UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO

STACIE RAY, *et al.*, Plaintiffs, v. AMY ACTON, *et al.*, Defendants.	)	Case No. 2:18-cv-00272 Judge Michael Watson Magistrate Judge Chelsey Vascura

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Plaintiffs file this Motion for Summary Judgment pursuant to Fed. R. Civ. P. 56. Defendants' Policy prohibiting transgender people from obtaining birth certificates with a corrected sex marker violates Plaintiffs' rights under the First, Fifth, and Fourteenth Amendments to the United States Constitution, and no state interest justifies these violations. As to all of Plaintiffs' claims, no material fact is in dispute and Plaintiffs are entitled to judgment as a matter of law. A Brief in Support is attached to this Motion.

Respectfully submitted,

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BRIEF IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Plaintiffs, four transgender people born in Ohio, brought this case against Defendants, Ohio Department of Health officials, to obtain birth certificates with sex markers that reflect their true sex. In approximately 2016, Defendants instituted a policy of refusing to correct sex markers on Ohio birth certificates whenever the basis for the requested correction is that the person is transgender (the "Policy"). This Policy, which is justified by no legitimate—much less compelling—government interest, violates Plaintiffs' constitutional rights to privacy, equal protection, and free speech.

STATEMENT OF THE UNDISPUTED FACTS

The Ohio Health Department, Vital Statistics Division (run by the Defendants) ("ODH") administers birth records, which includes the control of any change or correction. *See* Ohio Rev. Code § 3705.03. Under Defendants' Policy, Ohio is one of only two states in the country that still refuses to issue birth certificates with correct sex markers to transgender people.

I. ODH's Policy Has Harmed and Continues to Harm Plaintiffs

Stacie Ray, Ashley Breda, and Jane Doe are transgender women born in Ohio, and Basil Argento is a transgender man born in Ohio. Ohio will not permit them to correct the sex marker

on their birth certificates to reflect their identities. Each of them has repeatedly had to disclose their birth certificate as a routine part of their lives—each time outing them as transgender, causing them fear and humiliation, forcing them to endorse a message with which they emphatically disagree, and putting them at grave risk of physical harm.

It took Mr. Argento three years to obtain an accurate passport because his birth certificate did not match his true sex or his other identity documents. Argento Dep. 97:3-98:24. He has had to present his inaccurate birth certificate to several public officials. *Id.* 115:17-123:9. He was even refused a marriage license as a result of his incorrect birth certificate. *Id* 120:3-12. Each time, "it was very uncomfortable . . . a lot of hassles and a lot of emotional suffering." *Id.* 122:7-10. Each time he must explain the discrepancy, people "treat [him] like a zoo specimen and then d[o] not update [his] information anyway." *Id.* 115:23-116:15. It is a similar story for each Plaintiff—and for every Ohio-born transgender person who cannot obtain an accurate birth certificate.

When Ms. Ray had to show her birth certificate at work, she was bullied and physically threatened. Ray Dep. 106:2-110:3, 112:7-115:16. When she tried to get a background check from the TSA for employment purposes, the TSA contractor verbally harassed her and denied her the background check. *Id.* 127:2-128:13. When she went to ODH to correct her birth certificate the same day, an ODH supervisor told her "they would never change another birth certificate ever again." *Id.* 70:5-7. For Ms. Ray, beyond the physical threats and "anxiety," "the harm was that I identified as female and I had to out myself to other people that [when] I was born . . . the doctors had categorized me as . . . something that I don't agree with." *Id.* 160:9-20.

Dr. Doe was denied a change to her Social Security information when she had to show her inaccurate birth certificate, and she "ran out of that place in tears . . . humiliated." Doe Dep.

124:4-125:25. Ms. Breda was mocked, harassed, and threatened at work after her birth certificate outed her as transgender. Breda Dep. 48:19-51:9. Her boss told her she would "always be a man in God's eyes." *Id.* Beyond that, "there's a lot of things that require a birth certificate, especially involving the government . . . for anything like disability or food stamps or anything like that, I do need to present it every time" in addition to presenting it at "every job I applied to." *Id.* 114:4-17, 117:9. In each of these instances, suffering harm is "always a fear." *Id.* 118:18-24.

II. ODH's Policy Is Aimed at Transgender People

People born in Ohio may petition ODH to change or update various birth certificate fields for a host of reasons. For example, an adoptive parent may change their child's birth certificate to replace the birth parent's name with the adoptive parent's name. Ohio Rev. Code § 3705.12; ODH Dep. 42:8-46:1, 60:7-61:11. If someone obtains a legal name change, they may change their birth certificate to reflect that. Ohio Rev. Code § 3705.13; ODH Dep. 60:7-61:11. Some of the reasons that ODH may change or correct a birth certificate are listed explicitly in Ohio's statutes. *E.g.*, Ohio Rev. Code § 3705.15 (allowing any changes "to correct errors"). Some reasons for changing a person's birth certificate are expressly *prohibited* by Ohio law. *E.g.*, Ohio Rev. Code § 3705.29 (prohibiting issuance of birth record information for purposes of "deception"). Still other reasons are neither explicitly provided for nor prohibited by statute. Defendants, however, are empowered under Ohio Rev. Code § 3705.03 to modify or correct birth certificates according to their own non-codified policies. *See e.g.*, ODH Dep. 65:22-66:20 (describing ODH practice of "updat[ing]" the sex field on birth certificates of prematurely-born children who were marked as having an "undetermined" sex at birth). As to changing the sex marker specifically, Ohio law is entirely silent. *Id.* 190:15-18.

Prior to 2016, ODH permitted Ohio-born transgender people to correct the sex marker on their birth certificates. *Id.* 138:25-139:13, 150:5-152:11; Ex. A (Defs.' Resp. Interrog. No. 3 and Supplemental Response). ODH required a probate court order authorizing the correction, a nominal processing fee, and a completed ODH-provided form. *See* ODH Dep. at 138:14-140:18, 150:5-155:11. In most cases, the applicant's former (incorrect) birth certificate was then locked in a vault, no longer accessible to the public. *Id.* 48:15-52:20; *see also* 62:15-65:21. At least ten transgender people born in Ohio successfully obtained sex-corrected birth certificates prior to 2016. *Id.* 138:25-139:13; Ex. A.

At some point in 2015, ODH received two orders from Ohio probate courts directing ODH to make simultaneous name and sex marker changes to the birth certificates of two transgender applicants. ODH Dep.108:18-112:3; 169:13-170:14. At that time, ODH decided to review its policy on granting such requests. *Id.* 112:5-114:16, 163:23-165:3. During this review, the ODH Director advised ODH staff to hold all pending requests for sex marker changes, causing a backlog. *Id.* 165:8-170:14. In consultation with ODH's in-house counsel and with the Ohio Governor's office, ODH decided to stop making changes to the sex field on Ohio birth certificates where the basis for the requested change was that the person was transgender. *Id.* 129:14-134:4, 175:10-19. ODH never articulated any reason why it implemented this new Policy, except to say that it reached a conclusion that state law did not authorize making these changes. Instead, ODH maintains that any reason and any evidence of any reason are privileged. *Id.* 102:11-108:23, 163:14-170:1, 178:21-181:6.

To carry out this reversal of its past practice, ODH adopted new internal guidance on how to respond to transgender people making these requests. *See id*. at 94:5-100:21, 113:17-114:16; Ex. B (ODH internal guidance documents). Now, under the Policy, when a transgender person

requests a change to the sex marker on their birth certificate, ODH explains it is not possible and rejects the application. ODH Dep. 31:17-38:13, 42:4-45:1, 46:14-52:20, 94:5-100:21; Ray Dep. 69:9-70:7; Ex. B.

ODH continues to make changes to birth certificates, including to sex markers, so long as the basis for the change is not that the person is transgender. For example, ODH will correct the sex marker if it considers the basis for the request to be mistake. ODH Dep. 44:19-46:1 (discussing corrections for twins born with different genitalia accidentally marked as the same sex). Where a physician observes atypical genitalia at birth and records a U for "undetermined" or unknown, ODH will later change the U to M or F upon request. *Id.* 65:12-66:25, 73:25-74:21; Ex. C (records of U-marked birth certificates). And in at least one instance, ODH changed a petitioner's birth certificate sex marker to "H" designating "hermaphrodite," upon that individual's request. ODH Dep. 66:21-68:21; Ex. D (records requesting H-marked birth certificate). Defendants do not deny that ODH *can* change sex markers, nor that it does so. *See e.g.* ODH Dep. 35:15-38:13, 138:14-140:23. Rather, ODH's Policy selectively prohibits changes on the basis that the requester is transgender. *Id.* ODH has never explained why the Policy is necessary or even rational, nor has it explained why it could not achieve any purported interest by less intrusive means. *See id*. at 181:7-183:14.

LAW & ARGUMENT

Summary judgment is proper unless "a reasonable [factfinder] could return a verdict for [the non-moving] party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). The uncontroverted evidence proves that Defendants' Policy violates Plaintiffs' constitutional rights of speech, privacy, and equal protection as a matter of law. Defendants have produced no evidence to create any genuine issue of material fact, nor to demonstrate how the Policy could

survive either the strict scrutiny applied to Plaintiffs' privacy and compelled speech claims, or the heightened scrutiny applied to their equal protection claim.

I. Defendants' Policy Violates Plaintiffs' Due Process Right to Privacy

Defendants' Policy forces Plaintiffs to disclose that they are transgender every time they must produce their birth certificates. The undisputed evidence shows that these disclosures put Plaintiffs at risk of bodily harm and reveal highly sensitive, intimate information about them, in violation of their Fourteenth Amendment due process right to privacy.

A. The Policy compromises transgender people's safety.

Plaintiffs have a constitutional right to keep information private to preserve their "personal security and bodily integrity." *Kallstrom v. City of Columbus*, 136 F.3d 1055, 1062 (6th Cir. 1998). In denying Defendants' motion to dismiss, this Court ruled that "Plaintiffs have alleged facts which, accepted as true, suggest that forced disclosure of Plaintiffs' transgender status upon presentation of their birth certificates place their 'personal safety and bodily integrity in jeopardy.'" ECF No. 47 at 19; *see also Arroyo Gonzalez v. Rossello Nevares*, 305 F. Supp. 3d 327, 333 (D.P.R. 2018); *Love v. Johnson*, 146 F. Supp. 3d 848, 855 (E.D. Mich. 2015). Plaintiffs have now produced undisputed evidence showing that the Policy has compromised their safety and will continue to endanger them.

"Courts across the United States have explicitly acknowledged the general hostility and violence affecting the transgender population for at least the last decade." Order, ECF No. 47 at 15. Based on a 2015 survey, 36% of transgender people in Ohio who showed an ID that did not match their sex presentation were verbally harassed, denied benefits or service, asked to leave, or assaulted. National Center for Transgender Equality, 2015 U.S. Transgender Survey: Ohio State Report 3 (2017), https://bit.ly/2QyKNHF. Killings of transgender people, especially transgender

women of color, for being transgender remain high across the United States, including in Ohio. *See* National Coalition of Anti-Violence Programs, A Crisis of Hate: A Report on Lesbian, Gay, Bisexual, Transgender and Queer Hate Violence Homicides In 2017, https://bit.ly/2tOlhoQ; *see also, e.g.*, BJ Colangelo, *More than 15 Percent of this Year's Transgender Homicides Have Happened in Cleveland*, Cleveland Scene, June 27, 2018, https://bit.ly/2QIGWYJ.

Plaintiffs' experiences are representative examples of the harassment that transgender people routinely suffer when outed against their will. When Ms. Ray started a new job, she had to show her birth certificate to a human resources professional in a room with ten to fifteen new colleagues. Ray Dep. 119:11-120:9. As she began to realize how public the HR process would be, she became increasingly afraid for her safety. "[M]y anxiety level went through the roof of potential harm or fear for the documents I was holding, but I needed a job." *Id.* 119:21-24. The HR person asked—loudly enough for everyone else to hear—why the gender on her birth certificate and her driver's license did not match. *Id.* 112:14-113:5. Ms. Ray's co-workers overheard and began harassing her. They labeled her a "freak." *Id.* 114:1-19. One coworker threatened to "beat [her] ass" if she used a women's restroom. *Id*. These threats and harassment would not have happened if her birth certificate had not outed her. *Id.* 115:9-115:20.

When Ms. Breda had to show her birth certificate to an employer, she too was outed, and mocked and threatened as a result. The employer's head of HR told her that she would "never be a woman. [She will] always be a man in God's eyes." Breda Dep. 50:15-20. Ms. Breda's supervisors started misgendering her, commenting on her genitalia, and steering work away from her. *Id.* 53:11-55:5. This mistreatment would not have happened if her birth certificate showed the correct sex. *Id.* 69:23-70:6.

Plaintiff's expert witness Dr. Randi Ettner testified that this kind of violence is routine. In one instance, someone revealed a document outing Dr. Ettner's patient as transgender at work. Ettner Dep. 228:17-229:19. The patient's co-workers began harassing her and her husband by circulating a petition to ban her from using the women's restroom, smearing feces on her desk, leaving sex toys in her husband's office, and threatening to kill them both. *Id*. Someone acted on those threats and cut their brake lines. *Id.* Although they survived the attempt on their lives, both the woman and her husband became disabled with complex post-traumatic stress syndrome as a result of the harassment. *Id*. They can no longer leave their homes. *Id*.

B. The Policy reveals Plaintiffs' intimate personal information.

The Policy also infringes on Plaintiffs' right to control the disclosure of information "of an intimate nature which define[s] significant portions of our personhood." *Bloch v. Ribar*, 156 F.3d 673, 685 (6th Cir. 1998). Plaintiffs have produced undisputed evidence of the intimate, personal, and important nature of information about their transgender status, and how the exposure of this information, against their will and in a way that contradicts their core sense of self, has humiliated them.

