only effective treatment. The American Medical  
9 Association, the Endocrine Society, the American Psychological Association, and the American  
10 Psychiatric Association all endorse surgical therapy, in accordance with the WPATH *Standards of*  
11 *Care*, as medically necessary treatment for individuals with severe gender dysphoria. *See*  
12 *American Medical Association (2008), Resolution 122 (A-08); Endocrine Treatment of Gender-*  
13 *Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (2017)*  
14 *(“For many transgender adults, genital gender-affirming surgery may be the necessary step toward*  
15 *achieving their ultimate goal of living successfully in their desired gender role.”); American*  
16 *Psychological Association Policy Statement on Transgender, Gender Identity and Gender*  
17 *Expression Nondiscrimination (2009) (recognizing “the efficacy, benefit and medical necessity of*  
18 *gender transition treatments” and referencing studies demonstrating the effectiveness of sex-*  
19 *reassignment surgeries).*

20  
21  
22 36. Surgeries are considered “effective” from a medical perspective, if they “have a  
23 therapeutic effect” (Monstrey et al. 2007). More than three decades of research confirms that  
24 gender confirmation surgery is therapeutic and therefore an effective treatment for gender  
25 dysphoria. Indeed, for many patients with severe gender dysphoria, gender confirmation surgery  
26 is the only effective treatment.  
27  
28

1           37. In a 1998 meta-analysis, Pfafflin and Junge reviewed data from 80 studies, from 12  
2 countries, spanning 30 years. They concluded that “reassignment procedures were effective in  
3 relieving gender dysphoria. There were few negative consequences and all aspects of the  
4 reassignment process contributed to overwhelmingly positive outcomes” (Pfafflin & Junge 1998).

5  
6           38. Numerous subsequent studies confirm this conclusion. Researchers reporting on a  
7 large-scale prospective study of 325 individuals in the Netherlands concluded that after surgery  
8 there was “a virtual absence of gender dysphoria” in the cohort and “results substantiate previous  
9 conclusions that sex reassignment is effective” (Smith et al. 2005). Indeed, the authors of the study  
10 concluded that the surgery “appeared therapeutic and beneficial” across a wide spectrum of factors  
11 and “[t]he main symptom for which the patients had requested treatment, gender dysphoria, had  
12 decreased to such a degree that it had disappeared.”

13  
14           39. As a general matter, patient satisfaction is a relevant measure of effective treatment.  
15 Achieving functional and normal physical appearance consistent with gender identity alleviates the  
16 suffering of gender dysphoria and enables the patient to function in everyday life. Studies have  
17 shown that by alleviating the suffering and dysfunction caused by severe gender dysphoria, gender  
18 confirmation surgery improves virtually every facet of a patient’s life. This includes satisfaction  
19 with interpersonal relationships and improved social functioning (Rehman et al., 1999; Johansson  
20 et al., 2010; Hepp et al.; 2002; Ainsworth & Spiegel, 2010; Smith et al., 2005); improvement in  
21 self-image and satisfaction with body and physical appearance (Lawrence, 2003; Smith et al., 2005;  
22 Weyers et al., 2009); and greater acceptance and integration into the family (Lobato et al., 2006).

23  
24           40. Studies have also shown that surgery improves patients’ abilities to initiate and  
25 maintain intimate relationships (Lobato et al., 2006; Lawrence, 2005; Lawrence, 2006; Imbimbo et  
26 al., 2009; Klein & Gorzalka, 2009; Jarolim et al., 2009; Smith et al., 2005; Rehman et al., 1999;  
27 DeCuyper et al., 2005).

28

1           41.     Given the decades of extensive experience and research supporting the effectiveness  
2 of gender confirmation surgery, it is clear that reconstructive surgery is a medically necessary, not  
3 experimental, treatment for gender dysphoria. Therefore, decades of peer-reviewed research and a  
4 medical consensus support the inclusion of gender confirmation surgery as a medically necessary  
5 treatment in the WPATH *Standards of Care*.

6  
7           42.     In 2016 WPATH issued a “Position Statement on Medical Necessity of Treatment,  
8 Sex Reassignment, and Insurance Coverage in the U.S.A.” (“Position Statement”), affirming a  
9 statement originally issued in 2008. As the Position Statement explains, “These medical procedures  
10 and treatment protocols are not experimental: Decades of both clinical experience and medical  
11 research show they are essential to achieving well-being for the transsexual patient.”

