

**UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF TENNESSEE  
NASHVILLE DIVISION**

KAYLA GORE; JAIME COMBS; L.G.; and  
K.N.,

*Plaintiffs,*

v.

WILLIAM BYRON LEE, in his official  
capacity as Governor of the State of  
Tennessee; and LISA PIERCEY, in her  
official capacity as Commissioner of the  
Tennessee Department of Health,

*Defendants.*

Case No. 3:19-CV-00328

DISTRICT JUDGE RICHARDSON  
MAGISTRATE JUDGE HOLMES

**PLAINTIFFS' NOTICE OF FILING**

The plaintiffs, Kayla Gore, Jaime Combs, L.G., and K.N., filed a Motion for Summary Judgment [Doc 60] and Memorandum in Support [Doc 61] on March 9, 2020. Declarations of the plaintiffs' experts, Randi Ettner, Ph.D., and Shayne Sebold Taylor, M.D., were attached to the memorandum as Exhibit 1 [Doc 61-1] and Exhibit 2 [Doc 61-2]. These exhibits do not include the experts' C.V.s and bibliographies. In order to remedy this inadvertent mistake, the plaintiffs hereby give notice of their re-filing of correct and complete copies of the Declarations as Exhibits 1 and 2 hereto.

Dated: March 23, 2020

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Respectfully submitted,

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*Counsel for Plaintiffs*

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing was filed electronically using the Court's CM/ECF system, which provides electronic notice of the filing to all counsel of record, including:

Herbert H. Slatery III  
Attorney General and Reporter

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This 23<sup>rd</sup> day of March, 2020.

*s/John T. Winemiller*  
\_\_\_\_\_  
John T. Winemiller

# EXHIBIT 1

**UNITED STATES DISTRICT COURT  
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Case No. 3:19-CV-00328

DISTRICT JUDGE RICHARDSON  
MAGISTRATE JUDGE HOLMES

**EXPERT DECLARATION OF DR. RANDI C. ETTNER, Ph.D.**

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

1. I submit this expert declaration based on my personal knowledge.
2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-mentioned litigation. Specifically, I have been asked by Plaintiffs' counsel to provide my expert opinion on how Tennessee's policy prohibiting transgender persons born in Tennessee from obtaining accurate birth certificates reflecting their true sex and gender identity affects transgender individuals.
3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

**I. BACKGROUND AND QUALIFICATIONS**

4. 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.

5. 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.

6. 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*.

7. 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 2011. The WPATH promulgated *Standards of Care* (“Standards of Care”) are the internationally recognized guidelines for the treatment of persons with gender dysphoria and serve to inform medical treatment in the United States and throughout the world.

8. I have lectured throughout North America, South 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 the honoree of the externally-funded *Randi and Fred Ettner Fellowship in Transgender Health* at the University of Minnesota. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of gender dysphoria. I received a commendation from the United States Congress House of Representatives on February 5, 2019 recognizing my work for WPATH and Gender Dysphoria in Illinois.

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

10. A true and accurate copy of my Curriculum Vitae is attached hereto as Exhibit A. It documents my education, training, research, and years of experience in this field and includes a list of publications. 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.

11. 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, the

materials referenced in the Bibliography as Exhibit B and cited herein, and my extensive experience studying gender dysphoria and in treating transgender patients.

### **Previous Testimony**

12. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Eller v. Prince George's Cty. Public Sch.*, No. 8:18-cv-03649-TDC (D. Md. 2020); *Ray v. Acton*, No. 2:18-cv-00272 (S.D. Ohio 2019); *Monroe v. Jeffreys*, No. 3:18-cv-00156-NJR-MAB (S.D. Ill. 2019); *Soneeya v. Turco*, No. 07-12325-DPW (D. Mass. 2019); *Edmo v. Idaho Dep't of Correction*, No. 1:17-CV-00151-BLW, 2018 WL 2745898 (D. Idaho 2018); *Carillo v U.S. Dep't of Justice Exec. Office of Immig. Rev.* (2017); *Broussard v. First Tower Loan, LLC*, 135 F. Supp. 3d 540 (E.D. La. 2016); *Faiella v. American Medical Response of Conn., Inc.*, No. HHD-CV15-6061263-S (Conn. Super. Ct.).