The psychological toll of being both outed and misgendered by one's own birth certificate can be devastating. Routine daily events that most people take for granted are fraught with humiliation and repeated threats of serious bodily harm for transgender people with incorrect identity documents. Basil Argento, who has had multiple negative experiences showing his birth certificate, described feeling "a lot of anxiety about how [he'll] be treated" each time there is a forced disclosure. Argento Dep. 125:22-126:11. "[I]t's a lot of times dehumanizing because I'm telling something very personal about myself that I don't want to be telling a

stranger, especially one that I think is going to use it against me to make my life harder. So yeah, it's emotional. It takes an emotional toll." *Id*.

When Dr. Doe first tried to correct her sex with the Social Security Administration, a clerk refused to do so unless she produced a corrected birth certificate. Doe Dep. 123:24-124:13. The clerk's loud refusal outed Dr. Doe to about a hundred people nearby. *Id.* She remembers, "that experience in that Social Security Office was awful. I ran out of that place in tears. I sat in the parking lot in my car for about forty-five minutes crying. I still—when I have to think about that experience even currently I get emotionally distraught." *Id*. 125:10-16.

Dr. Ettner testified about a patient who died by suicide after having to show a document with the wrong sex listed. Ettner Dep. 228: 5-16. A 2015 study showed that having an identity document with the correct sex prevented more suicide attempts by transgender people than did treating patients with anti-depressants. *See* Ex. E (Expert Report of Dr. Randi Ettner) at ¶ 31; Ex. F. (Expert Report of Dr. Ryan Gorton) at ¶¶ 30-32. Dr. Gorton testified that some transgender people withdraw socially to avoid the fear and humiliation of using inaccurate identity documents: "[t]hey stay in a bad job that they don't like because it's too scary to try to apply for a better job, they don't go back to school, they don't register to vote, [and] they don't request services that they might be entitled to . . . ." Gorton Dep. 207:4-13.

These circumstances are precisely why such sensitive information is constitutionally protected from disclosure. *See Bloch*, 156 F.3d at 684; *Powell v. Schriver*, 175 F.3d 107, 111-12 (2d Cir. 1999). Privacy violations infringe on a fundamental right, and are subject to strict scrutiny. *Kallstrom*, 136 F.3d at 1064.

II. Ohio's Policy Violates Plaintiffs' Right to Equal Protection Under the Law

State actions based on transgender status and based on sex receive heightened scrutiny under the Equal Protection clause. The Policy is based on transgender status and sex, and it violates Plaintiffs' rights to equal protection.

A. The Policy is based on transgender status and sex.

The Policy discriminates against Plaintiffs on the basis of their transgender status and on the basis of sex. The Policy categorically denies sex marker corrections to transgender people, and it was adopted directly in response to such requests. ODH Dep. 163:14-170:14. Under the Policy, sex markers on Ohio birth certificates are assigned based on one thing: the appearance of external genitals at birth. *Id.* 57:21-58:20. For cisgender people, this is typically an accurate proxy for their true sex; for transgender people, it is not. Moreover, when a cisgender person requests to change the sex marker on their birth certificate, whether it is wrong because of a mistake or because of atypical genitalia at birth, ODH allows the change. *See id.* 65:22-68:15. But when a transgender person makes the same request, ODH denies it. *Id.* 102:11-105:18. As a result, all cisgender people born in Ohio may obtain a birth certificate that identifies their sex accurately and that they can use without sacrificing their safety or privacy. Transgender people born in Ohio are denied this on the basis of sex and transgender status.

Defendants have relegated transgender people—and *only* transgender people—born in Ohio to two choices: forgo use of a birth certificate at all, which often means giving up employment, marriage, benefits, and other opportunities; or use a birth certificate that reveals their transgender status, contradicts their sense of self, humiliates them, compromises their health, and puts them in danger of bodily harm.

B. The Policy is subject to heightened scrutiny.

Heightened scrutiny is required where the state targets a class that (1) has been "historically subjected to discrimination," (2) has a defining characteristic bearing no "relation to ability to perform or contribute to society," (3) has "obvious, immutable, or distinguishing characteristics," and (4) is "a minority or politically powerless." *Windsor v. United States*, 699 F.3d 169, 181 (2d Cir. 2012), *aff'd on other grounds*, 133 S. Ct. 2675 (2013) (internal quotation marks omitted). All these indicia are present for transgender people.

First, "[t]here is no denying that transgender individuals face discrimination, harassment, and violence because of their transgender identity." *Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017); Ex. E at ¶ 44 ("An abundance of research establishes that transgender people suffer from stigma and discrimination."); *see also* Ettner Dep. 23:22-24:21; 228:5-230; Ex. F at ¶ 31; Gorton Dep. 206:21-209:3. Plaintiffs' experiences illustrate that reality: they have all experienced some form of discrimination, harassment, or threat of violence because of their transgender identities. *E.g.* Ray Dep. 110:4-111:16, 112:4-21, 114:1-19, 117:7-121:7, 125:6-128:13; Breda Dep. 49:19-51:9, 52:19-55:25; Argento Dep. 45:1-9, 95:23-97:25, 125:22-126:15; Doe Dep. 117:5-118:14, 123:24-125:16.

Second, a transgender person is no less capable of contributing value to society than a cisgender person. *E.g. Adkins v. City of New York*, 143 F. Supp. 3d 134, 139 (S.D.N.Y. 2015). Third, as multiple courts have found, transgender people share common immutable characteristics. Their gender identities are core to their personhood and differ from the sex assigned based on their appearance at birth; these things cannot be changed. *E.g.*, *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 n.8 (N.D. Cal. 2015); *see also* Ex. E at ¶¶ 20, 22-25; Ex. F at ¶

37; Gorton Dep. at 167:13-20, 206:3-5. Finally, stigma and lack of representation have caused a status quo in which transgender people have very little political power. *See Adkins* at 140. As transgender people satisfy every criterion of a suspect or quasi-suspect class, discrimination against them is subject to heightened scrutiny.

Additionally, discrimination based on transgender identity is necessarily discrimination on the basis of sex, and thus receives heightened scrutiny for that additional reason. *E.g., Equal Emp't Opportunity Comm'n v. R.G. & G.R. Harris Funeral Homes, Inc*., 884 F.3d 560, 575 (6th Cir. 2018), *cert. granted*; *Barnes v. City of Cincinnati*, 401 F.3d 729, 739 (6th Cir. 2005); *Smith v. City of Salem*, 378 F.3d 566, 573-75 (6th Cir. 2004); *Glenn v. Brumby*, 663 F.3d 1312, 1319-20 (11th Cir. 2011). "[A]ll gender-based classifications . . . warrant heightened scrutiny." *United States v. Virginia*, 518 U.S. 515, 555 (1996) (quotations omitted). Here, Defendants' Policy explicitly differentiates based on sex and inflicts harm on transgender people. Defendants have adduced no evidence demonstrating anything but a "vague, speculative, and unsubstantiated" interest supporting their Policy, and have not even attempted to demonstrate the Policy is appropriately tailored to achieve any state interest. Order, ECF No. 47 at 31-32.

III. Ohio's Policy Compels Speech in Violation of the First Amendment

Throughout their lifetime, every Ohio-born person must show their birth certificate at various times to prove the basic facts of who they are. ODH has taken the ideological position that transgender people should be forever designated the sex assigned to them based on stereotypes about their genital appearance at birth, rather than their actual sex.[1] ODH is perhaps

[1] This indeed is an ideological position. The state has disingenuously juxtaposed the term "sex," which it argues designates only the record of a child's perceived genitals at birth, with "gender," a purportedly different concept that the birth certificate does not reflect. ECF No. 18 PAGEID# 84-85; ODH Dep. 38:1-13. But in fact, in implementing the Policy, Defendants always used the terms "sex," "gender," and "gender identity" colloquially and interchangeably, understanding that as a practical matter, that field on an identity document indicates all three to the rest of the world. E.g., ODH Dep. at 95:19-96:21; 97:25-100:21; 113:17-114:16 and Ex. B. The state's attempt to distinguish these terms is a post hoc rationale that cannot help the Policy survive constitutional scrutiny.

entitled to its unfortunate point of view. *Walker v. Texas Div. Sons of Confederate Veterans*, 135 S. Ct. 2239, 2241 (2015). But ODH's Policy oversteps the First Amendment's boundary by forcing Plaintiffs to endorse this message. Every time Stacie Ray has to produce her birth certificate—to enroll in college, get a job, apply for professional licensure, or even to rent a car or drive in certain states—Ohio forces her not only to reveal that she is transgender, but to represent that she is really a man. Ray Dep. 101:11-102:2, 104:15-105:11, 110:4-123:4, 126:14-130:4, 144:10-145:19, 163:1-13. The compelled speech doctrine prohibits the state from forcing people to divulge facts they wish to keep private, and equally prohibits forced endorsement of a state message. Plaintiffs have proven these repeated speech compulsions, and the damage they inflict, with uncontroverted evidence.

A. Ohio may not force Plaintiffs to endorse its viewpoint that transgender people are not who they know themselves to be.

"[C]ompelling individuals to speak a particular message" by making them "provide [others] a government drafted script" contrary to their own beliefs is a content-based imposition on the freedom of speech. *Nat'l Inst. of Family and Life Advocates v. Becerra*, 138 S.Ct. 2361, 2371 (2018) ("*NIFLA*"). Using strict scrutiny, the Supreme Court has repeatedly invalidated information disclosure requirements that force people to endorse a state message unwillingly. *E.g., id.; Agency for Int'l. Dev. v. All. for Open Soc'y Int'l., Inc.*, 570 U.S. 205, 212 (2013); *Riley v. Nat'l Fed'n of the Blind of North Carolina, Inc.*, 487 U.S. 781, 797 (1988); *Wooley v. Maynard*, 430 U.S. 705, 714 (1977). ODH's Policy forces Plaintiffs to convey to others the state-mandated message that they are not the sex they know themselves to be. The Policy expresses an ideology that ODH holds: that a transgender person's sex should only be evaluated based on the sex typically associated with their external genitalia at birth, regardless of their gender identity. ODH Dep. 57:15-59:10; Van Meter Dep. 82:1-83:25, 95:4-17, 104:12-110:15, 153:17-24;

258:21-261:23. Plaintiffs, of course, hold the opposite view, central to their identities: that they are the sex they know themselves to be. Ray Dep. 63:20-64:16, 91:25-93:20; Breda Dep. 105:11-106:19; Doe Dep. 101:2-104:6; Argento Dep. 76:8-77:6, 78:17-80:14. This too is a protected message, *e.g.*, *Doe v. Bell*, 754 N.Y.S.2d 846, 851 (Sup. Ct. N.Y. Co. 2003), but the state censors it on birth certificates.

It may be the state's prerogative, as a matter of First Amendment law, to express its position that transgender people should not be regarded according to their true sex. *Walker*, 135 S. Ct. at 2241. What the state may not do is force Plaintiffs to endorse that message by disclosing Ohio's opinion about their sex to others each time they produce their birth certificate. *Id.* at 2246; *see also NIFLA*, 138 S. Ct. 2361. "When speech is compelled … individuals are coerced into betraying their convictions. Forcing free and independent individuals to endorse ideas they find objectionable is always demeaning . . . ." *Janus v. Am. Fed'n of State, Cty., and Mun. Emps.*, 138 S. Ct. 2448, 2464 (2018). The coercion here forces Plaintiffs publicly to betray their most central convictions: their own identity.

B. Ohio may not force the disclosure of Plaintiffs' transgender status.

In addition to forcing Plaintiffs to endorse the state's viewpoint at the expense of expressing their own, Defendants' Policy forces unwanted disclosure of Plaintiffs' transgender status. Plaintiffs' experiences demonstrate the severe risk of harm that involuntary disclosure imposes on transgender people. *See supra* Section I; *see e.g.* Ray Dep. at 106:2-110:3, 112:7-115:16; Argento Dep. 89:14-19:2, 98:5-99:25, 115:16-119:16, 125:21-126:15; Breda Dep. 118:7-120:4; Doe Dep. 124:4-125:25; Ettner Dep. 205:20-206:7, 151:12-21, 189:16-192:10. Plaintiffs and their experts have amply demonstrated this, and Defendants have not contested it.

The First Amendment entitles Plaintiffs to keep their transgender status private because under compelled speech jurisprudence, "[t]he right to eschew association for expressive purposes

is likewise protected." *Janus*, 138 S. Ct. at 2463 (citing *Roberts v. United States Jaycees*, 468 U.S. 609, 623 (1984)); *Pacific Gas & Elec. Co. v. Public Util. Comm'n of Cal.*, 475 U.S. 1, 12 (1986). Defendants may not force Plaintiffs to disclose unwanted facts any more than unwanted viewpoints, *see Riley*, 487 U.S. at 797, especially when those facts put Plaintiffs at risk of harm upon disclosure. The First Amendment has long protected the need for people to keep their memberships in vulnerable groups anonymous because of fear of bodily harm. *NAACP v. State of Ala. ex rel. Patterson*, 357 U.S. 449, 462 (1958). And the harm caused by compelled speech "takes on an added dimension" where, as here, the privacy of *intimate* information is at stake—"[f]or also fundamental is the right to be free . . . from unwanted governmental intrusions into one's privacy." *Stanley v. Georgia*, 394 U.S. 557, 564 (1969). In Ms. Ray's words, "[t]he harm is that the State of Ohio shouldn't force me to out myself every time that I have to present a legal document and then I get the looks, the whispers, the generalized humiliation that I get after presenting [it]." Ray Dep. 161:5-10; *see also* 121:5-7 ("Q. You think that the disclosure of your private information to the group is harm? A. I don't think, I know it is"); 159:15-20.