12  
13           43.     Similarly, Resolution 122 (A-08) of the American Medical Association states:  
14 “Health experts in GID, including WPATH, have rejected the myth that these treatments are  
15 ‘cosmetic’ or ‘experimental’ and have recognized that these treatments can provide safe and  
16 effective treatment for a serious health condition.”

17           44.     On May 30, 2014, the Appellate Division of the Departmental Appeals Board of the  
18 United States Department of Health and Human Services issued decision number 2576, in which  
19 the Board determined that Medicare’s policy barring coverage for transition-related surgeries was  
20 not valid under the “reasonableness standard.” The Board found that the ban “was based principally  
21 on” a report from 1981 that has been rendered obsolete by numerous “medical studies published in  
22 the more than 32 years since issuance of the 1981 report.” The Board specifically concluded that  
23 transition-related surgeries are “safe and effective and not experimental.” As a result, Medicare’s  
24 exclusion was struck down and Medicare was directed to consider surgeries on a case-by-case basis.  
25  
26  
27  
28

1           45. The overwhelming scientific evidence indicates that transition-related care,  
2 including gender confirmation surgery, is medically necessary for the treatment of gender  
3 dysphoria in some patients.

4           46. Equating treatment gender confirmation surgery that has been prescribed to treat  
5 gender dysphoria with sterilization is medically inaccurate. Procedures undertaken for the purpose  
6 of sterilization are distinct from medical procedures undertaken for other purposes that incidentally  
7 affect reproductive function.

8           47. For some transgender people who desire children, reproduction may be possible  
9 even when such individuals have obtained transition-related medical care. For example, prior to  
10 the initiation of cross sex hormones, the preservation of gametes allows for future possible  
11 conception. If hormonal treatment for gender dysphoria has been initiated, it can be discontinued,  
12 and harvesting to retrieve gametes or stimulation of testicles or ovaries can be utilized for  
13 conception. In addition, for transgender men who retain a uterus, the discontinuation of  
14 masculinizing hormones may allow for pregnancy and childbirth.

#### 15                           **The Harmful Effects of Denial-of-Care to Transgender People**

16           48. The overarching goal of treatment is to eliminate the distress of gender dysphoria  
17 by aligning an individual patient's body and presentation with their internal sense of self, thereby  
18 consolidating identity. Developing and integrating a positive sense of self-identity formation is a  
19 fundamental undertaking for all human beings. Denial of medically indicated care to transgender  
20 people based on moral or religious objections signals that such people are "inferior" or "unworthy,"  
21 and triggers shame. The "Denial of Care Rule" provides a license to discriminate and challenges  
22 the legitimacy of identity. In so doing, the Rule erodes resilience and poses lifelong health risks to  
23 transgender and gender nonconforming individuals, including depression, posttraumatic stress  
24 disorder, cardiovascular and other disease, premature death and suicide.

1           49.     A wealth of research establishes that transgender people suffer from discrimination,  
2 stigma and shame. The “minority stress model” explains that the negative impact of the stress  
3 attached to being stigmatized is socially based. The stress process can be both external, *i.e.*, actual  
4 experiences of rejection and discrimination (enacted stigma), and as a result of such experiences,  
5 internal, *i.e.*, perceived rejection and the expectation of being rejected or discriminated against (felt  
6 stigma). A 2015 study of 28,000 transgender and gender nonconforming individuals found that  
7 30% reported being fired, discriminated or otherwise experiencing mistreatment in the workplace.  
8 Similarly, 31% of respondents had been mistreated in a public place, including 14% who were  
9 denied service, 24% who were verbally harassed and 2% who were physically attacked.

11           50.     This discrimination, often in the form of violence, abuse or harassment, is related to  
12 negative health outcomes. A 2012 study of transgender adults found fear of discrimination  
13 increased the risk of developing hypertension by 100%, owing to the intersectionality of shame and  
14 cardiovascular reactivity. Indeed, a 2012 study of discrimination and implications for health  
15 concluded: “living in states with discriminatory policies . . . was associated with a statistically  
16 significant increase in the number of psychiatric disorder diagnoses.” Another study found  
17 transgender adults’ access to college bathrooms and housing was related to suicidality.

