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*Attorneys for Plaintiff Jennifer Fletcher*

UNITED STATES DISTRICT COURT  
DISTRICT OF ALASKA

Jennifer Fletcher,

Plaintiff,

vs.

State of Alaska,

Defendant.

Case No. 1:18-cv-00007-HRH

**EXPERT DECLARATION OF RANDI C. ETTNER, PH.D. IN SUPPORT OF  
PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT**

*Fletcher v. Alaska*, No. 1:18-cv-00007-HRH

I, Randi C. Ettner, Ph.D., do hereby declare as follows:

**I. PRELIMINARY STATEMENT**

1. I have been retained by counsel for Plaintiff Jennifer Fletcher as an expert in connection with the above-captioned matter.

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

3. This declaration contains my opinions and conclusions, including (i) scientific information regarding gender dysphoria and its impact on health and well-being of individuals affected; (ii) information regarding best practices and the accepted standards of care for individuals with gender dysphoria, including the efficacy and cost-effectiveness of gender confirmation surgery (previously referred to as sex reassignment surgery), and (iii) the results of my evaluation of the medical necessity of Ms. Fletcher's gender confirmation surgery.

**II. BACKGROUND AND QUALIFICATIONS**

**A. Qualifications**

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

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

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

7. I have served as a member of the University of Chicago Gender Board, and am on the editorial boards of *The International Journal of Transgenderism* and *Transgender Health*. I am the secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH), and an author of the WPATH *Standards of Care for the Health of Transsexual, Transgender and Gender Nonconforming People* (7th version), published in 2011 (“Standards of Care”). The WPATH promulgated *Standards of Care* are the internationally recognized guidelines for

the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

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

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

10. Attached as Exhibit B is a bibliography of relevant medical and scientific materials related to transgender people and gender dysphoria. I generally rely on these

materials when I provide expert testimony, in addition to the documents specifically cited as supportive examples in particular sections of this declaration. I have also relied on my years of experience in this field, as set out in my curriculum vitae (Exhibit A), and on the materials listed therein. I also rely upon my clinical interview and evaluation of Ms. Fletcher on November 19, 2018, the results of psychodiagnostic exams, and Ms. Fletcher's mental health and medical records. The materials I have relied on in preparing this declaration are the same type of materials that experts in my field of study regularly rely upon when forming opinions on the subject.

**B. Compensation**

11. I am being compensated for my work on this matter at a rate of \$375.00 per hour for evaluation, assessment, and analysis of Ms. Fletcher and preparation of declarations and expert reports. I will be compensated \$500.00 per hour for any pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. I will receive a flat fee of \$2,500.00 for any travel time I expend to meet with Ms. Fletcher, or to attend deposition or trial, and will be reimbursed for reasonable out-of-pocket travel expenses incurred for the purpose of providing expert testimony in this matter. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

**C. Previous Testimony**

12. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Carillo v U.S. Dep't of Justice Exec.* (Office of Immig. Rev. 2017);

*Broussard v. First Tower Loan, LLC*, 135 F. Supp. 3d 540 (E.D. La.); *Soneeya v. Spencer*, 851 F. Supp. 2d 228 (D. Mass.); *Edmo v. Idaho Dep't of Correction*, No. 1:17-CV-00151-BLW, 2018 WL 2745898 (D. Idaho); *Faiella v. American Medical Response of Connecticut, Inc.*, No. HHD-CV15-6061263-S (Conn. Super. Ct.); *Kothmann v. Rosario*, 558 F. App'x 907 (11th Cir. 2014).

### III. EXPERT OPINIONS

#### Gender Identity and Gender Dysphoria

13. Gender identity is a well-established concept in medicine, referring to one's sense of self as belonging to a particular gender. All human beings develop this elemental internal view: the conviction of belonging to a particular gender, such as male or female. Gender identity is firmly established early in life.

14. Typically, people born with anatomical features associated with females (vagina, uterus, ovaries) identify as girls or women, and experience themselves as female. Conversely, those persons born with typically male characteristics ordinarily identify as males. However, for transgender individuals, this is not the case. For transgender individuals, the sense of one's self—one's gender identity—differs from the sex they were assigned at birth, giving rise to a sense of being “wrongly embodied.”

15. The medical diagnosis for that feeling of incongruence and accompanying distress is gender dysphoria, formerly known as gender identity disorder (“GID”). Gender dysphoria is a serious medical condition codified in the *International Classification of Diseases* (ICD 10<sup>th</sup> revision: World Health Organization) and the

American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders-5th edition* (DSM-5).