This intrusion causes Plaintiffs harm at each disclosure, and chills their participation in public life. "Forcing disclosure of transgender identity chills speech and restrains engagement in the democratic process in order for transgender[] [people] to protect themselves from the real possibility of harm and humiliation…[this] also hurts society as a whole by depriving all from the voices of the transgender community." *Arroyo Gonzalez*, 305 F. Supp. 3d at 333.

Finally, the violation in forcing this particular speech is intensified here because the state subjects *only* transgender people to its compulsion, "le[aving] unburdened those speakers whose messages are in accord with its own views." *NIFLA*, 138 S. Ct. at 2378 (citing *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 580 (2011)). The state's speech compulsion does not touch those in

the majority—Ohio-born cisgender people who agree with and fit the sex on their identity documents. The "curiously narrow subset of speakers" that the Policy targets makes it even more suspect under the compelled speech doctrine. *NIFLA*, 138 S.Ct. at 2377. Defendants demonstrate no compelling interest in, nor tailored approach to justify, this First Amendment intrusion.

IV. The Policy Fails Any Level of Scrutiny

Because the Policy infringes on Plaintiffs' fundamental right to privacy and freedom of speech, it is subject to strict scrutiny. Because the Policy infringes on Plaintiffs' right to equal protection, it is also subject to heightened (at least intermediate) scrutiny. But even if the Policy were subject only to rational basis review, it would still fail.

A. Defendants have offered no evidence of any compelling or important government interest for creating and maintaining the Policy.

Under heightened scrutiny, Defendants must demonstrate that their "classification [] substantially serve[s] an important governmental interest *today*.'" *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1690 (2017) (internal citations omitted) (emphasis in original). Post-hoc rationalizations cannot survive. *See United States v. Virginia*, 518 U.S. 515, 533 (1996). And it is ODH's burden to prove that it actually attempted to use less intrusive alternatives to meet its goals. *McCullen v Coakley*, 573 U.S. 464, 494 (2014). Under strict scrutiny, ODH's Policy must be narrowly tailored to achieve a compelling interest, and must not be over or under inclusive. *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 546 (1993).

Defendants have produced no evidence that the Policy was implemented to serve any state interest. At best, ODH has articulated post-hoc rationales, with no evidence that it tailored its Policy to achieve any of them. The sole reason ODH has offered for instituting its Policy is that, in 2016, its legal department began construing Ohio law to prohibit the correction of sex markers on transgender peoples' birth certificates. ODH Dep. 57:7-14; Ex. G (Defs.' Resp. to

Interrog., No. 2). ODH produced no evidence about why it reached that interpretation, whether it considered any alternatives, or why it rejected such alternatives. ODH Dep. 180:1-5. Instead, it maintains that any reason, and any evidence of any reason, are privileged, waiving any ability to rely on those reasons in this litigation. *New Phoenix Sunrise Corp. v. Comm'r*, 408 F. App'x 908, 919 (6th Cir. 2010), quoting *In re Lott*, 424 F.3d 446, 454 (6th Cir.2005) ("'[L]itigants cannot hide behind the privilege if they are relying upon privileged communications to make their case. The attorney-client privilege cannot at once be used as a shield and a sword'"); ODH Dep. 102:11-108:23, 163:14-170:1, 178:21-181:6. Even if, contrary to this Court's ruling that nothing in Ohio's statutes requires the Policy, ODH's reinterpretation of state law were accurate, compliance with state law is not a defense for violating rights protected by the U.S. Constitution.[2] *Brown v. Entm't Merchants Ass'n*, 564 U.S. 786, 799 (2011).

Besides its unexplained reinterpretation of state law, ODH has only alluded to post-hoc support for its Policy: preventing fraud, and keeping historical records or maintaining statistical information. ODH Dep. 193:20-24; 181:7-183:14. But ODH has produced no evidence that any of these considerations actually motivated its decision to prevent transgender people from obtaining birth certificates that accurately reflect their sex. *Id.* Nor has ODH produced any evidence showing the Policy actually serves these purposes, or that it is narrowly tailored to achieve them. *See* Order, ECF No.47 at 30.

B. Defendants' Policy fails even rational basis review.

Even under rational basis review, Defendants' justifications fall short. ODH has not identified and cannot identify any legitimate interest rationally related to the Policy. *See Romer*

[2] In fact, however, as this Court has already acknowledged, ECF No. 47 at 12, nothing in the relevant statutes actually precludes corrections to the sex field of a birth certificate because a person is transgender. Ohio Rev. Code §§ 3705.15; 3705.22; 3705.23.

v. Evans, 517 U.S. 620, 632-33 (1996). And ODH has not produced evidence that the Policy does anything but *undermine* any goal it may have. Courts in Alaska, Idaho, Michigan, and Puerto Rico have all held that policies barring transgender people from obtaining identity documents with the correct sex lack adequate justification. *See Arroyo Gonzalez v. Rossello Nevares*, 305 F. Supp. 3d 327, 333 (D.P.R. 2018); *F.V. v. Barron*, 286 F. Supp. 3d 1131, 1142 (D. Idaho 2018); *Love v. Johnson*, 146 F. Supp. 3d 848, 856 (E.D. Mich. 2015); *K.L. v. State, Dept. of Admin., Div. of Motor Vehicles*, No. 3AN-11-05431 CI, 2012 WL 2685183, at *6-8 (Alaska Super. Ct. Mar. 12, 2012).

First, Defendants suggest that birth certificates are "historical document[s]" with a "snapshot" of "statistical information," but they allow many kinds of amendments that render a birth certificate wholly useless to confirm facts at birth—including changes of paternity, parentage after adoptions, subjects' names, and even sex markers for certain people. ODH Dep. 59:8-10; 43:24-44:1. ODH also admits that the public policy reason to permit changes to this "historical document" is to let people use birth certificates for contemporaneous identity confirmation—a reason that would apply at least as strongly to transgender people. ODH Dep. 77:16-78:11. Defendants' argument is also belied by ODH's practice of granting sex marker changes for transgender people without any problem prior to 2016. ODH Dep. 138:25-139:13; 150:5-152:11; Ex. A. Compiling statistical information is simply not at issue in this case. ODH is free to compile statistical information however it wishes, using either an original or corrected sex marker. This case concerns only what sex marker appears on the public-facing birth certificate.

Second, ODH stretches credulity in arguing that an interest in fraud prevention or law enforcement justifies the Policy. ODH Dep. 181:7-183:14, 193:14-24. Because the Policy forces people to use Ohio birth certificates containing inaccurate information that conflicts with all

other available information about their sex, this undermines any purported state interest in using birth certificates to identify people—as well as undermining confidence in documents themselves. And by permitting transgender people to have accurate sex markers on some state-issued identity documents but not on others, Ohio is, if anything, *creating* a potential fraud problem—not solving one. *See* Order, ECF No. 47 at 30-31; *see also Love*, 146 F. Supp. 3d at 856; *K.L.*, 2012 WL 2685183, at *7. Forcing Plaintiffs to carry and produce mismatched, inaccurate identity documents also increases the likelihood that Plaintiffs will trigger false alarms of potential fraud, thereby exposing them to unnecessary, invasive scrutiny and potential discrimination, while wasting law enforcement resources. Finally, the Policy also undermines any interest in public safety by exposing Plaintiffs to violence. *See Arroyo Gonzalez*, 305 F. Supp. 3d at 333. Even if Defendants had met their burden of producing actual evidence supporting any of their purported rationales, these fail any level of constitutional scrutiny.

CONCLUSION

Based on the foregoing, no material fact is in dispute and Plaintiffs are entitled to judgment as a matter of law. Plaintiffs ask this Court to strike down Defendants' Policy as unconstitutional, allowing them and other Ohio-born transgender people to obtain the accurate birth certificates that they need to live their lives.

Dated January 16, 2020

Respectfully Submitted,

/s/ Elizabeth Bonham

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Attorneys for Plaintiffs

*Admitted *Pro Hac Vice*

CERTIFICATE OF SERVICE

I certify that on January 16, 2020, I filed the foregoing electronically. Notice of this filing will be sent to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

/s/ Elizabeth Bonham
Elizabeth Bonham (0093733)
Attorney for Plaintiffs

EXHIBITS

Ex. A	Defendants' Response and Supplemental Response to Interrogatory No. 3
Ex. B	ODH Internal Guidance Documents
Ex. C	ODH Records of U-marked Birth Certificates
Ex. D	ODH Records Requesting H-marked Birth Certificate
Ex. E	Expert Report of Dr. Randi Ettner
Ex. F	Expert Report of Dr. Ryan Gorton
Ex. G	Defendants' Response to Interrogatory No. 2

EXHIBIT A

Defendants' Response and Supplemental Response to Interrogatory No. 3

as reported to Defendants soon after an individual's birth, including a record of the individual's sex as reported at birth. The circumstances under which an individual may correct the sex recorded at birth are set forth in Ohio Rev. Code §§ 3705.15 and 3705.22.

2. Set forth and explain any and all government interest(s) that Defendants contend the Birth Certificate Policy serves, and how each of the reasons listed in response to Interrogatory 1 further such interest(s).

RESPONSE

Defendants object to this request because it is overbroad and unduly burdensome. Defendants further object because the defined term Ohio Birth Certificate Policy is vague, ambiguous, and subject to multiple interpretations. Defendants further object because Plaintiffs' definition of Ohio Birth Certificate Policy assumes that Ohio's birth certificates contain a gender marker. But Ohio's birth certificates do not contain a gender marker and Defendants do not collect information related to a person's gender marker. Finally, Defendants object because the request calls for information that is protected by the attorney-client privilege and work product doctrine. Subject to the foregoing, Defendants state that Ohio Rev. Code §§ 3705.15 and 3705.22 set forth the circumstances under which a person may correct the sex reflected on an Ohio birth certificate. Ohio's substantial interest in enforcing such statutes is set forth in the Motion to Dismiss (Doc.18 at 18–22) and the Reply in support of the Motion to Dismiss (Doc. 28 at 17–18).

3. Identify every instance in which any Defendant including any past Ohio Department of Health official has ever made any change to a gender marker on a birth certificate, as well as the reason for that change.

RESPONSE

Defendants object to this request because it is overbroad and unduly burdensome. Defendants further object because the defined term gender marker is vague, ambiguous, and subject to multiple interpretations. Defendants also object because Ohio's birth certificates do not contain a gender marker and Defendants do not collect information related to a person's gender marker. Therefore, because Ohio's birth certificates do not contain a gender marker, Defendants are unaware of any instance where a change to such marker was made. Finally, Defendants object to this request because it is unlimited in time and scope. Subject to the foregoing, Defendants state that the sex identifier has been changed for reasons other than set forth in Ohio Rev. Code §§ 3705.15 and 3705.22, for the following individuals:

Date	Change	Reason
1/8/2004	M to F	Court Order
8/17/2011	M to F	Court Order
8/17/2011	M to F	Court Order
4/18/2012	F to M	Court Order
11/19/2013	M to F	Court Order
9/9/2014	M to F	Court Order
9/9/2014	F to M	Court Order
1/20/2015	F to M	Court Order
3/2/2015	F to M	Court Order
9/25/2015	M to F	Court Order

4. Identify all current or former government officials involved in and documents related to every instance identified in response to Interrogatory 3.

RESPONSE

Defendants reassert the objections and response to Interrogatory No. 3. Additionally, Defendants object to the request because it calls for information that is protected by the attorney client privilege and work product doctrine. Subject to the foregoing, and excluding legal counsel, Defendants state the following:

- Mark Kassouf, Assistant State Registrar, Office of Vital Statistics, fmr.

* * *

The below sentence and accompanying chart are excerpted from an October 17, 2019 email from Defendants' Counsel Jason Blake to Plaintiffs' Counsel Elizabeth Bonham and Kara Ingelhart. The chart is a supplemental discovery response from Defendants that modifies Defendants' Responses to Plaintiffs' First Set of Interrogatories, No. 3 (above).

2. The updated table with relevant bates arranges is:

Date	Change	Reason	Beg. Bates	End Bates
1/8/2004	M to F	Court Order	ODH_000351	ODH_000354
8/17/2011	M to F	Court Order	OHD_000331	OHD_000335
8/17/2011	M to F	Court Order	OHD_000336	OHD_000338
4/18/2012	F to M	Court Order	OHD_000339	ODH_000340
11/19/2013	M to F	Court Order	ODH_000259	ODH_000263
			ODH_000342	OHD_000347
			ODH_000349	ODH_000350
9/9/2014	M to F	Court Order	ODH_000156	
			ODH_000365	ODH_000367
9/9/2014	F to M	Court Order	ODH_000156	
			ODH_001176	ODH_001180
			ODH_001135	ODH_001140
1/20/2015	F to M	Court Order	ODH_000156	
			ODH_001160	
3/2/2015	F to M	Court Order	ODH_000156	
			ODH_001142	ODH_001148
9/25/2015	M to F	Court Order	ODH_000156	
			ODH_001163	ODH_001164

EXHIBIT B

ODH Internal Guidance Documents

Parent Titles

It has come to our attention that some hospitals may select the incorrect title for a parent in IPHIS. If the hospital chose "father" instead of "mother" and now the book copy looks as if the child was born to two fathers, it has been decided that the Helpdesk staff will confirm with the hospital that it was their mistake and our office will correct the parent title in IPHIS so that an abstract can be issued. Helpdesk will notify Amy and myself so that once the incorrect book copy comes into our office we will create a new book copy. The parents will not need to go to court or complete a birth affidavit. On a 2017 record the book copy image should update once the correct parent titles have been chosen.

If we find that the parent titles in IPHIS match what was recorded on the parent worksheet the parents will need to contact the Probate Court in the county that the birth occurred in to execute a Court Ordered Correction.