### **Compensation**

13. I am being compensated for my work on this matter at a rate of \$375.00 per hour for preparation of declarations and expert reports. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

## **II. SUMMARY OF OPINIONS**

14. 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.

15. 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.

### **III. EXPERT OPINIONS**

#### **a. Sex and Gender Identity**

16. 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.

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

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

19. 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 detectable by self-disclosure in adolescents and adults.

20. 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. It is also the foremost predictor of satisfaction and quality of life. Psychologist Eric Erickson defined identity as "the single motivating force in life."

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

22. 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.

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

24. 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.

25. 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**

26. 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.

27. 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.

28. 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:

- i. 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).
  - 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 young adolescents, a desire to prevent the development of the anticipated 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.

29. 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.

30. 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.

31. 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 intersection 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 was not 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 ingravescient 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.

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I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated this 29 day of February, 2020.

Dr. Randi C. Ettner  
Dr. Randi C. Ettner

# Exhibit A – Curriculum Vitae

**RANDI ETTNER, PH.D.**  
**1214 Lake Street**  
**Evanston, Illinois 60201**  
**847-328-3433**

**POSITIONS HELD**

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

**EDUCATION**

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

## **CLINICAL AND PROFESSIONAL EXPERIENCE**

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

## **LECTURES AND HOSPITAL GRAND ROUNDS PRESENTATIONS**

*The Transgender Surgical Patient*, American Society of Plastic Surgeons, Miami, FL 2019

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

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

*Gender identity and the Standards of Care*, American College of Surgeons, Boston, MA, 2018

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

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

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

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

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

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

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

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

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

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

*Transgender 101 for Surgeons*, American Society of Plastic Surgeons, Chicago, IL, 2017.

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

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

*Foundations in mental health; role of the mental health professional in legal and policy issues, healthcare for transgender inmates; children of transgender parents; transfeminine genital surgery assessment:* WPATH global education initiative, Chicago, IL, 2015; Atlanta, GA, 2016; Ft. Lauderdale, FL, 2016; Washington, D.C., 2016, Los Angeles, CA, 2017, Minneapolis, MN, 2017, Chicago, IL, 2017; Columbus, Ohio, 2017; Portland, OR, 2018; Cincinnati, OH, 2018, Buenos Aires, 2018

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

*Gender affirming psychotherapy; Assessment and referrals for surgery-Standards of Care-*Fenway Health Clinic, Boston, 2015*Gender reassignment surgery-*Midwestern Association of Plastic Surgeons, 2015

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

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

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

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

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

*Understanding transgender-* Nielsen Corporation, Chicago, Illinois, 2013

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

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

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

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

*Gender Identity, Gender Dysphoria and Clinical Issues –*WPATH Symposium, Bangkok, Thailand, 2014; Argosy College, Chicago, Illinois, 2010; Cultural Impact Conference, Chicago, Illinois, 2005; Weiss Hospital, Department of Surgery, Chicago, Illinois, 2005; Resurrection Hospital Ethics Committee, Evanston, Illinois, 2005; Wisconsin Public Schools,

Sheboygan, Wisconsin, 2004, 2006, 2009; Rush North Shore Hospital, Skokie, Illinois, 2004; Nine Circles Community Health Centre, University of Winnipeg, Winnipeg, Canada, 2003; James H. Quillen VA Medical Center, East Tennessee State University, Johnson City, Tennessee, 2002; Sixth European Federation of Sexology, Cyprus, 2002; Fifteenth World Congress of Sexology, Paris, France, 2001; Illinois School of Professional Psychology, Chicago, Illinois 2001; Lesbian Community Cancer Project, Chicago, Illinois 2000; Emory University Student Residence Hall, Atlanta, Georgia, 1999; Parents, Families and Friends of Lesbians and Gays National Convention, Chicago, Illinois, 1998; In the Family Psychotherapy Network National Convention, San Francisco, California, 1998; Evanston City Council, Evanston, Illinois 1997; Howard Brown Community Center, Chicago, Illinois, 1995; YWCA Women's Shelter, Evanston, Illinois, 1995; Center for Addictive Problems, Chicago, 1994