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

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

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

18. Gender dysphoria is a highly treatable condition. Without treatment, however, individuals with gender dysphoria experience anxiety, depression, suicidality,

and other attendant mental health issues. They are also frequently isolated because they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently “defective.” This leads to stigmatization, and over time, ravages healthy personality development and interpersonal relationships. As a result, without treatment many such individuals are unable to function effectively in daily life. Studies show a 41%-43% rate of suicide attempts among this population, far above the baseline for North America (Haas *et al.*, 2014).

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

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

### **Treatment of Gender Dysphoria**

21. The standards of care for treating gender dysphoria are set forth in the WPATH *Standards of Care*, first published in 1979. The *Standards of Care* are the internationally recognized guidelines for the treatment of persons with gender dysphoria, and inform medical treatment throughout the world, and in this country. The American Medical Association, the Endocrine Society, the American Psychological Association the

American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology and the American Society of Plastic Surgeons all endorse protocols in accordance with the WPATH standards. *See, e.g.*, American Medical Association (2008) Resolution 122 (A-08); *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (2017); American Psychological Association Policy Statement on Transgender, Gender Identity & Gender Expression Non-discrimination (2008).

22. The *Standards of Care* identify the following evidence-based protocols for the treatment of individuals with gender dysphoria:

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

23. Once a diagnosis is established, a treatment plan should be developed based on the individualized assessment of the medical needs of the patient. WPATH specifies that treatment plans and provision of care must be undertaken by qualified professionals, with established competencies in the treatment of gender dysphoria.

24. **Psychotherapy**: Psychotherapy can provide support and help with many issues that arise in tandem with gender dysphoria. However, psychotherapy alone is not a

substitute for medical intervention when medical interventions are required, nor is it a precondition for medically indicated treatment. By analogy, counseling can be useful for patients with diabetes by providing psychoeducation about living with chronic illness and nutritional information, but counseling does not obviate the need for insulin.

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

26. **Hormone Therapy:** For individuals with persistent, well-documented gender dysphoria, hormone therapy is an essential, medically indicated treatment to alleviate the distress of the condition. Cross-sex hormone administration is a well-established and effective treatment modality for gender dysphoria. The American Medical Association, the Endocrine Society, the American Psychiatric Association and the American Psychological Association all concur that hormone therapy, provided in accordance with the WPATH *Standards of Care*, is the medically necessary, evidence-based, best practice care for most patients with gender dysphoria.

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

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

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

30. **Surgical Treatment:** For individuals with severe gender dysphoria, hormone therapy alone is insufficient. In these cases, dysphoria does not abate without surgical intervention. For transgender women such as Ms. Fletcher, genital confirmation

surgery has two therapeutic purposes. First, removal of the testicles eliminates the major source of testosterone in the body. Second, the patient attains body congruence resulting from the normal appearing and functioning female uro-genital structures. Both outcomes are crucial in attenuating or eliminating gender dysphoria. Additionally, breast augmentation procedures play the critical role in treatment mentioned in the paragraph immediately above.

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

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

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

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

35. As a general matter, patient satisfaction is a relevant measure of effective treatment. Achieving functional and normal physical appearance consistent with gender identity alleviates the suffering of gender dysphoria and enables the patient to function in

everyday life. Studies have shown that by alleviating the suffering and dysfunction caused by severe gender dysphoria, gender confirmation surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehman *et al.*, 1999; Johansson *et al.*, 2010; Hepp *et al.*; 2002; Ainsworth & Spiegel, 2010; Smith *et al.*, 2005); improvement in self-image and satisfaction with body and physical appearance (Lawrence, 2003; Smith *et al.*, 2005; Weyers *et al.*, 2009); and greater acceptance and integration into the family (Lobato *et al.*, 2006).

36. Studies have also shown that surgery improves patients' abilities to initiate and maintain intimate relationships (Lobato *et al.*, 2006; Lawrence, 2005; Lawrence, 2006; Imbimbo *et al.*, 2009; Klein & Gorzalka, 2009; Jarolim *et al.*, 2009; Smith *et al.*, 2005; Rehman *et al.*, 1999; DeCuypere *et al.*, 2005).

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

38. In 2016 WPATH issued a "Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A." ("Position Statement"), affirming their prior statement on the subject, originally issued in 2008. As

the Position Statement explains, “These medical procedures and treatment protocols are not experimental: Decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient.”

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

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

41. Because of the overwhelming scientific evidence that transition-related care, including gender confirmation surgery, is medically necessary for the treatment of gender dysphoria in some patients, many of the leading medical and professional organizations have stated their opposition to exclusions of insurance coverage for that

care, including the American Medical Association, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American Psychiatric Association, and WPATH. *See* American Medical Association (2008) Resolution 122 (A-08); American Academy of Family Physicians, Summary of Actions: 2012 National Conference of Special Constituencies, Action on Resolution No. 1004; American College of Obstetricians and Gynecologists, Committee Opinion of the Committee on Healthcare for Underserved Women, No. 512 (Dec. 2011); American Psychiatric Association, “Position Statement on Access to Care for Transgender and Gender Variant Individuals” (2012); American Psychological Association, “Transgender, Gender Identity & Gender Expression Non-Discrimination” Policy Statement (Aug. 2008); and WPATH *Standards of Care*.