What to say to customers: We will work with the hospital to ensure that the record in IPHIS matches the information provided on the parent worksheets.

What to say to hospitals: We can only correct records to what is on the parent worksheets.

Long Names

This issue has come up enough times that now we need to have some sort of process in place. If a hospital or LHD calls stating that the parent(s) name do not print completely on the abstract or book copy we will do the following steps. Whomever receives the call will need to make sure all the information in IPHIS is correct and the record has been registered.

The next step would be to notify Rena so that a book copy can be created outside of IPHIS (please give the SFN, parents full name, and the contact information for the caller). Once this has been done it will be printed and scanned into OnBase then get attached to the record in IPHIS. A footnote will be placed on the abstract stating "Do not issue abstract, the parent(s) names are not listed correctly". The LHD should proceed to issue the book copy by going to Actions>Display Image. If necessary contact the caller and inform them when the book copy can be purchased by the parents.

What to say to customers: We will need to create an updated certificate to accommodate the long name of the child/parent; a certificate will not be available until the Special Registration team can update the record.

What to say to LHDs: Do not have a customer wait in the lobby for this change to be made, as it will take at least one day for the updated image to be available.

Gender Changes

Below is our stance on changing the gender on a birth record in regards to someone that has had gender reassignment surgery or transitioned. Most gender change request come to our office with a legal name change together. We will offer the customer the option to only process the name change or they can have their paperwork returned to them and a refund issued (if applicable). If you receive a call from a customer in regards to changing their gender on their birth record you can read them the below statement. If they still want to speak to someone you can take their name and number and send it to me. I will either call them directly or have legal contact them. Please be detailed when emailing me their concern.

"The Ohio Department of Health, Bureau of Vital Statistics can process a name change but has no legal authority to process a gender change.

The Ohio Revised Code (R.C.) section 3705.15 specifies the procedure for updating a birth certificate after a legal name change, and for correcting mistakes on a birth certificate that were made shortly after the birth. It does not authorize changing a gender marker on a birth certificate to reflect gender transition.

Ohio Revised Code section 3705.22, which allows for amendment of a birth certificate to correct errors, also does not authorize changing the gender marker on a birth certificate to reflect gender transition.

Sorry for any inconvenience this may cause."

OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich / Governor

June 1, 2017

Redaction

Re: Request for Changes on Birth Certificate

Redaction

The Ohio Department of Health, Office of Vital Statistics, received your request to make changes to your birth certificate. The Bureau of Vital Statistics can process the name change but has no legal authority to process the gender change.

Revised Code (R.C.) section 3705.15 specifies the procedure for updating a birth certificate after a legal name change, and for correcting mistakes on a birth certificate that were made shortly after the birth. R.C. 3705.15 does not authorize changing a gender marker on a birth certificate to reflect gender transition. R.C. section 3705.22, which allows for amendment of a birth certificate to correct errors, also does not authorize changing the gender marker on a birth certificate to reflect gender transition.

Please call Vital Statistics Supervisor, Rena Boler, at (614) 387-7479 and let her know whether you would like the birth certificate with the name change only reflected, or to have your paperwork returned.

Sincerely,

Judith Nagy

State Registrar
Ohio Department of Health
Office of Vital Statistics

PLAINTIFF'S EXHIBIT
16
8-2-19

Each sub-committee reviewed their survey results. The sub-committees were tasked with outlining best practices in their focused registration area. After thorough review by the entire committee, the following best-practices have been accepted by the Registration Committee and are recommended to the NAPHSIS board.

When reviewing the recommendations listed below, the following interpretations are provided for contextual purposes:

- EBRS – Electronic Birth Registration System
- EDRS – Electronic Death Registration System
- EMRS – Electronic Marriage Registration System
- Statistical Purposes – demographic and medical data collected for submission to the National Center for Health Statistics
- Legal Purpose/Portion – specific to data collected for and reported as part of the legal document that is certified

1. **Gender Neutral Label:**
    a. Recommend the use of one gender neutral label
        i. Parent
            1. EBRS, EDRS, EMRS if applicable
        ii. Spouse
            1. EMRS

2. **Collection of Sex– Parents:**
    a. Recommend collection of sex of parents on a birth and death record for statistical purposes
    b. Encourage the new data items to be included for statistical purposes only.
        i. Not required by NCHS

3. **Collections of Sex of Registrant – Marriage/Dissolution:**
    a. Recommend collection of sex for registrants of marriage and dissolution records.
    b. Encourage the new data items to be included for statistical purposes only.

4. **Voluntary Paternity Acknowledgement:**
    a. Recommend that Voluntary Paternity Acknowledgment processes allow for the establishment of biological paternity only.

5. **Female Same Sex Marriages – Birth records:**
    a. Recommend that legal spouse of birth mother is listed as Parent 2, regardless of gender.

6. **Surrogacy:**
    a. Maintain the collection of data for the individual who gave birth (aka birth mother) from conception to time of birth, regardless of biological connection to the child born

i. Ensure that data for individual who gave birth is transmitted to NCHS for purposes of public health research

b. Recommend jurisdictions accept agreements established under statute or court orders that establish legal maternity and paternity where there is a biological connection of both intended parents to the child born of a surrogate birth mother
   i. Recommend all records establishing parentage be sealed or held confidential by statute

c. Recommend jurisdictions accept agreements established under statute or court orders that establish legal parentage when one or both intended parents have no biological connection to the child born of a surrogate birth mother
   i. Recommend all records establishing parentage be sealed or held confidential by statute

d. Recommend pre-birth orders, either surrogate or adoption, be accepted to establish a certificate of live birth as long as the public health data associated with the individual who gave birth will be transmitted to NCHS and the process is established under statute

7. **Multiple Parents:**
   a. Prohibiting the listing of multiple parents (more than 2) should not be based on data system restrictions
   b. Consultation with legal authority should be a priority if statute or rules are silent on total number of parents that are to be listed on a vital record

8. **Gender Identity:**
   a. Recommend collection of biological sex at time of birth for statistical purposes using the following biological sex labels:
      i. Female
      ii. Male
      iii. Not Yet Determined
   b. Recommend documenting gender identity or sex on the legal portion of the birth record using the following standard gender identity/sex labels:
      i. Female
      ii. Male
      iii. X
   c. Prohibiting multiple labels for gender identity/sex should not be based on data system restrictions
   d. Recommend jurisdictions accept documentation established by statute or court order that establish legal name of registrant and gender/sex.
   e. Consultation with legal authority should be a priority if statute or rules are silent on authority to change gender/sex on the legal certificate of birth.

In addition to the best practices outlined above, the Registration Committee recommends NAPHSIS Model Law (2011 revision) and the Uniform Parentage Act (2002 revision) for use by jurisdictions when addressing all other registration issues. Currently, the Uniform Parentage Act, 2017 edition, is in draft

form. Once adopted, the Registration Committee supports the use of this document as a tool for jurisdictions to use addressing registration issues.

References

1. Uniform Law Commission, The National Conference of Commissioners on Uniform State Laws; Uniform Parentage Act, Final Act (2002) http://www.uniformlaws.org/Act.aspx?title=Parentage%20Act
2. Model State Vital Statistics Act and Model State Vital Statistics Regulations, 2011 Revision. https://www.naphsis.org/
3. Hospitals' and Physicians' Handbook on Birth Registration and Fetal Death Reporting https://www.cdc.gov/nchs/data/misc/hb_birth.pdf

EXHIBIT C

ODH Records of U-marked Birth Certificates

CERTIFICATION OF BIRTH

STATE FILE NUMBER [redacted]

DATE RECORD FILED 10/31/2017

NAME [redacted]

DATE OF BIRTH [redacted]

SEX

BIRTHPLACE [redacted]

MOTHER'S NAME [redacted]

FATHER'S NAME [redacted]

LAST NAME PRIOR TO FIRST MARRIAGE [redacted]

MOTHER'S BIRTHPLACE [redacted]

FATHER'S BIRTHPLACE [redacted]

Note: This birth record is a delayed filing. (More than one year after the date of birth) And the file date is correct.

This is a true certification of the name and birth facts as recorded in the Office of Vital Statistics, Columbus, Ohio. Witness my signature and seal of the Department of Health this 06 day of January, 2020

State Registrar of Vital Statistics

CENTRAL LOCATION

Reg. Dist. No. 31___ - ___

Primary Reg. Dist. No. 3100 __

Ohio Department of Health
VITAL STATISTICS
CERTIFICATE OF LIVE BIRTH

Certificate No. Redaction

CHILD	1. CHILD'S NAME (First, Middle, Last, Suffix): Redaction		
	2. TIME OF BIRTH (24hr): Red	3. SEX: UNKNOWN	4. DATE OF BIRTH (Mo/Day/Yr): Redac
	5a. FACILITY NAME (If not institution, give street and number): Redaction		
	5b. CITY, TOWN OR LOCATION OF BIRTH: ANDERSON TWP		5c. COUNTY OF BIRTH: HAMILTON
ATTENDANT	6a. ATTENDANT'S NAME: OGBURN, CASEY ANDREW	6b. ATTENDANT'S TITLE: M.D.	
MOTHER	7a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix): Redaction		7b. DATE OF BIRTH (Mo/Day/Yr): Redact
	7c. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE: Red		7d. BIRTHPLACE (State, Territory, or Foreign Country): OHIO
	8a. STREET AND NUMBER OF MOTHER'S RESIDENCE: Redaction	8b. APT. NO.	8c. CITY, TOWN OR LOCATION: BATAVIA
	8d. STATE, TERRITORY, OR FOREIGN COUNTRY: OHIO	8e. ZIP CODE: 45103	8f. COUNTY: CLERMONT
FATHER	9a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		9b. DATE OF BIRTH (Mo/Day/Yr)
	9c. FATHER'S LAST NAME PRIOR TO FIRST MARRIAGE		9d. BIRTHPLACE (State, Territory, or Foreign Country)
ACKNOWLEDGEMENT OF FILING	10a. REGISTRAR'S SIGNATURE: TIMOTHY INGRAM		10b. DATE FILED BY REGISTRAR (Mo/Day/Yr): 08/30/2011

Rev4

Reg. Dist. No. 31

Primary Reg. Dist. No. 3101

Ohio Department of Health
VITAL STATISTICS
CERTIFICATE OF LIVE BIRTH

Certificate No. Redaction

CHILD	1. CHILD'S NAME (First, Middle, Last, Suffix) [redacted]		
	2. TIME OF BIRTH (24hr) [redacted]	3. SEX UNKNOWN	4. DATE OF BIRTH (Mo/Day/Yr) [redacted]
	5a. FACILITY NAME (if not institution, give street and number) UNIVERSITY HOSP OF CINCINNATI		
	5b. CITY, TOWN OR LOCATION OF BIRTH		5c. COUNTY OF BIRTH HAMILTON
ATTENDANT	6a. ATTENDANT'S NAME EDITH HARTE	6b. ATTENDANT'S TITLE M.D.	
MOTHER	7a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) [redacted]		7b. DATE OF BIRTH (Mo/Day/Yr) [redacted]
	7c. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE [redacted]		7d. BIRTHPLACE (State, Territory, or Foreign Country) [redacted]
	8a. STREET AND NUMBER OF MOTHER'S RESIDENCE [redacted]	8b. APT. NO.	8c. CITY, TOWN OR LOCATION [redacted]
	8d. STATE, TERRITORY, OR FOREIGN COUNTRY [redacted]	8e. ZIP CODE [redacted]	8f. COUNTY *
FATHER	9a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		9b. DATE OF BIRTH (Mo/Day/Yr)
	9c. FATHER'S LAST NAME PRIOR TO FIRST MARRIAGE		9d. BIRTHPLACE (State, Territory, or Foreign Country)
ACKNOWLEDGEMENT OF FILING	10a. REGISTRAR'S SIGNATURE STEVEN TAGGART		10b. DATE FILED BY REGISTRAR (Mo/Day/Yr) 01/31/2007

Rev4

Reg. Dist. No. 09

Primary Reg. Dist. No. 8310

Ohio Department of Health
VITAL STATISTICS
CERTIFICATE OF LIVE BIRTH

Certificate No. Redaction

CHILD	1. CHILD'S NAME (First, Middle, Last, Suffix) Redaction		
	2. TIME OF BIRTH (24hr) Re	3. SEX UNKNOWN	4. DATE OF BIRTH (Mo/Day/Yr) Redac
	5a. FACILITY NAME (If not institution, give street and number) Redaction		
	5b. CITY, TOWN OR LOCATION OF BIRTH Redaction		5c. COUNTY OF BIRTH WARREN
ATTENDANT	6a. ATTENDANT'S NAME ANDREW, WILLIAM	6b. ATTENDANT'S TITLE M.D.	
MOTHER	7a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) Redaction		7b. DATE OF BIRTH (Mo/Day/Yr) Redacti
	7c. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE Red		7d. BIRTHPLACE (State, Territory, or Foreign Country) OHIO
	8a. STREET AND NUMBER OF MOTHER'S RESIDENCE Redaction	8b. APT. NO.	8c. CITY, TOWN OR LOCATION Redaction
	8d. STATE, TERRITORY, OR FOREIGN COUNTRY OHIO	8e. ZIP CODE 45044	8f. COUNTY BUTLER
FATHER	9a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) Redaction		9b. DATE OF BIRTH (Mo/Day/Yr) Redacti
	9c. FATHER'S LAST NAME PRIOR TO FIRST MARRIAGE		9d. BIRTHPLACE (State, Territory, or Foreign Country) OHIO
ACKNOWLEDGEMENT OF FILING	10a. REGISTRAR'S SIGNATURE AMANDA MCDONALD		10b. DATE FILED BY REGISTRAR (Mo/Day/Yr) 04/04/2018

Rev4

EXHIBIT D

ODH Records Requesting H-marked Birth Certificate

AMENDED

PB12BR3100512

554337 102 Pages: 0001

written – Do not fold All Facts must be given as of Time of Birth

CORRECTION OF BIRTH RECORD

ion, Finding and Order for Registration of Birth

Ohio

Case No. [redacted]

In the Probate Court of Franklin County, Ohio, on the 10th day of Aug., 20 12, appeared [redacted] praying that the facts of birth be established in accordance with Section 3705.15 of the revised code, as follows:

CHILD	Full Name (At time of Birth) [redacted]		
	Exact Place of Birth Columbus, OH	Date of Birth Redacti	☒ Male ☐ Fem
FATHER	Name of Father [redacted]	MOTHER	Maiden Name of Mother [redacted]
	Age of Father (At time of birth) 39		Age of Mother (At time of this birth) 24
	Birthplace of Father Ohio		Birthplace of Mother Ohio

FT A Robert Franklin

ITEMS TO BE CORRECTED OR ADDED

ITEM Sex READS AS Male SHOULD READ Hermaphrodit

ITEM Sex READS AS Male SHOULD READ (Blank)

ITEM _____ READS AS _____ SHOULD READ _____

ITEM _____ READS AS _____ SHOULD READ _____

ITEM _____ READS AS _____ SHOULD READ _____

The undersigned being first duly sworn, says that the facts stated in the foregoing Application and prays that the Court order the registration of the birth.