19           51.     Until recently, it was not fully understood that these experiences of shame and  
20 discrimination could have serious and enduring consequences. But it is now known that  
21 marginalization, stigmatization and victimization are some of the most powerful predictors of  
22 current and future mental health problems, including the development of psychiatric disorders. The  
23 social problems that young transgender people face actually create the blueprint for future mental  
24 health, life satisfaction, and even physical health. A recent study of 245 gender-nonconforming  
25 adults found that stress and victimization during childhood and adolescence was associated with a  
26 greater risk for post-traumatic stress disorder, depression, life dissatisfaction, anxiety, and  
27  
28

1 suicidality in adulthood. A 2011 Institute of Medicine (IOM) report concurs: “the marginalization  
2 of transgender people from society is having a devastating effect on their physical and mental  
3 health.” And the American Journal of Public Health recently reported that more than half of  
4 transgender women “struggle with depression from the stigma, shame and isolation caused by how  
5 others treat them.”

6  
7 52. Conversely, Bauer et al. found a 62% reduction in risk of suicide ideation with the  
8 completion of medical transition. That corresponds to a potential prevention of 240 suicide  
9 attempts per 1,000 per year.

10 53. There is a growing body of documentation that structural forms of stigma (policies)  
11 harm the health of transgender people. For example, a 2018 study showed that structural stigma  
12 affects the health and well-being of LGBTQ people and leads to psychological harm. In other  
13 words, stigma—a chronic source of psychological stress—negatively affects health by disrupting  
14 physiological pathways, increases disease vulnerability, causes psychological harm, and possibly  
15 leads to premature death.

16  
17 54. Adding to the corpus of research in this area is a relatively new approach to the  
18 investigation of the relationship between discrimination and health. Neuroscientists have  
19 discovered that, in addition to causing serious emotional difficulties and physical harms,  
20 discrimination, harassment and verbal abuse permanently alter the architecture of the brain.  
21 Deviations in the myelin sheathing of the corpus callosum and damage to the hippocampus cause  
22 cognitive difficulties in individuals who have been routinely subjected to humiliation and  
23 ostracism.

24  
25 55. Transgender individuals currently face significant discrimination in health care  
26 settings and barriers to care. Forty percent (40%) fear accessing care, and forego routine screening  
27 and preventative care. A 2017 report by the Center for American Progress of 7,500 transgender  
28

1 adults found 29 % were refused treatment based on their gender identity and 21 % were verbally  
2 abused when seeking healthcare. The report also found that transgender individuals often had to  
3 travel to other states to find medical providers. A 2018 survey of 6,450 participants found 24%  
4 were denied treatment in doctor’s offices or hospitals, 13% in emergency rooms, 11% in mental  
5 health clinics and 5% for ambulance or emergency medical services. These experiences lead  
6 transgender patients to be less likely to advocate on their own behalves out of fear of discrimination  
7 and stigma, and to sometimes forego time-sensitive health care. As a result, transgender individuals  
8 have poorer health, greater stress, and higher rates of obesity, even when compared to lesbian and  
9 gay populations. Indeed, 23% of respondents to a 2015 study did not see a doctor when they needed  
10 to because of fear of being mistreated as a transgender person. These findings led to the Association  
11 of American Medical Colleges to convene an advisory committee to develop curricula based on  
12 competencies for medical education.  
13  
14

15 56. “The Denial of Care Rule” further endangers the health and well-being of vulnerable  
16 individuals by permitting providers to refuse healthcare on the basis of religious or moral objections  
17 to transgender individuals’ identities. The Rule seeks to create a license to discriminate, posing a  
18 serious risk to transgender people. The harms that will befall transgender people are predictable  
19 and dire: the exacerbation of symptoms of gender dysphoria, grave damage to mental and physical  
20 health, and the undermining of clearly established, evidence based treatment protocols.  
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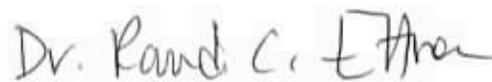
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I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated this 8 day of September, 2019.

Respectfully submitted,



Dr. Randi C. Ettner

# EXHIBIT A

*Curriculum Vitae*

**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 Institutionalized 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: Weiss Memorial Hospital Center for Gender Confirmation Surgery  
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**

*Mental health issues in transgender health care*, American Medical Student Association, webinar presentation, 2019

*Sticks and stones: Childhood bullying experiences in lesbian women and transmen*, Buenos Aires, 2018

*Gender identity and the Standards of Care*, American College of Surgeons, Boston, MA, 2018  
*The mental health professional in the multi-disciplinary team, pre-operative evaluation and assessment for gender confirmation surgery*, American Society of Plastic Surgeons, Chicago, IL, 2018; Buenos Aires, 2018

*Navigating Transference and Countertransference Issues*, WPATH global education initiative, Portland, OR; 2018

*Psychological aspects of gender confirmation surgery* International Continence Society, Philadelphia, PA 2018

*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, IL, 2017.

