

DECLARATION OF AMY RICHARDSON
PART II
REDACTED

Exhibit 23

1 UNITED STATES DISTRICT COURT
2 NORTH CAROLINA MIDDLE DISTRICT

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4 MAXWELL KADEL, et al.,

5 Plaintiffs,

6 vs.

Case No. 1:19-cv-00272-LCB-LPA

7 DALE FOLWELL, et al.,

8 Defendants.
9 -----

10 THE DEPOSITION OF GEORGE R. BROWN, M.D.

11 September 23, 2021

12 **PORTIONS ATTORNEYS' EYES ONLY**
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19 Reported by:

20 PATRICIA A. NILSEN, RMR, CRR, CRC

Licensed Court Reporter 717 for the State of

21 Tennessee
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1 The deposition of GEORGE R. BROWN,
2 M.D., taken on behalf of the Defendants, pursuant
3 to Notice on September 23, 2021, beginning at
4 approximately 9:31 a.m. EST taken remotely.

5 This deposition is taken in
6 accordance with the terms and provisions of the
7 Federal Rules of Civil Procedure. All objections
8 are reserved except as to form, and all sides
9 stipulate to the swearing of the witness remotely.

10 The signature of the witness is
11 reserved.

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INDEX

WITNESS:	PAGE
GEORGE R. BROWN, M.D.	
Examination	
By Mr. Knepper	9
Examination	
By Mr. Tishyevich	248
Examination	
By Mr. Knepper	251

EXHIBITS

NUMBER	DESCRIPTION	PAGE
EXHIBIT NO. 1	Initial expert report dated 26 February, '21	26
EXHIBIT NO. 2	Supplemental expert report dated 2 April, 2021	27
EXHIBIT NO. 3	Expert rebuttal disclosure report	27
EXHIBIT NO. 4	CV attached to initial report	27
EXHIBIT NO. 5	CV attached to rebuttal report	28
EXHIBIT NO. 6	Curriculum vitae updated September 19, 2021	52
EXHIBIT NO. 7	2013 DSM-5 on gender dysphoria	86
EXHIBIT NO. 8	Clinical Practice Guidelines	96

1	We Can Trust	
2	EXHIBIT NO. 9 Article titled A Follow-up	124
3	Study of Boys with Gender Identity	
4	Disorder	
5	EXHIBIT NO. 10 Branstrom and Pachankis study	135
6	titled Reduction in Mental Health	
7	Treatment Utilization Among	
8	Transgender Individuals After	
9	Gender-Affirming Surgeries: A Total	
10	Population Study	
11	EXHIBIT NO. 11 Letters to the editor	143
12	EXHIBIT NO. 12 WPATH Standards of Care,	153
13	Version 7	
14	EXHIBIT NO. 13 Section on gender dysphoria	174
15	from Merck Manual	
16	EXHIBIT NO. 14 Bibliography for expert	211
17	report	
18	EXHIBIT NO. 15 Bibliography for rebuttal	211
19	report	
20	EXHIBIT NO. 16 Document prepared by NICE	212
21	titled Evidence review:	
22	Gender-affirming hormones for	
23	children and adolescents with	
24	gender dysphoria	
25	EXHIBIT NO. 17 Document titled	217

1 Q. And -- and if an individual is Tanner
2 Stage II, are -- what would -- how would you
3 classify that?

4 MR. TISHYEVICH: Same objection.

5 A. I -- I would classify Tanner Stage II and
6 later as adolescents.

7 Q. Okay. So you would -- you would classify
8 Tanner Stage II and -- and later as postpubertal
9 adolescents?

10 A. Yes.

11 Q. Until the age of majority at 18?

12 A. Yes.

13 Q. At which point you would classify them as
14 no longer adolescents; is that correct?

15 A. No longer adolescents. Yes.

16 Q. So, Dr. Brown, what is gender dysphoria?

17 A. So gender dysphoria, first of all, is two
18 things: One, it's a diagnosis. And I generally
19 use capital G and capital D to make the
20 distinction. And it's also little G and little D,
21 gender dysphoria, as a set of symptoms of varying
22 degrees of intensity, where people experience some
23 level of incongruence between their sex of
24 assignment at birth and their felt gender.