[redacted]

Sworn to before me and signed in my presence
By the applicant or registrant aforesaid this 10th day of Aug. 2012

W A Reddenhouse
Deputy Clerk / Magistrate
Official Character

JOURNAL ENTRY

The Court on consideration of the aforesaid evidence submitted finds and orders that notice of hearing be dispensed with and the birth of applicant be accordance with the facts hereinabove set forth; and that a summary of the finding and order of the Court, duly certified, be forthwith transmitted to th Health, at Columbus, Ohio, as provided by law.

Robert G Montgomery
ROBERT G. MONTGOMERY
Probate Judge

I her opy of the application and entry in the foregoing matter.

12/6/12

Robert G Montgomery
ROBERT G. MONTGOMERY
Probate Judge

By _____
Deputy Clerk

FILED #1
AUG 31 2012
Robert G. Montgomery, Judge
Franklin County Probate Court

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103

SS

IN THE PROBATE COURT OF FRANKLIN COUNTY, OHI(
ROBERT G. MONTGOMERY, JUDGE

In re Delayed Birth Certificate of:
In re Birth Correction of: Redaction

CASE NO.:

CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the ☐ Application and Entr

Delayed Birth Certificate ☒ Application and Entry for Birth Correction was mailec

regular United States Mail, postage prepaid, to:

Ohio Department of Health
P.O. Box 15098
Columbus, Ohio 43215

on the 3rd day of December, 20 12.

Deputy Clerk

FILED #15
DEC 0 3 2012
Robert G. Montgomery, Judge
Franklin County Probate Court

PROBATE COURT OF FRANKLIN COUNTY, OHIO
ROBERT G. MONTGOMERY, JUDGE

In the Matter of the Application for Correction
Of the Birth Record of
Redaction

Case Number Redac

ENTRY APPROVING MAGISTRATE'S DECISION

The Court in review of this matter, finds a Decision was rendered and filed on t 31st day of August, 2012 by William A. Reddington, a Magistrate of this Court. All parti were duly served with a notice and a copy of the Magistrate's Decision. The Court fin that the 14 day period has expired within which to make objections.

No objections were filed to the Magistrates' Decision.

Following an independent review pursuant to Civ. R. 53, the Court finds that t Magistrate has properly determined the pertinent facts and applied the salient law there Hence, this Court adopts the Magistrate's Decision as its own, including the findings fact and conclusions of law contained therein.

THEREFORE, this Court accepts the recommendation of the Magistrate Decision and hereby Orders the Ohio Department of Health, Division of Vital Statistics correct the birth record of Redaction formerly known as Redaction born at White Cross Hospital in the City of Columbus, County of Franklin, Ohio Redaction to Redaction fro showing sex as "Male " to showing sex as "Hermaphrodite".

Date: 9-19-12

ROBERT G. MONTGOMERY
Judge of the Probate Court

FILED #:
SEP 19 201
Robert G. Montgomery, J
Franklin County Probate

IN THE PROBATE COURT OF FRANKLIN COUNTY, OHIO
ROBERT G. MONTGOMERY, JUDGE

In re Delayed Birth Certificate of:
In re Birth Correction of: Redaction

CASE NO.:

CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the ☐ Application and Entry for Delayed Birth Certificate ☒ Application and Entry for Birth Correction was mailed by regular United States Mail, postage prepaid, to:

Ohio Department of Health
P.O. Box 15098
Columbus, Ohio 43215

on the 20th day of September, 20 12.

Deputy Clerk

vs – Certificate of Service to ODH - Vital Statistics

PROBATE COURT OF FRANKLIN COUNTY, OHIO
ROBERT G. MONTGOMERY, JUDGE

In re: Application for Correction of Birth Record of [Redaction]

Case Number [Redac]

MAGISTRATE'S DECISION

Pursuant to a prior order referring the above entitled proceeding to me for hearing and report, I proceeded under the provisions of §2315.37 of the Ohio Revised Code to hear and examine such proceeding and respectfully submit the following decision thereon.

The matter was heard on the 10th day of August, 2012 upon the application of [Redaction] formerly known as [Redaction] correct her birth record. Appearances were made by [Redaction] and her attorney Frederick L. Berkemer.

A copy of the decision of the magistrate was filed on the above stamped date with the Court and copies were mailed to the parties and/or their attorneys of record.

Findings of fact and recommendations are as stated in this report, attached thereto.

FILED #1
AUG 31 2012
Robert G. Montgomery, Judge
Franklin County Probate Court

17d
17b
17c
COS

In re: Application for Correction of Birth Record of Redaction
Case Number: Redacted

NOTICE TO ATTORNEYS AND PARTIES

Ohio Civil Rule of Procedure 53(D)(3)(b)(i) provides as follows:

> "*(i) Time for filing.* A party may file written objections to a magistrate's decision within fourteen days of the filing of the decision, whether or not the court has adopted the decision during that fourteen-day period as permitted by Civ.R. 53(D)(4)(e)(i). If any party timely files objections, any other party may also file objections not later than ten days after the first objections are filed. If a party makes a timely request for findings of fact and conclusions of law, the time for filing objections begins to run when the magistrate files a decision that includes findings of fact and conclusions of law."

Ohio Civil Rule of Procedure 53(D)(4)(e)(i) provides as follows:

> "(i) *Judgment.* The court may enter a judgment either during the fourteen days permitted by Civ.R. 53(D)(3)(b)(i) for the filing of objections to a magistrate's decision or after the fourteen days have expired. If the court enters a judgment during the fourteen days permitted by Civ.R. 53(D)(3)(b)(i) for the filing of objections, the timely filing of objections to the magistrate's decision shall operate as an automatic stay of execution of the judgment until the court disposes of those objections and vacates, modifies, or adheres to the judgment previously entered.

These and all other provisions of the Ohio Rules of Civil Procedure must be in compliance or objections will be overruled.

A party shall not assign as error on appeal the Court's adoption of any finding of fact or conclusion of law unless the party timely and specifically objects to that finding or conclusion as required by Civ. R. 53(E)(3).

FILED #1
AUG 3 1 2012
Robert G. Montgomery, Judge
Franklin County Probate Court

In re: Application for Correction of Birth Record of Redactio
Case Number Re

DECISION OF MAGISTRATE

The Ohio Department of Health, Division of Vital Statistics is to correct the birth record of Redaction formerly known as Redaction born at White Cross Hospital in the City of Columbus, County of Franklin, Ohio on Redaction

Re from showing sex as "Male" to showing sex as (Hermaphrodite).

Respectfully submitted

William A. Reddington
Magistrate

CERTIFICATE OF SERVICE

I certify of copy of the foregoing Magistrate's Decision was sent by me by prepaid United States first class mail to:

Frederick L. Berkemer
Redaction
1335 Dublin Road, Suite 215B
Columbus, Ohio 43215

this 31st day of August, 2012.

Deputy Clerk

FILED #1
AUG 31 2012
Robert G. Montgomery, Judge
Franklin County Probate Court

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IN THE PROBATE COURT OF FRANKLIN COUNTY, OHIO
ROBERT G. MONTGOMERY, JUDGE

In re Delayed Birth Certificate of:
In re Birth Correction of: Redaction

CASE NO.:

CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the ☐ Application and Entry Delayed Birth Certificate ☒ Application and Entry for Birth Correction was mailed regular United States Mail, postage prepaid, to:

Ohio Department of Health
P.O. Box 15098
Columbus, Ohio 43215

on the 20th day of September, 20 12.

Deputy Clerk

In re: Application for Correction of Birth Record of Redactio
Case Numbe

FINDINGS OF FACT

The applicant, Redaction was born on Redacti at White Cross Hospital in the Franklin County, City of Columbus, Ohio and named Redaction Her parents were Redaction Red She was born a true hermaphrodite with both male and female sex organs. According to the affidavit of Dr. Gary J. Smith, M.D., marked as exhibit 4:

"
3. Redaction has been my patient. I am familiar with her medical condition and history.
4. Redaction was a trueborn hermaphrodite, having both male and female sexual organs and characteristics. From a medical standpoint, her sex was never solely male or female at birth.
5. She had an irreversible orchietomy in 2006. Her legal sex is now female."

The applicant testified she was born with both a penis and a vagina with ovatestes, meaning her testicles and ovaries were combined into one. Ovatestes produce both testosterone and estrogen. She went through puberty having post menstrual syndrome for ten days every month. She was raised as a boy not feeling she had any choice and tried to hide who she was.

Talessa L. Powell, M.D. also found in a medical record completed by her that the applicant "is a true hermaphrodite and was raised as male. Struggled w/PMS and breast development in the teens and went through surgery to be classified as female this past year." See exhibit 5. Exhibit 6 from Dr. Powell's records show the result of the applicant's bond density report as a normal score for post-menopausal Caucasian women.

FILED #1
AUG 31 2012
Robert G. Montgomery, Judge
Franklin County Probate Court

In re: Application for Correction of Birth Record o Redaction
Case Numbe

This issue of the correction of a birth record has been addressed in *In re: Declaratory Relief for Ladrach*, (1987) 32 Ohio Misc.2d 6; 513 N.E.2d 828; 1987 Ohio Misc. LEXIS 145. That Court found:

> "It is the position of this court that the Ohio correction of birth record statute, *R.C. 3705.20* (now *R.C. 3705.15*). Is strictly a 'correction' type statute, which permits the probate court when presented with appropriate documentation to correct errors such as spelling of names, dates, race and sex, if in fact the original entry was in error. There was no error in the designation of Edward Franklin Ladrach as a 'Boy' in the category of 'sex' on his birth certificate, and for this reason the previously mentioned application for correction of birth record was dismissed by this court.
>
> The Supreme Court of Oregon in *K. v. Health Division (1977), 277 Ore. 371, 560 P. 2d 1070*, considered whether to grant the petition of a transsexual to order the change of sex on birth and school records from female to male. The court said, 'it was the intent of the legislature of Oregon that a 'birth certificate' is an historical record of the facts as they existed at the time of birth * * *,' *id. At 375, 560 P. 2d at 1072*, and further concluded that it was up to the legislature to authorize any such change which would permit the birth certificate to reflect facts as they presently exist."

In the matter at hand the applicant's birth record indicates sex as "male". While it is true that the applicant had male sex organs at the time of her birth, she also had female sex organs. Therefore her birth record is incorrect by indicated her sex only as "male" while she had female attributes as well. Because the birth record is an historical record of the facts as they existed at the time of birth, the birth record should be corrected to show the sex of the applicant as "hermaphrodite".

FILED #1
AUG 31 2012
Robert G. Montgomery, Judge
Franklin County Probate Court

EXHIBIT E

Expert Report of Dr. Randi Ettner

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO

STACIE RAY, *et al.*, Plaintiffs, v. LANCY HIMES, *et al.*, Defendants.	Case No. 2:18-cv-00272 Judge: Michael Watson Magistrate Judge: Chelsey Vascura

EXPERT REPORT OF DR. RANDI C. ETTNER, Ph.D.

I. INTRODUCTION

1. My name is Randi C. Ettner. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have been asked by Plaintiffs' counsel to provide my expert opinion on how Ohio's policy banning accurate birth certificate gender markers for transgender people born in Ohio affects transgender individuals.

3. I prepared this report to set forth the opinions I may express at trial and the basis for my opinions. The opinions expressed in this report are based on the information that I have reviewed to date. I reserve the right to revise and supplement the report if any new information becomes available in the future.

4. My curriculum vitae, which includes a list of publications, is attached to this report as Exhibit A. Materials that I considered in forming my opinions are listed in Exhibit B or referenced in this report. I also relied on my considerable professional experience in reaching the conclusions in this report.

5. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *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); and *Carillo v. U.S. Dept. of Justice*, Exec. Office of Immgr. Rev. (2017).

6. I am being compensated: $400 per hour for preparation of this report, $325 per hour for any pre-deposition and/or pre-trial preparation, $425 per hour for any deposition testimony or trial testimony, and a $2,000 flat fee for any travel time to attend a deposition or trial in the Litigation.

II. SUMMARY OF QUALIFICATIONS

7. I am a licensed clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria. I received my doctorate in psychology from Northwestern University in 1979. I was the chief psychologist at the Chicago Gender Center from 2005 to 2016, when it moved to the Weiss Memorial Hospital. Since that time, I have held the sole psychologist position at the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. The center specializes in the treatment of individuals with gender dysphoria. I have been involved in the treatment of patients with gender dysphoria since 1977, when I was an intern at Cook County Hospital in Chicago.