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

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

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

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

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

## **PROFESSIONAL AFFILIATIONS**

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

## **AWARDS AND HONORS**

Letter of commendation from United States Congress for contributions to public health in Illinois, 2019  
WPATH Distinguished Education and Advocacy Award, 2018  
*The Randi and Fred Ettner Transgender Health Fellowship* – Program in Human Sexuality, University of Minnesota, 2016  
Phi Beta Kappa, 1972  
Indiana University Women’s Honor Society, 1970-1972  
Indiana University Honors Program, 1970-1972  
Merit Scholarship Recipient, 1970-1972  
Indiana University Department of Psychology Outstanding Undergraduate Award Recipient, 1970-1972  
Representative, Student Governing Commission, Indiana University, 1970

## **LICENSE**

Clinical Psychologist, State of Illinois, 1980

## Exhibit B – Bibliography

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## **EXHIBIT 2**

**UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF TENNESSEE  
NASHVILLE DIVISION**

KAYLA GORE; JAIME COMBS; L.G.; and  
K.N.,

*Plaintiffs,*

v.

WILLIAM BYRON LEE, in his official  
capacity as Governor of the State of  
Tennessee; and LISA PIERCEY, in her  
official capacity as Commissioner of the  
Tennessee Department of Health,

*Defendants.*

No. 3:19-CV-00328

DISTRICT JUDGE RICHARDSON  
MAGISTRATE JUDGE HOLMES

**EXPERT DECLARATION OF DR. SHAYNE SEBOLD TAYLOR, M.D.**

I, Dr. Shayne Sebold Taylor, declare as follows:

1. I submit this expert declaration based on my personal knowledge.
2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

**QUALIFICATIONS AND BASIS OF OPINION**

4. I am an Assistant Professor of Internal Medicine and Pediatrics at Vanderbilt University Medical Center and the Monroe Carrol Jr. Children's Hospital at Vanderbilt in Nashville, Tennessee.
5. I am licensed in the state of Tennessee to practice medicine (TN License #55151).

6. I am board certified in both Internal Medicine and Pediatrics by the American Board of Internal Medicine and the American Board of Pediatrics, respectively.

7. I obtained my undergraduate degree at Emory University with a BS in Biology and a BA in Women and Gender Studies. I received my medical degree from Drexel University College of Medicine and completed my Internal Medicine and Pediatrics residencies at Vanderbilt University Medical Center.

8. I have lived and practiced medicine in state of Tennessee since 2014.

9. Additional information about my professional background and experience is outlined in my curriculum vitae, a true and accurate copy of which is attached as Exhibit A to this declaration.

10. In conjunction with serving as an Assistant Professor of Internal Medicine and Pediatrics at Vanderbilt, I am the creator and Lead Clinician of the Vanderbilt Clinic for Transgender Health, a multi-disciplinary patient-centered medical home for transgender adults. My clinical duties include providing primary care and transition-related care (particularly hormone therapy), as well as providing care navigation with specialists across the Vanderbilt medical community.

11. I have over 300 transgender patients under my care with a 3-6 month waitlist to be seen for services. The majority of my patients reside in Middle Tennessee, however I have patients traveling 3-4 hours to come to the clinic spanning from Memphis to the west and Kingsport to the east. Additionally, I estimate that about 15% of my patients are traveling from neighboring states, including Kentucky, Alabama and even Indiana.

12. In addition to my clinical work, I provide guidance to physicians throughout Vanderbilt and Middle Tennessee who care for transgender patients. I do this by giving grand

rounds, presentations to medical students and residents, and training to various community providers on the importance of culturally competent care for the transgender patient.

13. As part of my practice, I stay current on medical research and literature relating to the care of transgender persons and patients suffering with gender dysphoria.

14. I am a member of the World Professional Association of Transgender Health (WPATH), American Academy of Pediatrics (AAP), American College of Physicians (ACP), the Alpha Omega Alpha (AOA) medical honor's society, and the Gay and Lesbian Medical Association (GLMA).

15. This declaration sets forth my opinions in this case and the basis for my opinions. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I have not examined the Plaintiffs in this case. In preparing this declaration, I have reviewed the materials listed in the bibliography attached as Exhibit B to this declaration. I also rely on my years of clinical experience caring for transgender adults and children, and my professional knowledge.