42. I understand that the State of Alaska provides non-surgical medical care in connection with gender transition, including psychotherapy and hormone therapy. In light of that, the surgical exclusion is particularly arbitrary. As described above, psychotherapy and hormone therapy are not substitutes for surgical intervention where such intervention is needed. I am aware of no support in the medical or scientific literature for policies that provide access to non-surgical care, while simultaneously maintaining a blanket exclusion of surgical care regardless of an individual’s medical needs.

43. Finally, insuring transition-related care is affordable and cost-effective for a number of reasons. First, only a small percentage of the population is transgender.

While there are a range of estimates, most studies indicate that transgender people compromise less than 1 percent (ranging from approximately .1 to .6 percent) of the United States population. Second, even among this small population, not every person will require various surgical procedures because individual medical needs vary, and some may be precluded from surgery based on age or other health conditions. While absorbing the cost of this care can be challenging on an individual's personal budget, researchers affiliated with the Johns Hopkins Bloomberg School of Public Health, and the RAND Corporation, have demonstrated that the cost of insuring surgical care through a group health plan is negligible at most. (Padula *et al.*, 2015; RAND Corp., 2016). Moreover, offering access to medically necessary transition-related care is far more cost-effective than denying coverage and having to treat the resulting consequences, which can include depression, anxiety, suicidality, and other conditions.

### **Evaluation of Ms. Fletcher**

#### **A. Relevant Background**

44. Jennifer Fletcher is a 37-year-old transgender woman, assigned male at birth. At the request of counsel, I met with Ms. Fletcher on November 19, 2018, at my office in Evanston, Illinois.

45. At an early age, Ms. Fletcher was aware that she felt “different” than other boys. She vividly remembers a playmate being beaten by his father for playing with dolls, when she was six years of age. Although Ms. Fletcher would furtively try on her

mother's and sister's clothing, she knew she could never speak openly about her feelings of gender incongruity.

46. As a child, understandably, Ms. Fletcher did not know why these perplexing feelings of gender incongruence arose. Like most gender dysphoric individuals, she tried to conform to society's expectations of male behavior.

47. During adolescence, Ms. Fletcher saw transgender individuals portrayed on television, but always in a disparaging manner. She tried to "bury" her escalating feelings of femininity, a strategy that inevitably fails, as gender dysphoria intensifies with age. By adulthood, Ms. Fletcher's despair was overwhelming and she was forced to address her condition.

48. To that end Ms. Fletcher sought professional help, and in 2014 began medically supervised cross-sex hormone therapy. Also in 2014, she transitioned socially and at work, where she is employed as a legislative librarian.

49. Five years of exogenous estrogen administration and testosterone suppression have resulted in Ms. Fletcher's hormonal confirmation. In other words, she has the same circulating sex steroids as female peers. However, hormones cannot, for many people, reduce the anatomical dysphoria that results from having a female identity and presentation but typically male appearing genitals. For Ms. Fletcher, this anatomical incongruence created significant distress and rekindling of dysphoria. There are no treatment options to address this other than surgery. Prior to surgery, in addition to the dysphoria, there were many embarrassing social impediments that arose from having

incongruent anatomy. Exercising or using locker rooms left Ms. Fletcher exposed and unable to participate in physical activity, isolating her from her communal spaces and negatively impacting her mental health. Romantic relationships were short-lived, ending prior to the initiation of physical intimacy. Even everyday activities of living became fraught for Ms. Fletcher. Indeed, for some gender dysphoric individuals, only surgery to confer congruent primary and secondary sex characteristics can alleviate the gender dysphoria. Additionally, patients can lower or eliminate anti-androgenic medications after undergoing surgery, reducing the potential for negative metabolic effects and liver dysfunction.

50. In 2017, Jennifer Fletcher underwent medically necessary gender confirmation surgery in Thailand. Although the Thai surgeons who perform these procedures are world-renowned, patients usually elect to undergo surgery in Thailand for financial reasons, which were relevant to Ms. Fletcher, as she had been denied coverage for this care.

#### **B. Clinical and Psychometric Evaluation**

51. At five feet six inches and 175 pounds, Jennifer Fletcher makes an authentic female presentation. She is of above average intelligence (by estimation), and high-functioning. She is well-oriented, all sensorium are intact, and she is free of any psychiatric disorders. Memory, abstract reasoning, judgment and insight are all well above average. Her health is good and medical history is unremarkable.