8. During the course of my career, I have evaluated and/or treated between 2,500 and 3,000 individuals with gender dysphoria and mental health issues related to gender variance.

9. 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* (Ettner, Monstrey & Eyler, 2007) and the second edition (Ettner, Monstrey & Coleman, 2016). I have authored numerous articles in peer-reviewed journals regarding the provision of care to this population. I serve as a member of the editorial boards for the *International Journal of Transgenderism* and *Transgender Health*. I received a commendation from the United States Congress House of Representatives on February 5, 2019 recognizing my work for WPATH and Gender Dysphoria in Illinois.

10. I am the Secretary and member of the Executive Board of Directors of the World Professional Association for Transgender Health ("WPATH") (formerly the Harry Benjamin Gender Dysphoria Association) and an author of the *WPATH Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People*, 7th version, published in 2012. The WPATH promulgated Standards of Care ("Standards of Care") are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

11. I have lectured throughout North America, Europe, and Asia on topics related to gender dysphoria, and on numerous occasions I have presented grand rounds on gender dysphoria at medical hospitals. I am an honoree of the *Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota*, and have been an invited guest at the National Institutes of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities.

12. I have been retained as an expert regarding gender dysphoria and its treatment in multiple federal court proceedings, and have repeatedly qualified as an expert.

13. A true and accurate copy of my Curriculum Vitae is attached hereto as Exhibit A, which documents my education, training, research, and years of experience in this field. A bibliography of the materials reviewed in connection with this declaration is attached hereto as Exhibit B. The sources cited therein are authoritative, scientific peer-reviewed publications. I generally rely on these materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this declaration. 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.

14. I have not met or spoken with the Plaintiffs for purposes of this declaration. My opinions are based solely on the information I have been provided by Plaintiffs' attorneys as well as my extensive experience studying gender dysphoria and in treating transgender patients.

III. SUMMARY OF OPINIONS

15. Medical management of gender dysphoria includes the alignment of appearance, presentation, expression, and often, the body, to reflect a person's true sex as determined by their gender identity. Correcting the gender marker on identification documents confers social and legal recognition of identity and is crucial to this process. The necessity and importance of privacy is universal, and exists even in animals. A wide range of species avoid predators by managing information about internal states and future intentions, for purposes of survival. Privacy enables normal psychological functioning, the ability to have experiences that promote healthy personal growth and interpersonal relationships, and allows for measured self-disclosure. It is the basis for the development of individuality and autonomy.

16. For a transgender person, a birth certificate bearing an incorrect gender marker invades privacy, releases confidential medical information, and places the individual at risk for grave psychological and physical harm.

IV. OPINIONS

a. Sex and Gender Identity

17. At birth, infants are assigned a sex, typically male or female, based solely on the appearance of their external genitalia. For most people, that assignment turns out to be accurate, and their birth-assigned sex matches that person's actual sex. However, for transgender people, the sex assigned at birth does not align with the individual's genuine, experienced sex, resulting in the distressing condition of gender dysphoria.

18. External genitalia alone—the critical criterion for assigning sex at birth—is not an accurate proxy for a person's sex.

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

20. Gender identity is a person's inner sense of belonging to a particular sex, such as male or female. It is a deeply felt and core component of human identity. It is detectible by self-disclosure in adolescents and adults.

21. When there is divergence between anatomy and identity, one's gender identity is paramount and the primary determinant of an individual's sex designation. Developmentally, identity is the overarching determinant of the self-system, influencing personality, a sense of

mastery, relatedness, and emotional reactivity, across the life span. Identity is also the foremost predictor of satisfaction and quality of life. Psychologist Eric Erickson defined identity as "the single motivating force in life."

22. Like non-transgender people (also known as cisgender people), transgender people do not simply have a "preference" to act or behave consistently with their gender identities. Every person has a gender identity. It is a firmly established elemental component of the self-system of every human being.

23. The only difference between transgender people and cisgender people is that the latter have gender identities that are consistent with their birth-assigned sex whereas the former do not. A transgender man cannot simply turn off his gender identity like a switch, any more than anyone else could.

24. In other words, transgender men are men and transgender women are women.

25. A growing assemblage of research documents that gender identity is immutable and biologically based. Efforts to change an individual's gender identity are therefore both futile and unethical.

26. The evidence demonstrating that gender identity cannot be altered, either for transgender or for non-transgender individuals, further underscores the innate and immutable nature of gender identity. Past attempts to "cure" transgender individuals by means of psychotherapy, aversion treatments or electroshock therapy, in order to change their gender identity to match their birth-assigned sex, have proven ineffective and caused extreme psychological damage. All major associations of medical and mental health providers, such as the American Medical Association, the American Psychiatric Association, the American Psychological Association, and WPATH's Standards of Care, consider such efforts unethical.

b. Gender Dysphoria and Its Treatment

27. Gender Dysphoria is the clinically significant distress or impairment of functioning that can result from the incongruence between a person's gender identity and the sex assigned to them at birth. Gender dysphoria is a serious medical condition associated with severe and unremitting emotional pain from the incongruity between various aspects of one's sex. It is codified in the *International Classification of Diseases* (10th revision: World Health Organization), the diagnostic and coding compendia for mental health and medical professionals, and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* Fifth Edition (DSM-5). People diagnosed with gender dysphoria have an intense and persistent discomfort with their assigned sex.

28. Gender dysphoria was previously referred to as gender identity disorder. In 2013, the American Psychiatric Association changed the name and diagnostic criteria to be "more descriptive than the previous DSM-IV term gender identity disorder and focus[] on dysphoria as the clinical problem, not identity per se." DSM-5 at 451.

29. The diagnostic criteria for Gender Dysphoria in Adolescents and Adults are as follows:

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

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

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

30. Once a diagnosis of gender dysphoria is established, individualized treatment should be initiated. Without treatment, individuals with gender dysphoria experience anxiety, depression, suicidality and other attendant mental health issues and are often unable to adequately function in occupational, social, or other areas of life.

31. Although rates of suicide are higher amongst the transgender community than the general population, a 2015 study identified several factors that were associated with large reductions in suicide risk. The study reported that having an identity document with a gender marker notation that matched their lived gender was associated with a large reduction in suicidal ideation and attempts. The study noted that having one or more of these concordant identity

documents has the potential to prevent suicidal ideation and suicide attempts—demonstrating that in a hypothetical sampling of 1,000 transgender people who were permitted to change an identity document gender marker, 90 cases of ideation could be prevented, and, in a hypothetical sampling of 1,000 transgender people with suicidal ideation who were permitted to change an identity document gender marker, 230 suicide attempts could be prevented. The medically accepted standards of care for treatment of gender dysphoria are set forth in the *WPATH Standards of Care* (7th version, 2011), first published in 1979. The WPATH-promulgated Standards of Care are the internationally recognized guidelines for the treatment of persons with gender dysphoria, and inform medical treatment throughout the world.

32. 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 *National Commission of Correctional Health Care*, the *American Public Health Association*, the *National Association of Social Workers*, the *American College of Obstetrics and Gynecology*, the *American Society of Plastic Surgeons*, and *The American Society of Gender Surgeons* all endorse protocols in accordance with the WPATH standards. (*See, e.g.*, American Medical Association (2008) Resolution 122 (A-08); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009).)

33. The Standards of Care identify the following treatment protocols for treating individuals with gender dysphoria, which should be tailored to the patient's individual medical needs:

- Changes in gender expression and role, also known as social transition (which involves living in the gender role consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body in order to reduce the distress caused by the discordance between one's gender identity and sex assigned at birth;
- Surgery to change primary and/or secondary sex characteristics; and
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; and promoting resilience.

34. These treatments do not change a transgender person's sex, which is already determined by their gender identity. Attempts to change a person's gender identity to bring it into alignment with their birth-assigned sex are not only futile, but also dangerous and unethical.

c. The Process of Gender Transition

35. Gender transition is the process through which a person begins bringing their outer appearance and lived experience into alignment with their core gender. Transition may or may not include medical or legal aspects such as taking hormones, having surgeries, or correcting the sex designation on identity documents. Social transition—which often includes correcting one's identity documents to accurately reflect one's sex—is the most important, and sometimes the only, aspect of transition that transgender people undertake. Changes often associated with a social transition include changes in clothing, name, pronouns, and hairstyle.

36. A complete transition is one in which a person attains a sense of lasting personal comfort with their gendered self, thus maximizing overall health, well-being, and personal safety. Social role transition has an enormous impact in the treatment of gender dysphoria. An early seminal study emphasizes the importance of aligning presentation and identity. Greenberg and Laurence (1981) compared the psychiatric status of individuals with gender dysphoria who had socially transitioned with those who had not. Those who had implemented a social transition showed "a notable absence of psychopathology" compared to those who were living in their birth-assigned sex.

37. Hormones are often medically indicated for patients with gender dysphoria, and are extremely therapeutic. In addition to inducing a sense of wellbeing, owing to the influence of sex steroids on the brain, hormones induce physical changes which attenuate the dysphoria. One or more surgical procedures are medically indicated for some, but by no means all, transgender individuals.

38. A person's gender identity is an innate, immutable characteristic; it is not determined by a particular medical treatment or procedure. The medical treatments provided to transgender people (including social transition), do not "change a woman into a man" or vice versa. Instead, they affirm the authentic gender that an individual person *is*.

39. The goal of proper treatment is to align the person's body and lived experience with the person's fixed identity as male or female, which already exists. Treatment creates more alignment between the person's identity and the person's appearance, attenuating the dysphoria, and allowing the person's actual sex to be seen and recognized by others. Treatments fall below the accepted Standards of Care if they fail to recognize that a person's affirmed gender identity is not how they feel, but rather essentially who they are.

d. The Importance of Accurate Identity Documents, Including Birth Certificates, for Transgender People

40. Being unable to correct the gender marker on one's identity documents, including one's birth certificate, means that transgender people are forced to display documents that indicate their birth-assigned sex (typically assumed based only by the appearance of genitalia at birth), rather than their actual sex as determined by their gender identity and their lived experience. This discordance creates a myriad of deleterious social and psychological consequences.

41. Identity documents consistent with one's lived experience affirm and consolidate one's gender identity, mitigating distress and functional consequences. Changes in gender presentation and role, to feminize or masculinize appearance, and social and legal recognition, are crucial components of treatment for gender dysphoria. Social transition involves dressing, grooming, and otherwise outwardly presenting oneself through social signifiers of a person's true sex as determined by their affirmed gender identity.

42. Through this process, the shame of growing up living as a "false self" and the grief of being born into the "wrong body" are ameliorated. Being socially and legally recognized with correct identification is essential to successful treatment. The WPATH Standards of Care explicitly state that changing the gender marker on identity documents greatly assists in alleviating gender dysphoria. Uncorrected identity documents serve as constant reminders that one's identity is perceived by society and government as "illegitimate." Individuals who desire and require surgery must, as a prerequisite, undergo social role transition, which can be thwarted or upended by inaccurate identification documents.

43. An inability to access identity documents that accurately reflect one's true sex is harmful and exacerbates gender dysphoria, kindling shame and amplifying fear of exposure.

Inaccurate documents can cause an individual to isolate, in order to avoid situations that might evoke discrimination, ridicule, accusations of fraud, harassment, or even violence—experiences that are all too common among transgender people. Ultimately, this leads to feelings of hopelessness, lack of agency, and despair. Being stripped of one's dignity, privacy, and the ability to move freely in society can lead to a degradation of coping strategies and cause major psychiatric disorders, including generalized anxiety disorder, major depressive disorder, posttraumatic stress disorder, emotional decompensation, and suicidality. Research has demonstrated that transgender women who fear disclosure are at 100% increased risk for hypertension, owing to the intersectionality of stress and cardiac reactivity.

44. An abundance of research establishes that transgender people suffer from stigma and discrimination. The "minority stress model" explains that the negative impact of the stress attached to being stigmatized is socially based. This stress can be both *external*, i.e., actual experiences of rejection or discrimination (enacted stigma), and, as a result of such experiences, *internal*, i.e., perceived rejection or the expectation of being humiliated or discriminated against (felt stigma). Both are corrosive to physical and mental health.

45. Until recently, it wasn't understood that these experiences of humiliation and discrimination have serious and enduring consequences. It is now well documented that stigmatization and victimization are the most powerful predictors of current and future mental health problems. The presentation of a birth certificate is required in numerous situations. For the transgender individual, an inaccurate birth certificate can transform a mundane interaction into a traumatic experience. Repeated negative experiences inevitably erode resilience, creating an ingravescent course of gender dysphoria and attendant psychiatric disorders.

46. Many people who suffer from gender dysphoria go to great lengths to align their physical characteristics, voice, mannerisms and appearance to match their gender identity. Since gender identity is immutable, these changes are the appropriate, and indeed the only treatment for the condition. Understandably, the desire to make an authentic appearance is of great concern for transgender individuals, as the *sine qua non* of the gender dysphoria diagnosis is the desire to be regarded in accordance with one's true sex as determined by one's gender identity. Privacy, and the ability to control whether, when, how, and to whom to disclose one's transgender status, is essential to accomplishing this therapeutic aim.

47. Thus, when an individual implements a social role transition, legal recognition of that transition is vital and an accurate birth certificate is a crucial aspect of that recognition, in large part because congruent identity documentation confers privacy—the right to maintain stewardship of personal and medical information—allowing an individual to live a safe and healthy life.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: July 1, 2019

Dr. Randi C. Ettner

Dr. Randi C. Ettner

RANDI ETTNER, PHD
1214 Lake Street
Evanston, Illinois 60201
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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.

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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.

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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.