25 And that incongruence is what we -- and

1 the -- the emotional experience of that
2 incongruence is what we call gender dysphoria, with
3 "dysphoria" referring to what I would refer to as a
4 rich amalgam of depression, anxiety, and
5 irritability, in varying amounts, depending on the
6 individual and how they experience it, related to
7 this incongruence or mismatch.

8 Q. So is that -- is that the distinction made
9 by the DSM-5, between --

10 A. What --

11 Q. Does the -- does the DSM-5 diagnosis for
12 gender dysphoria make the distinction you just
13 described between gender dysphoria, the diagnosis,
14 and gender dysphoria, the emotional experience
15 of -- of the individual's incongruence?

16 A. I think the distinction that -- that DSM-5
17 makes is -- is that the symptom -- that the
18 diagnosis, capital G, capital D, in DSM-5 means
19 that a person who has the symptoms of gender
20 dysphoria have reached a clinically significant
21 level of distress, disability, or dysfunction in
22 occupational or other important areas of their
23 life.

24 So they -- they distinguish between little
25 G, little D, people having gender dysphoria, who

1 don't necessarily reach clinical criteria, in much
2 the same way that human beings experience
3 depression, with a little D, versus major
4 depression, with a big D, as a clinical diagnosis.

5 Q. And so -- so one can -- one can feel
6 gender dysphoria, this incongruence, without
7 suffering from gender dysphoria, the medical
8 diagnosis; is that correct?

9 A. Absolutely.

10 Q. And -- and then this is -- because it's
11 not a pop quiz. I'm just going to introduce the
12 DSM-5 pages on gender dysphoria, because I want
13 to -- I want to be able to refer to them as you --
14 as we discuss this diagnosis.

15 (EXHIBIT NO. 7, 2013 DSM-5 on
16 gender dysphoria, was marked for
17 identification and attached hereto.)

18 BY MR. KNEPPER:

19 Q. Exhibit 7 should be available, if not now,
20 in a couple of moments.

21 A. I'm there.

22 Q. Do you -- do you recognize this -- this
23 page and these -- these nine pages?

24 A. I do.

25 Q. Is this the entry from the DSM-5 for

1 gender dysphoria?

2 A. Yes. 2013 DSM-5.

3 Q. And this is -- this is the diagnostic
4 manual that you use in your practice for diagnosis
5 and treatment of gender dysphoria?

6 A. Yes. Used by me, and widely throughout
7 the United States and other countries as well.

8 Q. So if you'll look at the first page, just
9 down -- just before the end of the second
10 paragraph, there's a sentence that begins, "Gender
11 dysphoria as a general descriptive term refers to
12 an individual's affective/cognitive discontent with
13 the assigned gender but is more specifically
14 defined when used as a diagnostic category."

15 Did I read that correctly?

16 A. Yes.

17 Q. And that -- and that definition of -- that
18 description of gender dysphoria is what you refer
19 to as "little G, little D gender dysphoria," the
20 emotional experience of incongruence?

21 A. Yeah. I think I've reasonably paraphrased
22 what's here.

23 Q. Yeah, absolutely. I'm not -- I think you
24 did. I'm just trying to make clear what you
25 testified and tie it to the -- to the DSM.

Exhibit 23(a)

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, *et al.*,

Defendants.

No. 1:19-cv-00272-LCB-LPA

**EXPERT DISCLOSURE REPORT OF
GEORGE RICHARD BROWN, M.D., DFAPA**

I. PRELIMINARY STATEMENT

1. I, George R. Brown, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated and would so testify if called as a witness. I reserve the right to supplement or amend this report based on any future information that is provided to me, including but not limited to information produced by Defendants in discovery or in response to Defendants' expert disclosures.

3. This report contains my opinions and conclusions, including: (1) the medical condition known as gender dysphoria; (2) the prevailing treatment protocols for gender dysphoria, their efficacy, and the cost-effectiveness of this care; (3) whether there is a legitimate medical basis for the exclusions in the health plans offered by the North Carolina State Health Plan for Teachers and State Employees ("NCSHP"), which I

understand to exclude “[t]reatment or studies leading to or in connection with sex changes or modifications and related care”; and (4) the results of my evaluation of each of the transgender Plaintiffs’ gender dysphoria diagnosis, and the medical necessity of the care for which they have been and are being denied coverage under NCSHP.