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

*Transgender 101 for Surgeons*, American Society of Plastic Surgeons, Chicago, IL, 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, IL, 2015; Atlanta, GA, 2016; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017,

Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018

*Pre-operative evaluation in gender-affirming surgery*-American Society of Plastic Surgeons, Boston, MA, 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 transgender 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

*Psychonueroimmunology 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 transmen. *Journal of Child and Adolescent Psychiatry*.

Narayan, S., Danker, S Esmonde, N., Guerriero, J., Carter, A., Dugi III, D., Ettner, R., Radix A., Bluebond-Langner, R., Schechter, L., Berli, J. (2018) A survey study of surgeons' experience with regret and reversal of gender-confirmation surgeries as a basis for a multidisciplinary approach to a rare but significant clinical occurrence, submitted.

Ettner, R. Mental health evaluation. *Clinics in Plastic Surgery*. (2018) Elsevier, 45(3): 307-311.

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Ettner, R. Pre-operative evaluation in Schechter (Ed.) Surgical Management of the Transgender Patient. Elsevier, 2017.

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.

Ettner, R., Ettner, F. & White, T. Choosing a surgeon: an exploratory study of factors influencing the selection of a gender affirmation surgeon. *Transgender Health*, 1(1), 2016.

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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.

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

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.

White, T. and Ettner, R. Adaptation and adjustment in children of transsexual parents. *European Journal of Child and Adolescent Psychiatry*, 2007: 16(4)215-221.

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Ettner, R., White, T., Brown, G., and Shah, B. Client aggression towards therapists: Is it more or less likely with transgendered clients? *International Journal of Transgenderism*, Vol. 9(2), 2006.

Ettner, R. and White, T. in Transgender Subjectives: A Clinician's Guide Haworth Medical Press, Leli (Ed.) 2004.

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.

Ettner, R. Book reviews. *Archives of Sexual Behavior*, April, 2002.

Ettner, R. Gender Loving Care: A Guide to Counseling Gender Variant Clients. WW Norton, 2000.

“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 Transgender. 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**

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019

WPATH Distinguished Education and Advocacy Award, 2018  
*The Randi and Fred Ettner Transgender Health Fellowship*-Program in Human Sexuality,  
University of Minnesota, 2016  
Phi Beta Kappa, 1972  
Indiana University Women's Honor Society, 1970-1972  
Indiana University Honors Program, 1970-1972  
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*

## BIBLIOGRAPHY

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Brown, G., & McDuffie, E. (2009). Health care policies addressing transgender inmates in prison systems in the United States. *Journal of Correctional Health Care*, 15, 280–291.

Budge, S., Adelson, J. & Howard, K. (2013). Anxiety and depression in transgender individuals: The role of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology* 81(3): 545.

Chung, W., De Vries, G., Swaab, D. (2002). Sexual differentiation of the bed nucleus of the stria terminalis in humans may extend into adulthood. *Journal of Neuroscience* 22(3): 1027-1033.

Cohen-Kettenis, P. & Gooren, L. (1992). The influence of hormone treatment on psychological functioning of transsexuals. In Gender Dysphoria: Interdisciplinary Approaches in Clinical Management. Bockting & Coleman (eds). Haworth Press.

Colizzi, M. et al. (2014). Transsexual patients' psychiatric comorbidity and positive effect of cross-sex hormonal treatment on mental health: Results from a longitudinal study. *Psychoneuroendocrinology* 39: 65-73.

Colton Meier, S., Fitzgerald, K., Pardo, S. & Babcock, J. (2011). The effects of hormonal gender affirmation treatment on mental health in female-to-male transsexuals. *Journal of Gay & Lesbian Mental Health* 15(3): 281-299.

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Eldh, J., Berg, A., Gustafsson, M. (1997). Long term follow up after sex reassignment surgery, *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery* 31: 39-45.

Ettner, R. (1999). Gender loving care: A guide to counseling gender-variant clients. New York, NY, US: W W Norton & Co.

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

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Fernandez, R., Esteva, I., Gomez-Gil, E., Rumbo, T. et al (2014). The (CA) in polymorphism of ERb gene is associated with FtM transsexualism. *Journal of Sexual Medicine* 11:720-728.

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