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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

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Gomez-Gil, E., Esteva, I., Almaraz, M,C. et al (2010). Familiarity of gender identity disorder in non-twin siblings. *Archives of Sexual Behavior* 39(2): 265-269.

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Seelman, K. (2016). Trans adults' access to college bathrooms and housing and the relationship to suicidality. *Journal of Homosexuality* 63(10).

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

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its relation to transsexuality. *Nature* 378(6552): 68-70.

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EXHIBIT F

Expert Report of Dr. Ryan Gorton

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO

STACIE RAY, *et al.,* Plaintiffs, v. LANCY HIMES, *et al.,* Defendants.	Case No. 2:18-cv-00272 Judge: Michael Watson Magistrate Judge: Chelsey Vascura

EXPERT REPORT OF DR. RYAN NICHOLAS GORTON, M.D.

I. INTRODUCTION

1. My name is Ryan Nicholas Gorton. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have been asked by Plaintiffs' counsel to provide my expert opinion to respond to and rebut the opinions offered by Dr. Quentin L. Van Meter, M.D ("Dr. Van Meter") in his expert report in order to show how Ohio's policy refusing to provide accurate birth certificate gender markers for transgender people born in Ohio harms transgender individuals.

3. I prepared this report to set forth the opinions I may express at trial and the basis for my opinions. I have not examined the Plaintiffs in this case. The opinions expressed in this report are based on the information that I have reviewed to date, which includes the Complaint, the report of Randi Ettner, PhD, and the report of Quentin Van Meter, M.D. I reserve the right to revise and supplement the report if any new information becomes available in the future. My opinion is based on my clinical experience, professional knowledge, and review of relevant research. A bibliography is attached as Exhibit B.

4. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Corbitt v. Taylor*, 2:18-CV-91-MHT-GMB (M.D. Ala. filed Feb. 6, 2018); *Edmo v. Idaho Department of Correction*, 358 F. Supp. 3d 1103 (D. Idaho 2018); *Keohane v. Jones*, 328 F. Supp. 3d 1288 (N.D. Fl. 2018); and *Cruz v. Zucker*, 218 F. Supp. 3d 246 (S.D.N.Y. 2016).

5. I am not being compensated for preparation of this report and will also prepare for deposition or trial testimony and provide deposition or trial testimony on a pro bono basis. I do not charge fees for travel time, but, if I do incur out-of-pocket costs to attend a deposition or a trial in the Litigation, Plaintiffs will reimburse me.

II. SUMMARY OF QUALIFICATIONS

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

7. Since 2005, I have worked as an Emergency Medicine physician at Sutter Davis Hospital and served as a primary care physician at Lyon-Martin Health Services ("Lyon-Martin") in San Francisco. At Lyon-Martin, I have provided primary care and transition-related care to more than 400 transgender patients. I provide medical assessments including the diagnosis of Gender Dysphoria, initiate and monitor hormonal treatment, and refer for mental health treatments. I also determine whether and when patients are appropriate for referral for sex reassignment surgeries, provide pre-operative preparation and clearance, and provide post-operative care in consultation with the appropriate surgeon. I also provide supervision to Nurse Practitioners and Physician Assistants treating transgender patients at Lyon-Martin. Lyon-Martin

is an historically LGBT clinic that has been serving transgender patients for over 30 years. Lyon-Martin is also one of just a handful of sites in the United States that trains medical students, residents, and fellows to provide transgender primary care, and I have been a primary clinical instructor for these trainees. I have provided extensive clinical instruction to over 100 trainees during this time.

8. I also serve as a lead clinician consultant for TransLine,[1] a national transgender medical consultation service for clinicians needing expert advice about the care of their individual patients. I am a member of the World Professional Association for Transgender Health (WPATH).

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

10. A copy of my *Curriculum Vitae* is attached as Exhibit A.

III. TERMINOLOGY

11. In this report, I will use a number of terms that are important to understand my rebuttal to the opinions offered by Dr. Van Meter in this case. These include the following:

12. **Gender Dysphoria (GD)**, like Depression, is both a diagnosis and the predominant symptoms of that diagnosis. The symptom of gender dysphoria is the psychological

[1] TransLine. (n.d.). Retrieved from http://project-health.org/transline/.

distress one feels when there is a conflict between, on the one hand, one's internal gender identity, and on the other, one's physical characteristics and perception and treatment by others in society. Like depression, this can range from being mild to severe emotional distress.

13. **Gender Identity Disorder (GID)** is the prior name for what is now called Gender Dysphoria. This change was first recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition ("DSM-5") and the DSM-4 versions used GID. I may use the terms GD and GID roughly interchangeably, though generally GID is used for older medical records and discussion.

14. **Gender Identity** is the internal sense of oneself as, for example, being a male or female.

IV. BACKGROUND ON GENDER DYSPHORIA

15. Gender Dysphoria (GD) is a medical condition in the DSM-5. Individuals with Gender Dysphoria experience incongruence between their gender identity and birth-assigned sex, and experience distress as a result. This diagnosis was previously referred to as Gender Identity Disorder (GID).

16. The diagnostic criteria for Gender Dysphoria in the DSM-5 for adults and adolescents are twofold:

a. A marked incongruence between one's experiences/expressed gender and assigned gender, of at least six months' 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 (or in younger adolescents, the anticipated secondary sex characteristics).

ii. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in younger adolescents, a desire to prevent the development of the anticipated 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 (or some alternative gender different from one's assigned gender).

v. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

vi. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

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

17. Individuals with Gender Dysphoria, if not treated, often suffer clinically significant emotional distress, including depression or suicidal thoughts, and/or impairment of functioning in their daily lives. Without appropriate treatment, a significant proportion (30-40%) become suicidal, with many attempting and completing suicide.

18. The accepted medical protocols for treatment of people with Gender Dysphoria involve both social and medical interventions to assist patients to live in accordance with their gender identity. The widely accepted standards of care in the U.S. and internationally are published by the World Professional Association for Transgender Health ("WPATH"). WPATH is an international not-for-profit organization that held its first international symposium in 1969 and published its initial standards of health care for transgender individuals in 1979. As the American Medical Association has stated, the medical community recognizes the WPATH Standards of Care as the standards of care for treating gender dysphoria. Social transition is the process by which the patient begins living their life authentically in the gender role that corresponds with their gender identity. This typically involves adopting a new name, changing name and gender markers on identity documents, dressing and grooming appropriate to the patient's gender identity, using pronouns and other markers of their gender, and using restrooms and other sex-segregated spaces congruent with their gender identity.

19. In contradistinction to the mainstream social and medical interventions to assist patients with Gender Dysphoria to live in accordance with their gender identity, attempts to change an individual's gender identity are ineffective, dangerous, and medically both unorthodox and unsound.

V. OPINIONS

a. Sex and Gender Identity

20. Gender identity is the internal sense of oneself as, for example, male or female, and arises from the central nervous system. Sex is the biological characteristics of an individual or organism that place it along a spectrum or in discreet categories including male and female.

While there is a great variation in sex in other organisms (for example, the well-known haplodiploidy in bees), in humans, the majority of people fall into one of two categories: male and female.

21. From a clinical and basic scientific perspective, sex is determined by numerous biological characteristics which include sex chromosomal type, in humans presence of the SRY-gene, hormonal milieu and sexual characteristics produced by this hormonal milieu (*e.g.*, external genitalia or secondary sex characteristics), size of gametes produced (generally large for female, small for male), gender identity (which is biologically based and determined by many factors including genetics and in utero environment including the hormonal milieu as above), and gonad type (testes, ovaries, or other variants). While we can describe these biological characteristics as different categories, these often have strong but not absolute influence on the others. For example, the SRY gene is generally found on the Y chromosome, but rarely this can be translocated to the X chromosome leading to an XX fetus that develops in every other way along the typical male fashion.

22. In the majority (at least 95%) of people, sex is correctly assigned at birth based on a cursory examination of the genitals by a pediatrician, family practitioner, or delivering obstetrician or midwife. This determination, which is recorded on the birth certificate as sex, is in most cases correct and reflects a congruence of most or all of the characteristics that make up sex. However, in a minority of cases these determinations are either incorrect or may not be initially recorded at all due to notably atypical genitalia (medically referred to as "ambiguous genitalia").

23. Cases where sex is not initially recorded are because of sufficiently visibly

obvious atypical genitalia and are generally referred to specialists for a more thorough diagnostic evaluation. These infants are a subset of those who have Disorders of Sexual Development ("DSD"). Some children with DSDs have atypical genitalia and are generally identified at birth, while others may have genitalia that appear sufficiently male or female typical that they are not identified by genital examination at birth.

24. Cases where the initially recorded sex is incorrect may include both transgender individuals (most of whom, before treatment, meet the DSM-5 diagnostic criteria for gender dysphoria) and people with DSDs who do not have sufficiently abnormal genitalia as to be identified at birth.

25. As noted above, sex is a characteristic determined by numerous biological characteristics of an individual. In cases where they are incongruent, of these many biological characteristics the single most important characteristic for identifying sex in an individual human being is their gender identity, which is determined by both genetics and early environment (including prenatal hormonal milieu).

26. Gender identity is the most important biologic determinant of overall sex (in transgender people and those with DSDs). This concept is accepted broadly in the medical community. This is reflected by the fact that people whose gender identity is incongruent with other sex characteristics (including external genitals which generally determine sex assigned at birth) are diagnosed with gender dysphoria and are prescribed treatment by the medical community for hormonal, surgical, and social transition. This is supported by major medical organizations including the American Medical Association, the American College of Obstetricians and Gynecologists, the Endocrine Society, the American Academy of Family

Physicians, the American Psychological Association, the American Psychiatric Association, the World Health Association, and the World Professional Association for Transgender Health.

27. In the case of people with DSDs (whether correctly identified at birth or not), the Consensus Statement Management of Intersex Disorders published in Pediatrics, the journal of the American Academy of Pediatrics[2] (which Dr. Van Meter incorrectly attributes to the Intersex Society of North America in his paragraph 17) specifically notes the frequency with which certain DSDs have male or female gender identity in adulthood. This varies from near 100% certainty in some conditions, such as girls with XY chromosomes and Complete Androgen Insensitivity Syndrome who are almost universally reared as girls, and in whom virtually all identify as women in adulthood, to barely better than a coin-flip certainty in XY children with 5 alpha reductase deficiency. Individuals with this condition are often misidentified at birth as female because they have underdeveloped penises that may be misidentified as clitorises in infancy but that virilize at puberty. Sixty percent of these individuals live as males in adulthood.

28. The above examples illustrate that even in humans who are commonly thought to be either male or female, there are many people, both transgender and those with DSDs, who do not fit into these binary classifications. From a biological perspective, sex is better understood as a spectrum in which there are a number of biological characteristics that range from male typical to female typical. Most individuals will have alignment of these characteristics in a largely male or female typical development.

29. The single most important determinant of sex is the patient's gender identity.

[2] Lee, P. A., *et al.* (2006). Consensus statement on management of intersex disorders. *Pediatrics*, 118(2), e488-e500.

For individuals who meet the diagnostic criteria for gender dysphoria (whether or not they have a DSD), it is the well accepted standard of care to provide these patients with individualized care that, depending on the needs of the individual, may include medical, surgical, and social treatment that diminish both their gender dysphoria and the well-known associated psychiatric morbidity such as depression, anxiety, suicide attempts, and suicide completions. Social treatments include supporting patients with social transition by providing medical information to agencies issuing identity documents such as drivers' license, passport, and birth certificates where required to change the gender marker to reflect the patient's gender identity.

30. Identity documents that are congruent with a patient's gender identity have significant clinical benefits. A 2015 study demonstrated that having one or more identity documents concordant with gender identity was statistically significantly associated with reduced suicidal ideations and attempts. Based on this study's results, changing 1000 identity documents would prevent 90 episodes of suicidal ideation and 20 suicide attempts over the course of one year.[3]

31. This study correlates with my clinical experience treating hundreds of patients with gender dysphoria over the course of nearly one and a half decades. Congruent identity documents diminish dysphoria, anxiety, and depression. They improve social function and ability of patients to have normal functional lives. For example, without identity documents, my patients have reported that they have been unable to or limited in their ability to apply for

[3] Bauer, G. R.,*et al*. (2015). Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. *BMC public health*, 15(1), 525, available at https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1867-2.

work, use a credit or bank card, apply to college, fill prescriptions, travel by plane domestically or internationally, rent a car, vote, serve on a jury, and obtain public services and benefits including homeless shelter placement. My patients have reported that attempts to undertake these mundane tasks have resulted in harassment or physical violence. They have also reported that they have withdrawn from these and other activities that may require use of identity documents due to fear of harassment and violence.

32. Thus, in addition to the purely scientific mandate that gender identity is the appropriate, determinative factor for selecting male or female gender markers on identity documents, there is a clinical imperative that gender identity be used to make that determination.

33. Transgender men with or without DSDs should be identified as men for the purposes of all identity documents including birth certificate. Transgender women with or without DSDs should be identified as women for the purposes of their identity documents including their birth certificate.

b. Medical Community Norms for Recognizing and Discussing Gender

i. Dr. Van Meter

34. Dr. Van Meter's report contains a number of errors and offers conclusions that are not only wrong but in opposition to generally recognized understanding of sex, gender, gender dysphoria, and DSDs by the broader medical community.

35. In paragraph 16, Dr. Van Meter states "These aberrations of normal development are responsible for what we classify as Disorders of Sexual Differentiation (DSDs) and they represent a very small fraction of the human population. The incidence of

such circumstances occurs in 1:4500 to 1:5500 births." He cites a paper[4] which states clearly that this number (1:4500 to 1:5500) represents the portion of DSDs that have sufficiently atypical genitalia at birth such that a physician, midwife, or nurse facilitating delivery are unable to assign sex based on a visual inspection of the newborn's genitalia, and notes that this is an estimate. "There are no clear estimates of the incidence of subjects presenting with atypical genitalia at birth, and only a proportion of them present a major challenge regarding male or female assignment. However, it has been estimated to be approximately 1 in 4,500-5,500." The paper goes on to cite the incidence of other DSDs such as Kleinfelters syndrome (infants born with 3 sex chromosomes: XXY) as 1:500-1:1000.