II. QUALIFICATIONS AND BACKGROUND

A. Qualifications

4. I am a Professor of Psychiatry and the Associate Chairman for Veterans Affairs in the Department of Psychiatry at the East Tennessee State University, Quillen College of Medicine. My responsibilities include advising the Chairman; contributing to the administrative, teaching, and research missions of the Department of Psychiatry; consulting on clinical cases at the University and at Mountain Home Veterans Health Administration (“VHA”) Medical Center, where I also hold an appointment; and acting as a liaison between the VHA Medical Center and the East Tennessee State University Department of Psychiatry. The majority of my work involves researching, teaching, and consulting about health care in the military veteran and civilian transgender populations.

5. In 1979, I graduated *summa cum laude* with a double major in biology and geology from the University of Rochester in Rochester, New York. I earned my Doctor of Medicine degree with Honors from the University of Rochester School of Medicine in 1983. From 1983-1984, I served as an intern at the United States Air Force Medical Center at Wright-Patterson Air Force Base in Ohio. From 1984-1987, I worked in and completed the United States Air Force Integrated Residency Program in Psychiatry at

Wright State University and Wright-Patterson Air Force Base in Dayton, Ohio. A true and correct copy of my Curriculum Vitae is attached hereto as Exhibit A.

6. I first began seeing patients in 1983. I have been a practicing psychiatrist since 1987, when I completed my residency. From 1987-1991, I served as one of the few U.S. Air Force teaching psychiatrists. In this capacity, I performed over 200 military disability evaluations and served as an officer on medical evaluation boards (“MEBs”) at the largest hospital in the Air Force. Additionally, I was awarded a military medal in recognition of my research activities while serving in the Air Force.

7. Over the last 35 years, I have evaluated, treated, and/or conducted research in person with 700-1,000 individuals with gender dysphoria and during the course of research-related chart reviews with over 5,200 patients with gender dysphoria. The vast majority of these patients have been active duty military personnel or veterans.

8. For over three decades, my research and clinical practice has included extensive study of health care for transgender individuals, including leading and authoring three of the largest studies ever conducted which focused on the health care needs of transgender service members and veterans. Throughout that time, I have done research on, taught on, and published peer-reviewed professional publications specifically addressing the needs of transgender individuals. *See Brown Ex. A (CV).*

9. I have authored or coauthored 40 papers in peer-reviewed journals and 26 book chapters on topics related to gender dysphoria and health care for transgender individuals, including the chapter concerning gender dysphoria in *Treatments of*

Psychiatric Disorders (3d ed. 2001), a definitive medical text published by the American Psychiatric Association.

10. I have served for more than 15 years on the Board of Directors of the World Professional Association for Transgender Health (“WPATH”), the leading international organization focused on health care for transgender individuals. WPATH has over 2,000 members throughout the world and is comprised of physicians, psychiatrists, psychologists, social workers, surgeons, and other health professionals who specialize in the diagnosis and treatment of gender dysphoria.

11. I was a member of the WPATH committee that authored and published in 2011 the current version of the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (Version 7) (the “WPATH standards”), <https://www.wpath.org/publications/soc>. The WPATH standards are the operative collection of evidence-based treatment protocols for addressing the health care needs of transgender individuals. I also serve on the WPATH committee that will author and publish the next edition of the Standards of Care (Version 8), likely to be released in 2021.

12. Without interruption, I have been an active member of WPATH since 1987. Over the past three decades, I have frequently presented original research on topics relating to gender dysphoria and the clinical treatment of transgender people at the national and international levels (seven countries).

B. Materials Considered in Preparing This Report

13. Attached as Exhibit B is a bibliography of scientific and medical materials that I considered in forming my opinions in this report, in addition to the specific materials cited below in the text of my report. I have also undertaken a thorough evaluation of each transgender Plaintiff. I have also reviewed the Complaint for Declaratory, Injunctive, and Other Relief, ECF No. 1; proposed First Amended Complaint for Declaratory, Injunctive, and Other Relief, ECF No. 62-1; and transgender Plaintiffs' medical records.