16. 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, the materials referenced in the Bibliography as Exhibit B, and my experience studying gender dysphoria and in treating transgender patients.

17. I am being compensated \$350/hour for my time preparing this testimony. My compensation does not depend on the outcome of the litigation, the opinions I express, or the testimony I provide.

## EXPERT OPINIONS

### A. Sex and Gender Identity

18. The sex of a child is often determined after delivery based on the visual appearance of an infant's external genitals. Prenatal determination of sex is determined again by visualization of the fetus' external genitals on ultrasound. These methods are successful in assigning sex in an overwhelming majority of individuals. In transgender individuals, however, the sex determined at birth by these above methods does not accurately reflect the patient's sex.

19. Research has identified that determination of sex is far more complex than what is seen on genital exam. Instead, sex is a complex compilation of multiple factors including one's chromosomal make up (XX or XY, for example), gonadal sex (presence of ovaries or testes), fetal hormonal sex (production of sex hormones *by* the fetus or exogenous exposure of sex hormones *to* the developing fetus), pubertal hormonal sex (the change in hormonal milieu that results in the development of secondary sexual characteristics, such as facial hair and deep voice for those assigned male at birth, or breasts and menstrual cycles for those assigned female at birth), hypothalamic sex (variations in brain structure and function as a result of embryonal exposure of sex hormones), and gender identity.

20. For each of the above factors that contribute to the development of sex, there can be variations. Sex related characteristics do not always align as either completely male or completely female. For example, many children are born with ambiguous genitalia, and as a result it is difficult to assign these infants as either male or female at birth. These children often see multiple specialists throughout their lifespan for this Disorder of Sex Development (DSD). Other examples of DSDs are those of chromosomal differences. The typical human chromosomal make up includes 46XY for males and 46XX for females. However, in male patients with Klinefelter's

syndrome their chromosomal makeup is 47XXY. These chromosomal male individuals have an extra X chromosome. The results include breast development and small testes, in addition to other physical findings. Patients with Turner Syndrome are 45XO. These female individuals are missing an X chromosome, and as such many of them do not develop normal female puberty and are often infertile. These variations are common. The Monroe Carrell Children's Hospital at Vanderbilt has an entire clinic to cater to the medical needs of this patient population.

21. Gender identity is a person's inner sense of belonging to a particular gender. Identifying as male or female is a core component of one's overall identity. Every person has a gender identity. Research has shown that children begin to develop and express their gender identity during their toddler years, at around the age of 3 years old. It has a strong biological basis and cannot be changed.

22. A leading explanation for the biological basis of gender identity is the fact that a fetus' sexual organs develop in the first two months of pregnancy, while the sexual differentiation of the brain occurs in the second half of pregnancy. Rarely, this can result in situations where the sexual organs do not match the brain's sexual differentiation

23. The testes (male gonad) develop under the influence of a cascade of genes that begin with expression of the SRY gene present on the Y chromosome. Prior to this, the fetus has an "indifferent" gonad, one with the potential to develop into either a teste or an ovary. The presence of the SRY gene on the Y chromosome begins the differentiation for that indifferent gonad to become a teste. Soon after, the testes begin to produce testosterone that results in the formation of the scrotum and penis. Female gonads conversely develop in the absence of the SRY gene and that testosterone. This happens at around 7-8 weeks gestation.

24. Later, in the second half of pregnancy there is a testosterone surge that masculinizes the brain. The absence of this testosterone surge results in a feminine brain. The intrauterine spike in testosterone results in permanent organizing effects of the developing brain. Since this occurs at a time much later in gestation, it is possible that these two process (the differentiation of sexual organs and the sexual differentiation of the brain) occur independently of one another. During puberty, those circuits that have been developed in the womb, will then be activated by sex hormones.

25. One example of the effect of prenatal testosterone exposure is in the condition Congenital Adrenal Hyperplasia (CAH). Due to an enzyme deficiency, fetuses with typically female genitalia with CAH are exposed to high levels of intrauterine testosterone. These children tend of choose boy playmates, prefer boy's toys and exhibit behaviors more commonly associated with male children. It is no surprise that children with typically female genitalia born with CAH have a much higher chance of developing gender dysphoria when compared to children with typically female genitalia born without CAH (3% vs 0.003%).