36. In paragraph 19, Dr. Van Meter states, "DSD patients are not 'transgender'; they have an objective, physical, medically verifiable, physiologic condition. Transgender people generally do not have intersex conditions or any other verifiable physical anomaly. People who identify as 'feeling like the opposite sex' or 'somewhere in between' do not comprise a third sex. They remain biological men or biological women as determined by their chromosomes and sex at birth." Dr. Van Meter is wrong that these are mutually exclusive categories. While there are many people with DSDs who are not transgender and do not have gender dysphoria and many transgender people who do not have a diagnosable DSD (based on the current limitations of the diagnostic ability of medicine), Dr. Van Meter oversimplifies and exaggerates this distinction. Counting those I have diagnosed primarily and those presenting with a prior diagnosis of a DSD, I have personally treated more than 20 patients who both had gender

[4] Lee, P. A., *et al.* (2016). Global disorders of sex development update since 2006: perceptions, approach and care. *Hormone research in paediatrics*, 85(3), 158-180, available at: https://www.karger.com/Article/FullText/442975/27603905.

dysphoria and a DSD. In the DSM-5, having a DSD does not exclude a patient from being diagnosed with gender dysphoria.

37. Gender identity is an immutable characteristic in adolescents and adults, and not merely "feeling like the opposite sex" as Dr. Van Meter suggests. As discussed above, attempts to alter a patient's gender identity are harmful and ineffective, and the clinical benefits of recognizing a patient's gender identity are profoundly beneficial. A biological origin of transgender identity is supported by scientific evidence including a significant heritability demonstrated by a higher concordance of gender dysphoria among identical rather than fraternal twins[5] and gene mutations associated with gender dysphoria in transgender men and women.[6] However, scientific recognition of the complex biological nature of gender identity does not imply that we currently have a simple blood test or imaging study that will diagnose patients with gender dysphoria. The current best clinical diagnostic indicator of gender dysphoria is evaluation by a licensed health care professional who assesses the patient's gender identity.[7]

38. In paragraph 24 Dr. Van Meter states, "Gender incongruity occurs in 0.001% of biological females and 0.033% of biological males." To support this, he cites an article by Eric

[5] Coolidge, F. L., *et al*. (2002). The heritability of gender identity disorder in a child and adolescent twin sample. *Behavior genetics*, 32(4), 251-257; Diamond, M. (2013). Transsexuality among twins: identity concordance, transition, rearing, and orientation. *International Journal of Transgenderism*,14(1), 24-38.

[6] Henningsson, S., *et al*. (2005). Sex steroid-related genes and male-to-female transsexualism. *Psychoneuroendocrinology*, 30(7), 657-664; Bentz, E. K., *et al*. (2008). A polymorphism of the CYP17 gene related to sex steroid metabolism is associated with female-to-male but not male-to-female transsexualism. *Fertility and sterility*, 90(1), 56-59; Hare, L., *et al*. (2009). Androgen receptor repeat length polymorphism associated with male-to-female transsexualism. *Biological psychiatry*, 65(1), 93-96.

[7] However, there is no demonstrated clinical benefit to requiring medical documentation to update the sex designation on an identity document. An opportunity for the individual to attest to their own gender identity is, in my opinion, the most clinically appropriate policy for sex designations on identity documents because it minimizes unnecessary delay to a potentially life-saving intervention.

Seaborg in Endocrine News.[8] The citation does not mention incidence at all. Numerous studies demonstrate a higher incidence than Dr. Van Meter suggests.[9] Prevalence of transgender people is an evolving number. For example, a 2016 systematic review and meta-analysis of worldwide studies ranging including Iran, Taiwan, Japan, multiple European countries, Australia, Iceland, and the United States showed that overall the rate of receiving a transgender specific diagnosis (such as gender dysphoria or GID in older studies), was 6.8/100,000 or 0.068%. However, this meta-analysis spanned studies from 1968-2014 and the authors note that the prevalence has significantly increased in later studies. Moreover, in this same meta-analysis, in population studies (from 2010 to 2015), assessing for transgender identity, demonstrated a prevalence of 355/100,000 or 0.35% of the total population.

39. In paragraphs 31-34, Dr. Van Meter makes clinical pronouncements and assumptions about the plaintiffs that I do not believe are supported by the clinical information that he states he has reviewed. While it is reasonable to assume that since Ms. Rey's, Ms. Breda's, and Ms. Doe's birth certificates list them as male, that their genitals at birth most likely appeared to be male, and that Mr. Argento's similarly likely appeared to be female, it is inappropriate to assume their karyotype (the 23 pairs of chromosomes in a typical human cell, with one pair isolated as "sex chromosomes"—typically either an XX pairing or an XY pairing) based on only knowing the sex recorded on their birth certificate. A 2011 study of karyotypes in transgender patients found that the rate of abnormal karyotypes was 3.2% among transgender

[8] Seaborg, E. About-Face, *Endocrine News* (May 2014), https://endocrinenews.endocrine.org/may-2014-about-face/.
[9] Collin, L., *et al*. (2016). Prevalence of transgender depends on the "case" definition: A systematic review. *J. Sex. Med.*, 13(4), 613-626.

women.[10] This is compared to about 0.5% in the normal population. The authors of this study concluded that karyotyping transgender patients is not clinically supported and I concur, as it rarely provides clinically useful information. However, knowing that transgender people have a higher percentage of chromosomal abnormalities, I would never state, as Dr. Van Meter did, that "I can conclude that Ray's chromosomes are, and have always been, XY."

40. In summary, Dr. Van Meter's views expressed in his declaration oversimplify the current scientific and medical understanding of sex and gender. His views about the sex of transgender people are highly unorthodox within the community of clinicians that treat transgender patients and scientists who perform research in this area. Moreover, his conclusions about identity document changes—in this case Ohio birth certificates—place patients' health and welfare at risk and run contrary to the day-to-day treatments provided to patients by their treating clinicians, which includes assistance with social transition and the change of identity documents to accurately reflect the patient's sex. He makes assumptions and diagnostic pronouncements about the plaintiffs that are not supported by the data he reports to have reviewed. He makes unsupported claims of much lower prevalence of both DSDs and gender dysphoria than the currently accepted prevalence rates.

ii. American College of Pediatricians

41. The American Academy of Pediatrics ("AAP") is the largest professional organization of pediatricians in the United States with 67,000 members, 45,000 of which are board certified by the American Board of Pediatrics.[11] AAP has issued 179 policy statements

[10] Inoubli, A., *et al*. (2011). Karyotyping, is it worthwhile in transsexualism? *J. Sex. Med.*, 8(2), 475-478.
[11] *About the American Academy of Pediatrics*, https://www.healthychildren.org/English/Pages/About-AAP.aspx, (last visited July 30, 2019).

covering topics including: car seats, asthma treatment, school start times, vaccination, intravenous fluids, summer camps, water safety, children with special needs, radiation emergencies, health insurance, cleft lip, palliative care, sepsis in neonates, teen drivers, hypertension, pain assessment, breastfeeding, impacted earwax, and one entitled "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents."

42. Contrary to the AAP, the American College of Pediatricians ("ACPeds") is a designated anti-LGBT hate group by the Southern Poverty Law Center which describes ACPedse as "a fringe anti-LGBT hate group that masquerades as the premier U.S. association of pediatricians to push anti-LGBT junk science, primarily via far-right conservative media and filing amicus briefs in cases related to gay adoption and marriage equality."[12]

43. In contrast to the AAP's 67,000 members, ACPeds has, by its own claim, 500 members.

44. The ACPeds has 41 policy statements, a disproportionate number having to do with LGBT issues, which, in all cases, run contrary to currently accepted mainstream clinical practice and the policy statements of legitimate medical organizations. For example, the ACPeds's policy "Psychotherapy for Unwanted Homosexual Attraction Among Youth" supports reparative therapy in gay and lesbian children, a practice that has been discredited by research as junk science that can cause irreparable damage to children, been condemned by the AAP, the AMA, both APAs, and has also been outlawed in a number of states and municipalities due to

[12] Southern Poverty Law Center. *American College of Pediatricians*. https://www.splcenter.org/fighting-hate/extremist-files/group/american-college-pediatricians (last visited July 30, 2019).

the danger it presents to gay, lesbian, and bisexual children. Other ACPeds policy statements on LGBT issues such as "On the Promotion of Homosexuality in the Schools", "Homosexual Parenting: A Scientific Analysis", "Defending Traditional Marriage for the Well-being of the Family and the Child" and "Empowering Parents of Gender Discordant and Same-Sex Attracted Children" similarly advocate fringe ideas far from mainstream medicine.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: July 30, 2019

Dr. Ryan Nicholas Gorton, M.D.

Exhibit A

Dr. Ryan Nicholas Gorton, M.D. CV

Ryan Nicholas Gorton, MD, DABEM
901 Douglass Ave, Davis CA 95616
(504) 261-8379 (mobile)
(530) 297-7880 (home)
nickgorton@gmail.com

Professional Practice

February 2005 – Current	Emergency Medicine Physician Sutter Davis Hospital Davis, CA
July 2002 – February 2005	Emergency Medicine Physician St Tammany Parish Hospital Covington, LA

Professional Practice: Volunteer Activities

March 2005 – Current	Primary Care Provider and Clinical Instructor Lyon-Martin Health Services San Francisco, CA.
August 2005 – February 2006	Acting Medical Director Lyon-Martin Health Services San Francisco, CA.
September 2008 – Current	Executive Committee Member and Lecturer Project HEALTH http://www.project-health.org/ San Francisco, CA.
January 2011 – Current	Lead Clinician TransLine National Clinical Consultation Line
Medical-Legal Consultant:	Sylvia Rivera Law Project, New York, NY Lambda Legal Defense and Education Fund, Inc., New York, NY Transgender Law Center, San Francisco, CA National Center for Lesbian Rights. San Francisco, CA Northwest Justice Project, Seattle, WA The Legal Aid Society, New York, NY National Center for Transgender Equality, Washington, DC TGI Justice Project, Oakland, CA. ACLU Florida

Post Graduate Training

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

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

Education

August 1994 – May 1998	Doctor of Medicine University of North Carolina School of Medicine Chapel Hill, NC
August 1988 – August 1991	Bachelor of Science in Biochemistry, Summa Cum Laude North Carolina State University Raleigh, NC

Professional Affiliations

World Professional Association for Transgender Health (formerly HBIGDA)
- Transgender Medicine and Research Committee
- Institutionalized Persons Committee

University of California at San Francisco Center of Excellence for Transgender Health
- Medical Advisory Board 2010-2013 (during development of original Primary Care Protocols)

American Medical Association
- GLBT Advisory Committee 2009-2011

Gay and Lesbian Medical Association
- LGBT Medical Experts Panel

Licensure/Certification

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

Publications and Papers

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

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Gorton, R, Jaffe, JM, Tescher, J, and Baker, K. "Mini-Symposium: As California Goes, So Goes the Nation (Hopefully)". USPATH. February, 2017.

Gorton, R. Sessuion Moderator. USPATH Symposium. San Francisco CA. February, 2017.

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

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

Gorton R. "Transgender Patient Care in the Emergency Department". American

Academy of Emergency Medicine Scientific Assembly. Las Vegas, Nevada. February 2016.

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

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

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

Gorton R. "History of Transgender Medicine". UCSF School of Medicine Transgender Health elective. San Francisco, CA. March 2015.

Gorton R. "Transgender Healthcare". UC Davis School of Medicine. Sacramento, CA.
December 2015.

Gorton R. "Engaging and Retaining Transgender Patients in Ongoing Primary Care". National Association of Community Health Centers Health Institute and Expo. San Diego, CA. August 2014.

Gorton R. "Sexual and Reproductive Health: A Focus on Transgender Patients". California Family Health Council. Webinar. March 2014.

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Awards

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

Exhibit B

Dr. Ryan Nicholas Gorton, M.D. Bibliography

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EXHIBIT G

Defendants' Response to Interrogatory No. 2

as reported to Defendants soon after an individual's birth, including a record of the individual's sex as reported at birth. The circumstances under which an individual may correct the sex recorded at birth are set forth in Ohio Rev. Code §§ 3705.15 and 3705.22.

2. Set forth and explain any and all government interest(s) that Defendants contend the Birth Certificate Policy serves, and how each of the reasons listed in response to Interrogatory 1 further such interest(s).

RESPONSE

Defendants object to this request because it is overbroad and unduly burdensome. Defendants further object because the defined term Ohio Birth Certificate Policy is vague, ambiguous, and subject to multiple interpretations. Defendants further object because Plaintiffs' definition of Ohio Birth Certificate Policy assumes that Ohio's birth certificates contain a gender marker. But Ohio's birth certificates do not contain a gender marker and Defendants do not collect information related to a person's gender marker. Finally, Defendants object because the request calls for information that is protected by the attorney-client privilege and work product doctrine. Subject to the foregoing, Defendants state that Ohio Rev. Code §§ 3705.15 and 3705.22 set forth the circumstances under which a person may correct the sex reflected on an Ohio birth certificate. Ohio's substantial interest in enforcing such statutes is set forth in the Motion to Dismiss (Doc.18 at 18–22) and the Reply in support of the Motion to Dismiss (Doc. 28 at 17–18).

3. Identify every instance in which any Defendant including any past Ohio Department of Health official has ever made any change to a gender marker on a birth certificate, as well as the reason for that change.

RESPONSE