14. In preparing this report, I rely on my scientific education and training, my research experience, my knowledge of the scientific literature in the pertinent fields and my 38 years of clinical experience in evaluating, treating, and conducting research with patients with gender dysphoria and other issues related to gender identity.

15. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

C. Prior Testimony

16. I have testified or otherwise served as an expert on the health issues of transgender individuals in numerous cases heard by several federal district and tax courts. A true and correct list of federal court cases in which I have served as an expert is

contained in the “Forensic Psychiatry Activities” section of my Curriculum Vitae, which is attached hereto as Exhibit A.

D. Compensation

17. I am being compensated at an hourly rate for actual time devoted, at the following rates: \$400.00 per hour for work that does not involve depositions or court testimony; \$500.00 per hour for time spent on depositions, with a half-day flat fee of \$2,000.00; \$600.00 per hour for in-person court testimony; \$4,000.00 for a full work-day out of office for deposition testimony billed in half day increments assuming an eight hour work day; and \$4,800.00 for a full work-day out of office for trial testimony billed in half day increments assuming an 8 hour work day.

18. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

III. EXPERT OPINIONS

A. Gender Dysphoria

19. The term “transgender” is used to describe someone who experiences any significant degree of misalignment between their gender identity and their sex assigned at birth.

20. Gender identity describes a person’s internalized, inherent sense of their gender. For most people, their gender identity is consistent with their sex assigned at birth. Most individuals assigned female at birth grow up, develop, and manifest a gender identity typically associated with girls and women. Most individuals assigned male at

birth grow up, develop, and manifest a gender identity typically associated with boys and men. For transgender people, that is not the case. Transgender women are individuals assigned male at birth who have a persistent female identity. Transgender men are individuals assigned female at birth who have a persistent male identity.

21. Although the precise etiology of gender identity is unknown, research indicates that gender identity has a biological component, meaning that each person's gender identity (transgender and non-transgender individuals alike) is, in part, influenced by biological factors, and not just social, cultural, and behavioral ones (Skorska, et al., 2021; Kreukels, et al., 2016; Byne, et al., 2012).

22. Regardless of the precise origins of a person's gender identity, there is a medical consensus that gender identity is deep-seated, set early in life, and impervious to external influences (Ettner and Guillamon, 2016).

23. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2013) ("DSM-5") is the current, authoritative handbook on the diagnosis of conditions that present with mental signs and symptoms. Mental health professionals in the United States, Canada, and other countries throughout the world rely upon the DSM-5. The content of the DSM-5 reflects a science-based, peer-reviewed process by experts in the field.

24. Gender dysphoria is the diagnostic term in the DSM-5 for the condition that can manifest when a person suffers from clinically significant distress or impairment

associated with an incongruence or mismatch between a person's gender identity and sex assigned at birth.

25. The diagnosis of gender dysphoria in the DSM-5 (pps. 451-459) involves two major diagnostic criteria for adolescents and adults, summarized below:

- 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 experience/expressed gender and primary and/or secondary sex characteristics.
 - ii. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experience/expressed gender.
 - iii. A strong desire for the primary and/or secondary sex characteristics of another gender.
 - iv. A strong desire to be of another gender.
 - v. A strong desire to be treated as another gender.
 - vi. A strong conviction that one has the typical feelings and reactions of another gender.
- b. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

26. Being transgender is not a mental disorder. *See* DSM-5. Men and women who are transgender have no impairment in judgment, stability, reliability, or general social or vocational capabilities solely because of their transgender status.

27. The clinically significant emotional distress experienced as a result of the incongruence of one's gender with their birth-assigned sex and the physiological developments associated with that sex is the hallmark symptom associated with gender dysphoria.

28. Individuals with gender dysphoria may live for a significant period of their lives in denial of these symptoms (see, for example, Brown, 1988; McDuffie and Brown, 2010). Some transgender people may not initially have the language for their distress or the resources to find support until well into adulthood (Lev, 2004).

29. Particularly as societal acceptance towards transgender individuals grows and there are more examples of successful transgender individuals represented in media and public life, younger people in increasing numbers have access to medical and mental health resources that help them understand their experiences and allow them to obtain medical support at an earlier age and resolve the clinical distress associated with gender dysphoria (Butler, et al., 2018; Pullen Sansfaçon, et al., 2019).