52. In addition to a clinical interview, I administered a series of psychodiagnostic tests to Ms. Fletcher. Standardized psychometric indices with high levels of reliability and validity corroborate the clinical assessment. These tests include extensive validity measures which detect malingering, random response patterns, exaggeration of symptoms, or “faking good,” *i.e.*, an attempt to present oneself as overly virtuous.

53. Ms. Fletcher produced valid test protocols, demonstrating an honest and self-disclosing response style, with no scores indicating any clinical problems or emotional disturbance. I am confident, to a reasonable degree of medical certainty, that the data generated regarding her current status is valid and reliable. It is my opinion that gender confirmation surgery was medically necessary for Jennifer Fletcher and the only means of alleviating her lifelong gender dysphoria.

#### **IV. CONCLUSION**

54. Given the extensive scientific research, spanning decades, that supports the efficacy and necessity of gender confirmation surgery, it is clear that gender confirmation surgery is neither experimental nor cosmetic, but rather is a medically necessary treatment for gender dysphoria in patients prescribed this treatment. Additionally, this treatment is affordable and cost-effective. My evaluation of Ms. Fletcher confirmed that the surgical care she received was medically indicated. Accordingly, I am aware of no medical or scientific basis for the State of Alaska’s policy of excluding gender confirmation surgery from its employee medical benefits plan, or for denying coverage

for such surgery to Ms. Fletcher. A blanket exclusion of surgical care has no basis in the scientific literature and is contrary to the medical consensus recognizing the efficacy and necessity of access to gender confirmation surgery.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and corrected. Executed this 23<sup>rd</sup> day of June, 2019.

Randi C. Ettner Ph.D.  
Randi C. Ettner, Ph.D.

## CERTIFICATE OF SERVICE

I hereby certify that on July 1, 2019, I electronically filed the foregoing document and all attachments with the Clerk of the Court by using the CM/ECF system, causing a copy of the foregoing document and all attachments to be served on all counsel of record.

/s/ Tara L. Borelli

Peter C. Renn (admitted *pro hac vice*)  
Tara L. Borelli (admitted *pro hac vice*)  
Meredith Taylor Brown (admitted *pro hac vice*)  
Eric Croft (Alaska Bar No. 9406031)

*Attorneys for Plaintiff Jennifer Fletcher*

# Exhibit A

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

**POSITIONS HELD**

Clinical Psychologist  
Forensic Psychologist  
Fellow and Diplomate in Clinical Evaluation, American Board of Psychological Specialties  
Fellow and Diplomate in Trauma/PTSD  
President, New Health Foundation Worldwide  
Secretary, World Professional Association of Transgender Healthcare (WPATH)  
Chair, Committee for 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

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

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

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

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

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

## **PUBLICATIONS**

Ettner, R., White, T., Ettner, F., Friese, T., Schechter, L. (2018) Tomboys revisited: A retrospective comparison of childhood behaviors in lesbians and 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.

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

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Ettner, R. & Guillamon, A. Theories of the etiology of transgender identity. In Principles of Transgender Medicine and Surgery. Ettner, Monstrey & Coleman (Eds.), 2nd edition; Routledge, June, 2016.

Ettner, R., Monstrey, S, & Coleman, E. (Eds.) Principles of Transgender Medicine and Surgery, 2nd edition; Routledge, June, 2016.

Bockting, W, Coleman, E., Deutsch, M., Guillamon, A., Meyer, I., Meyer, W., Reisner, S., Sevelius, J. & Ettner, R. Adult development and quality of life of transgender and gender nonconforming people. *Current Opinion in Endocrinology and Diabetes*, 2016.

Ettner, R. Children with transgender parents in Sage Encyclopedia of Psychology and Gender. Nadal (Ed.) Sage Publications, 2017

Ettner, R. Surgical treatments for the transgender population in Lesbian, Gay, Bisexual, Transgender, and Intersex Healthcare: A Clinical Guide to Preventative, Primary, and Specialist Care. Ehrenfeld & Eckstrand, (Eds.) Springer: MA, 2016.

Ettner, R. Etiopathogenetic hypothesis on transsexualism in Management of Gender Identity Dysphoria: A Multidisciplinary Approach to Transsexualism. Trombetta, Liguori, Bertolotto, (Eds.) Springer: Italy, 2015.

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

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

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

Ettner, R. Psychotherapy in Voice and Communication Therapy for the Transgender/Transsexual Client: A Comprehensive Clinical Guide. Adler, Hirsch, Mordaunt, (Eds.) Plural Press, 2012.

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

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

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

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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.*

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

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

Confessions of a Gender Defender: A Psychologist's Reflections on Life amongst the 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

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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.

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World Professional Association for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, 7<sup>th</sup> version (2012).

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Information pertaining to Jennifer Fletcher, including medical records, clinical and visual evaluation, and the complaint filed in this matter.