26. Most people have a gender identity that matches the sex assigned at birth. Transgender people, however, have a gender identity that does not match the sex that they were assigned at birth.

27. According to a Williams Institute study in 2016, there are approximately 1.6 million people in the United States that identify as transgender. In this same study, it was revealed that an estimated 31,000 transgender people (or 0.6% of the state's population) live in the state of Tennessee. Tennessee is ranked 10th in the nation for its percentage of transgender individuals (Hawaii being the highest and North Dakota with the lowest).

28. Gender identity is innate, and cannot be voluntarily altered. Experts agree that being transgender is a normal variation of human development.

29. Moreover, given that gender identity is permanent and cannot be changed, attempts at changing one's gender identity have severe and often life threatening repercussions including major depression, anxiety, psychotic disorders and suicide. Therefore, the medical community at large believe this to be a futile and unethical treatment approach.

30. From a medical perspective, in the event that one's gender identity does not match their sex assigned at birth, i.e. in transgender people, one's gender identity should be the determining factor of their sex. The medical consensus recognizes that when one's sex-related characteristics are not in alignment, a person's gender identity is the determining factor, more important than the presence of their genitals, their chromosomal analysis, or their hormone levels.

31. It would be extremely harmful for a patient with ambiguous genitalia whose sex was incorrectly assigned at birth to be forced to maintain that incorrect determination legally and socially for the rest of that person's life. As such, since being transgender is a normal variation of development, one where sex is also incorrectly assigned at birth, it would be equally harmful and dangerous to force a person to legally remain encumbered by this incorrect assignment.

32. Therefore, from a social perspective, the appropriate determinant of a person's sex is that person's gender identity.

### **B. Gender Dysphoria and its Treatment**

33. Transgender people have a gender identity that differs from the sex that was assigned to them at birth.

34. This lack of alignment of assigned sex and gender identity can result in severe distress, depression, and anxiety. This constellation of symptoms is termed gender dysphoria.

35. Gender dysphoria is the medical diagnosis for the significant distress and/or problems functioning that result from the incongruity between various aspects of one's sex. It is a serious medical condition and it is codified in both the American Psychiatric Association's *Diagnostic and Statistical Manual*, Fifth Edition (DSM-5) and the World Health Organization's *International Classification of Diseases*, the diagnostic and coding compendia for mental health and medical professionals. People diagnosed with gender dysphoria have an intense and persistent discomfort with their birth-assigned sex.

36. 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.

37. The World Professional Association for Transgender Health (WPATH) is an international multi-specialty professional organization that publishes the widely adopted medical *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* ("WPATH Standards of Care").

38. The protocols and policies set forth by the WPATH Standards of Care are endorsed and cited as authoritative by many professional medical associations including the American Medical Association, the Endocrine Society, the American Psychological Association, the American Psychiatric Association, the American College of Obstetrics and Gynecology, the American Academy of Family Physicians, the American College of Physicians, and the World Medical Association, to name a few.

39. The WPATH Standards of Care highlight best practices in treating transgender persons or people suffering from gender dysphoria. As mentioned above, trying to change someone's gender identity through counseling, medications, or institutionalization is considered unethical and futile. Therefore, health care providers in both the mental health arena and medical arena work to bring a patient's body, appearance and lived experience into alignment with their

gender identity. The WPATH Standards of Care provides a framework or roadmap to help guide clinicians in this important work.

40. Treating gender dysphoria results in significant improvement in the quality of life, mental and physical health of transgender persons. Transgender people undergoing treatment for their gender dysphoria can live long, happy, productive and meaningful lives.

41. Gender transition for those that suffer from gender dysphoria is a lengthy process with multiple components. These components include social transition, medical transition, and surgical transition. Each transgender individual approaches transition differently, as the decision to undergo any aspect of transition is deeply personal and depends on the degree and type of dysphoria the patient is experiencing.

42. Notably, these treatments do not change a transgender person's sex, which is already determined by their gender identity.