B. Treatment for Gender Dysphoria

30. Gender dysphoria is a condition that is highly amenable to treatment (Coleman, et al., 2012). With appropriate treatment, individuals with a gender dysphoria

diagnosis can experience significant relief, and potentially be fully cured of all clinically significant symptoms.

31. Treatment of gender dysphoria has well-established community standards for treatment and is highly effective in treating the clinically significant symptoms of this condition (Coleman, et al., 2012; Ettner, et al., 2016; Murad, et al., 2010; Tucker, et al., 2018).

32. The American Medical Association (“AMA”), the Endocrine Society, the American Psychiatric Association, and the American Psychological Association all agree that medical treatment for gender dysphoria is medically necessary and effective.¹ See American Medical Association (2008), Resolution 122 (A-08); American Psychiatric Association, Position Statement on Discrimination Against Transgender & Gender Variant Individuals (2012); Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (2017); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2008).

33. The protocol for treatment of gender dysphoria is set forth in the WPATH standards and in the Endocrine Society Clinical Practice Guidelines for Endocrine

¹ Additional organizations that have made similar statements include: the American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American College of Nurse Midwives, American College of Obstetrics and Gynecology, American College of Physicians, American Medical Student Association, American Nurses Association, American Public Health Association, National Association of Social Workers, and National Commission on Correctional Health Care.

Treatment of Gender-Dysphoric/Gender-Incongruent Persons.² First developed in 1979 and currently in their seventh version, the WPATH standards set forth the authoritative protocol for the evaluation and treatment of gender dysphoria. This approach is followed by clinicians caring for individuals with gender dysphoria, including veterans in the VHA. As stated above, I was a member of the WPATH committee that authored the WPATH standards (Version 7), published in 2011.

34. Depending on the needs of the individual, a treatment plan for persons diagnosed with gender dysphoria may involve components that are psychotherapeutic (*i.e.*, counseling as well as social role transition—living in accordance with one’s gender in name, dress, pronoun use); pharmacological (*i.e.*, hormone therapy); and surgical (*i.e.*, gender confirmation surgeries, such as hysterectomy for transgender men and orchiectomy for transgender women; Ettner, et al., 2016; Byne, et al., 2018). Under each patient’s treatment plan, the goal is to enable the individual to live all aspects of one’s life consistent with his or her gender identity, thereby eliminating the distress associated with the incongruence.

35. Individual patients’ treatment needs vary (Coleman, et al., 2012; Lev, 2004; Ettner, et al., 2016). For example, some patients need hormone therapy and surgical intervention, while others need just one or neither. Generally, medical intervention is

² Available at <https://www.endocrine.org/guidelines-and-clinical-practice/clinical-practice-guidelines/gender-dysphoria-gender-incongruence>.

aimed at bringing a person's body into some degree of conformity with their gender identity.

36. Treatment protocols for gender dysphoria are comparable to those for other mental health and medical conditions. Counseling, hormone therapy, and surgical care for gender dysphoria—including procedures such as mastectomies, hysterectomies, and genital reconstruction—are routinely performed as medically necessary care for other medical conditions.

37. Under the WPATH standards, hormone therapy and surgical care as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals. Hormone therapy and surgical treatment may be obtained once there is written documentation that this assessment has occurred and that the person has met the criteria in the WPATH standards for the relevant form of care.

38. Under the WPATH standards, the number of referrals from qualified mental health professionals varies based on the treatment needed. Patients must also meet the following criteria:

- a. Persistent, well-documented gender dysphoria.
- b. Capacity to make a fully informed decision and to consent for treatment.
- c. Age of majority in a given jurisdiction (if younger, follow the WPATH standards for children and adolescents).

- d. If significant medical or mental health concerns are present, they must be reasonably well controlled.

C. North Carolina’s Categorical Exclusion of Coverage for Gender-Confirming Care

39. There is no basis in medicine or science for NCSHP’s exclusion of coverage for “[t]reatment or studies leading to or in connection with sex changes or modifications and related care,” which appears to categorically bar coverage for gender-confirming mental health, hormonal, and surgical care for transgender people.