43. The social transition is a formative aspect of a transgender person's experience. Social transition can include going by a different name, using different pronouns, or changing one's haircut, or clothing to match one's gender identity. Some transgender people opt to solely transition socially as there may be medical contraindications to medications or surgeries, or they may find that their gender dysphoria is treated with social transition alone.

44. One central aspect of social transition includes having one's personal documentation match their gender identity. To accomplish this, many transgender people legally change their names as part of this transition. Additionally, social transition includes having one's driver's license, passport, birth certificate, school or employee ID have the gender marker of the sex with which they identify. This allows the transgender individual to be legally recognized by their gender identity in all aspects of their life.

45. In addition to social transition, transgender individuals often interface with a healthcare setting for medical or surgical intervention. Medical transition often includes the prescription of hormones so that the transgender person can develop secondary sexual characteristics of the sex with which they identify. For example, a transgender woman (an individual assigned male at birth but who has a female gender identity) may be prescribed estrogen. This can result in breast development, softening of the skin, and changes in fat distribution from a more typically male pattern to a more typically female pattern. Alternatively, a transgender man (or someone assigned female at birth with a male gender identity) may be prescribed testosterone. This could result in a deeper voice, facial and body hair growth. This process is generally monitored under close supervision with medical professionals, including office visits and laboratory monitoring.

46. Some transgender patients seek surgical transition. Surgical treatment can include facial plastic surgery to allow for more traditionally feminine features, breast augmentation, or the creation of a vagina (procedure referred to as vaginoplasty) for transgender women. Transgender men are often interested in a mastectomy for the removal of breast tissue for a more masculine appearing chest. Genital surgery for men include the creation of a penis, often created from tissue from the patient's forearm or thigh. Not all transgender patients obtain surgery. Specifically, a small minority of transgender patients pursue genital surgeries. This is for a variety of reasons. For example, some patients may have chronic medical problems that would otherwise preclude them from having surgery, such as cancer, heart disease, poorly controlled diabetes, or advanced HIV to name a few. Some patients are financially unable to obtain surgery as they are either uninsured or have insurance policies that refuse to pay for gender affirming surgeries. Lastly, surgical

intervention may not be medically indicated for some patients, as their gender dysphoria is appropriately treated with social or hormonal transition alone.

47. Given that many transgender individuals do not undergo a surgical sex reassignment procedure, this should not be a determining factor in an individual's pursuit to change their legal documentation to reflect their true sex, consistent with their gender identity, such as on their driver's license or birth certificate.

### **C. The Importance of Accurate Identity Documentation for the Transgender Individual**

48. Identity documentation is required in all aspects of our lives. From applying for health insurance, to enrolling our children in school, to getting on an airplane, to applying for a credit card or a marriage license. Our documentation allows us to move through this world safely and legally.

49. Transgender people often desire to change their names legally and the gender markers on their legal documentation as part of their social transition.

50. When a transgender person's legal documentation does not accurately reflect their identity, that transgender person is at risk for workplace discrimination, housing discrimination, voting discrimination, health care discrimination and even violence.

51. For example, according to a 2015 study, approximately one-third of individuals who have shown identification documents with a name or gender that did not match their gender presentation reported negative experiences, such as being harassed, denied services, and/or attacked. More specifically, as a result of showing an identification document with a name or gender that did not match their gender presentation, 25% of people were verbally harassed, 16% were denied services or benefits, 9% were asked to leave a location or establishment, and 2% were assaulted or attacked.

52. In addition, a person's gender dysphoria can worsen if the person legally cannot complete their social transition. Gender dysphoria can worsen if a transgender person has discordant documentation, where some documents accurately reflect their gender identity and others do not.

53. This can affect patients in a variety of ways, and my patients have reported several negative downstream ramifications from incorrect documentation. For example, a student applying to college may not get assigned appropriate and safe housing if their legal documentation is incorrect or incongruent. This could lead to significant anxiety about changing, bathing, and even safety, so much so that transgender youth may opt out of applying to college altogether. A transgender woman with incorrect documentation may be unable to stay in a women's homeless shelter forcing her to feel unsafe and at risk for violence in an all men's shelter or, worse, on the street.

54. My patients frequently report the challenges they face at the pharmacy filling prescriptions, going to the DMV, or talking to their health insurance companies. All of these are daily examples of how an ordinarily routine task for a non-transgender person (also called cisgender) can be anxiety provoking and isolating for a transgender individual.