40. These treatments are not elective or cosmetic. Rather, sixty years of clinical experience have demonstrated the efficacy of treatment of the distress resulting from gender dysphoria. For example, WPATH has explained:

The medical procedures attendant to gender affirming/confirming surgeries are not “cosmetic” or “elective” or “for the mere convenience of the patient.” These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition. In some cases, such surgery is the *only* effective treatment for the condition, and for some people genital surgery is essential and life-saving.

WPATH, “Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.” (Dec. 21, 2016) (footnote omitted).

41. As recently summarized by WPATH’s “Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.,” decades of studies and research have demonstrated that transition-related care, including hormone therapy and surgery, is safe and effective. Based on this robust body of research, an independent medical board in the U.S. Department of Health & Human

Services issued a decision in 2014, rescinding a Medicare policy that had excluded surgery from Medicare coverage. The decision explained that the Medicare surgery exclusion was based on a medical review conducted in 1981 and failed to take into account subsequent developments in surgical techniques and medical research. The Board stated: “We have no difficulty concluding that the new evidence, which includes medical studies published in the more than 32 years since issuance of the 1981 report underlying the” surgery exclusion “demonstrates that transsexual surgery is safe and effective and not experimental.”

42. Nor is there any uncertainty or dispute in the medical field regarding the medical necessity of this care. *See* WPATH, “Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.” (Dec. 21, 2016) (explaining that based on clinical and peer reviewed evidence, gender-confirming care meets standard definitions of medical necessity used by insurers in the United States). As discussed above, every major medical organization in the United States, including the AMA, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association agrees that gender-confirming care, including hormone therapy and surgery, is medically necessary and effective treatment for individuals with gender dysphoria.

43. The research and studies supporting the necessity, safety, and effectiveness of counseling, hormone therapy, and surgical care for gender dysphoria is the same type of evidence-based data that the medical community routinely relies upon when treating

other medical conditions (van de Grift, et al., 2017; Tucker, et al., 2018; Asscheman, et al., 2011; De Cuypere, et al., 2005; Gijs and Brewaeys, 2007; Murad, 2010; Smith, et al., 2005; Nguyen, et al., 2019; Colizzi et al., 2013; Colizzi, et al., 2014; Smith, et al., 2005; Dhejne, 2016; Fisher, et al., 2016; Keo-Meier, et al., 2015; Oda, et al., 2017; Davis, et al., 2014; Owen-Smith, et al., 2018; de Vries, et al., 2014). Outcome studies have been published since the 1990's and those published in recent times, cited above, have concluded that "most people are very satisfied after gender-confirming therapy: their gender dysphoria is alleviated, psychological functioning and body satisfaction have improved, and their quality of life has increased. In these follow-up studies psychiatric comorbidity is diminished and individual sexual health is increased" (De Cuypere G., 2016). My own clinical experience treating hundreds of patients with gender dysphoria also confirms the medical necessity and efficacy of this care.

44. In addition to being effective for the treatment of gender dysphoria, these interventions are also cost effective for the health care systems that provide them for several reasons (Padula, et al., 2015; Elders, et al., 2014; Schaefer, et al., 2016).

45. First, based on decades of medical experience and research, it is clear that only a very small percentage of the overall population is transgender (DSM-5; Coleman, et al., 2012).

46. Second, not all medical interventions will be indicated for every transgender person. As discussed earlier, treatment for gender dysphoria can vary widely across individual transgender patients and surgery may not be medically indicated for

some because of contraindicated health conditions, age, or treatment goals. This clinical reality is reflected in research from the RAND Corporation and the Johns Hopkins Bloomberg School of Public Health which demonstrates that the cost of insuring surgical treatments for gender dysphoria through a group health plan is at most, negligible (Schaefer, et al., 2016; Padula, et al., 2015; Elders, et al., 2014).

47. Third, the cost effectiveness of gender confirming care for persons with gender dysphoria, including both cross-sex hormones and gender confirming surgery is reflected in findings that such treatment is associated with avoidance of a number of negative outcomes experienced by those who are not treated. The incremental cost to health plans of providing comprehensive care is insignificant. One recent study calculated a cost of \$0.016 per member per month (Padula, et al., 2016). Authors Padula, Heru, and Campbell concluded that “health insurance coverage for the U.S. transgender population is affordable and cost-effective and has a low budget impact on U.S. society” (*id.*).