55. Transgender people may feel that they are unable to participate in their communities, neighborhoods, schools or jobs without having documentation that reflects their gender identity. This can further lead to social isolation and worsening gender dysphoria.

56. A 2015 Canadian 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, for every 1,000 people whose identity

documents are correct, 90 episodes of suicidal ideation and 20 suicide attempts would be prevented over the course of one year. (Bauer, G.R. et al).

57. As mentioned above, the World Professional Association for Transgender Health is the leading professional body with which almost all other professional medical bodies align.

58. In the WPATH Identity Recognition Statement published in 2017, it is written:

“The World Professional Association for Transgender Health (WPATH) recognizes that, for optimal physical and mental health, persons must be able to freely express their gender identity, whether that identity conforms to the expectations of others. WPATH further recognizes the right of all people to identity documents consistent with their gender identity, including those documents which confer legal gender status. Such documents are essential to the ability of all people to enjoy rights and opportunities equal to those available to others; access accommodation, education, employment, and health care; travel; navigate everyday transactions; and to enjoy safety. Transgender people, regardless of how they identify or appear, should enjoy the gender recognition all persons expect and deserve. Medical and other barriers to gender recognition for transgender individuals may harm physical and mental health. WPATH opposes all medical requirements that act as barriers to those wishing to change legal sex or gender markers on documents. These include requirements for diagnosis, counseling or therapy, puberty blockers, hormones, any form of surgery (including that which involves sterilization), or any other requirements for any form of clinical treatment or letters from doctors . . . . Further, court and judicial hearings can produce psychological, financial and logistical barriers to legal gender change, and may also violate personal privacy rights or needs.”

59. As a member of WPATH, and as a physician that cares for transgender individuals every day, I agree with the above statement.

60. A patient’s right to privacy includes what they choose to do with their own documentation.

61. Having inconsistent or gender incongruent documentation can worsen the severity of gender dysphoria by limiting an individual’s ability to enjoy the rights and opportunities equal to those around them.

62. Aside from intentionally trying to discriminate against transgender people and infringing on their rights to privacy, I can think of no other plausible reason why the State of

Tennessee would refuse to change a person's gender marker on their birth certificate. As estimated by the Williams Institute, there are roughly 31,000 transgender people living in the state of Tennessee which is composed of 6.77 million people (United States Census Bureau). Even if every transgender Tennessean took advantage of changing their birth certificates, the likelihood that it would have any statistically relevant impact on the state's vital statistics is slim to nonexistent.

63. Additionally, there are 48 states in the United States (as well as DC and Puerto Rico) that allow transgender individuals to correct their birth certificates in a manner consistent with their gender identity. These states and other jurisdictions have the same interests in ensuring accurate vital statistics records as Tennessee, and yet they have determined that the overall impact of allowing transgender people to correct the sex designation on their birth certificates was insignificant for the state and did not negatively affect the states' interests in ensuring accurate and useful vital statistics records.

64. Moreover, to the extent the State of Tennessee needs data regarding the sex assigned at birth to persons born in the state, such data can easily be preserved by maintaining such records under seal and without requiring transgender people born in Tennessee to have birth certificates (an identification) that are inconsistent with their gender identity.

### **CONCLUSIONS**

65. From a purely medical and scientific understanding, gender identity is the appropriate, determinative factor for selecting male or female gender markers on identity documents. Moreover, there is also a clinical imperative that gender identity be used to make that determination.

66. Transgender men are men and therefore should be identified as men for the purposes of all identity documents including their birth certificate. Transgender women are women

and therefore should be identified as women for the purposes of their identity documents including their birth certificate. This intervention improves the lives of transgender people, decreasing their risk of suicide.

67. Allowing a transgender person the right to change their documentations has very little impact on the state of Tennessee; however, it has an extremely significant impact in the lives of transgender Tennesseans. The decision, therefore, is a simple one.

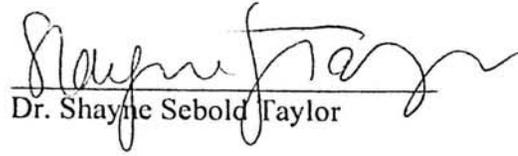
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I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated this 29 day of February, 2020.

 MB  
Dr. Shayne Sebold Taylor

# Exhibit A – Curriculum Vitae



## HOSPITAL APPOINTMENTS

Active Medical Staff

VANDERBILT UNIVERSITY SCHOOL OF MEDICINE, Nashville, TN

August 2018 – present

## PROFESSIONAL ORGANIZATIONS

- American Academy of Pediatrics (AAP)
- American College of Physicians (ACP)
- Alpha Omega Alpha (AOA)
- Cumberland Pediatrics Foundation (CPF)
- National Med-Peds Residency Association (NMPRA)
- Gay and Lesbian Medical Association (GLMA)
- World Professional Association for Transgender Health (WPATH)

## PROFESSIONAL ACTIVITIES

- Drexel University College of Medicine
  - Women's Health Scholar, 2010-2011
  - Humanities Health Scholar, 2010-2011
  - Summer for Reproductive Health at the University of Groningen, Netherlands, Summer 2011
  - Drexel Univ. College of Medicine Admissions Committee Member, 2011-2012
  - Honor Court Member, 2012-2014
  - Basic Science Tutor, 2012-2014
  - Indian Health Services Rotation, September 2013
  - Medical Students for Choice Member and President, 2010-2014
- Vanderbilt University, Med-Ped Residency Program
  - Physicians for Reproductive Health Board Member, 2014-2017
  - LGBTI Health Provider, 2015-present
  - World Professional Association for Transgender Health (WPATH) Conference Attendee, February 2016
  - Nexplanon Resident Education Organizer, 2016-2017
  - Vanderbilt Gender Clinic Committee Member, 2016-present
  - Page Campbell Moonlighter, 2016-2018
  - Bioethics Certificate Program Participant, 2017-2018
  - Med-Peds Wellness Chief, 2017-2018

## AWARDS AND SPECIAL RECOGNITION

- Writer's Award from The Emory University President's Commission on the Status of Women, "*Young Venuses and Old Hags: a feminist critique on the media's portrayal of aging women,*" 2009
- Pathology Honor Society at Drexel University, 2010

- The Lila Kroser Scholarship at Drexel University, 2013
- The Drexel University Peer Commendation for Professional Behavior, 2014
- Alpha Omega Alpha, Drexel University College of Medicine, 2014

## TEACHING ACTIVITIES

- Creator for the LGBTQ Health Curriculum for Residents, 2017-present
- Research mentor to Mollie Limb, VUSM student, 2018-present
- QI research mentor to Kalin Wilson, VUSM student, 2018-present
- Faculty partner with Internal Medicine Residency Social Medicine Club 2019
- Contributor to Internal Medicine Resident Handbook 2019

## PUBLICATIONS AND PRESENTATIONS

### Presentations:

“Caring for the Transgender Patient: With little evidence, but a lot of love.” Vanderbilt University Division of Infectious Disease Grand Rounds and Division of General Internal Medicine Grand Rounds, 4/4/2019 and 5/22/2019.

“A Primer for Transgender Health.” Southeast/TN AIDS Education and Training Center, webcast 1/30/2019.

“The Clinic for Transgender Health: A Passion Project for our Patients.” Vanderbilt University Program for LGBTQ Health Grand Rounds, 11/14/2018.

“Caring for the Transgender Patient.” Vanderbilt University School of Nursing, 10/23/19.

### Articles in Refereed Journals:

**Taylor, S.S.**, Ehrenfeld, J.M. “Electronic Health Records and Preparedness: Lessons from Hurricanes Katrina and Harvey” *Journal of Medical Systems*. (2017) 41:173.

Gamble, R, **Taylor SS**, Ehrenfeld J.M., Huggins, A. “Trans-specific Geriatric Health Assessment (TGHA): An inclusive clinical guideline for the geriatric transgender patient in a primary care setting.” *Maturitas*, Volume 132, 70 – 75.

## RESEARCH PROJECTS

Healthcare Needs and Barriers Among New Patients at a Clinic for Transgender Health  
IRB NUMBER: 192299  
PI: Shayne Taylor

## Exhibit B – Bibliography

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