48. Finally, there is not a disproportionate cost between providing medical care to transgender people for the treatment of gender dysphoria that is also provided to cisgender people for the treatment of other medical conditions. For example, some cisgender women are prescribed estrogen treatment after menopause in similar doses and at similar costs as estrogen treatment prescribed to transgender women for the treatment of gender dysphoria. Though the billing codes might be different, the costs for hormone therapy for transgender and cisgender patients is not. Similarly, the cost of a double

ATTORNEYS EYES ONLY, continued

[REDACTED]

[REDACTED]

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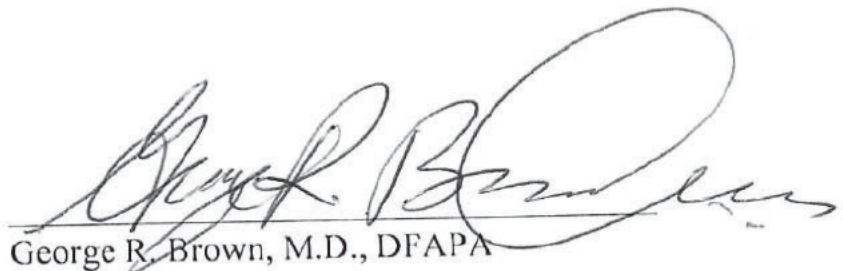
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IV. CONCLUSION

68. In summary, there is no scientific, medical, or other legitimate basis for NCSHP's categorical exclusion of gender-confirming care. My evaluation of the Plaintiffs confirms that all have been properly diagnosed with Gender Dysphoria, and that the care they have been denied pursuant to the exclusion is medically necessary for each of them, consistent with national standards of care for the diagnosis of Gender Dysphoria. I may supplement these opinions in response to information produced by Defendants in discovery or in response to Defendants' expert disclosures.

I declare under penalty of perjury that the foregoing is true and correct. Executed this 26th day of February, 2021.


George R. Brown, M.D., DFAPA

CERTIFICATE OF SERVICE

I hereby certify that on March 1, 2021, I caused a copy of the foregoing document and all attachments to be served upon the following parties via email:

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Exhibit 23(b)

Exhibit B

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80. Medical records for the transgender plaintiffs in this matter.

Exhibit 23(c)

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, *et al.*,

Defendants.

No. 1:19-cv-00272-LCB-LPA

**SUPPLEMENTAL EXPERT DISCLOSURE REPORT OF
GEORGE RICHARD BROWN, M.D., DFAPA**

1. I, George R. Brown, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
2. I have actual knowledge of the matters stated and would so testify if called as a witness. I reserve the right to supplement or amend this report based on any future information that is provided to me, including but not limited to information produced by Defendants in discovery or in response to Defendants' expert disclosures.
3. I previously signed an expert report that served on March 1, 2021 setting forth my opinions on: (1) the medical condition known as gender dysphoria; (2) the prevailing treatment protocols for gender dysphoria, their efficacy, and the cost-effectiveness of this care; (3) whether there is a legitimate medical basis for the exclusions in the health plans offered by the North Carolina State Health Plan for Teachers and State Employees ("NCSHP"), which I understand to exclude "[t]reatment

or studies leading to or in connection with sex changes or modifications and related care”; and (4) for each transgender individual named as a plaintiff at that time, the results of my evaluation of their gender dysphoria diagnosis, and the medical necessity of the care for which they have been and are being denied coverage under NCSHP.

4. Since that time, I understand that the Court has accepted Plaintiffs’ First Amended Complaint for Declaratory, Injunctive, and Other Relief for filing, and that Dana Caraway is now a plaintiff in this action. I now provide this report to supplement my expert opinion regarding the results of my evaluation of Ms. Caraway’s gender dysphoria diagnosis, and the medical necessity of the care for which NCSHP denies her coverage.

A. Materials Considered in Preparing This Supplemental Report

5. In preparing this supplemental report, I considered the materials disclosed in the body of and bibliography attached to my initial expert report. I have also undertaken a thorough evaluation of Ms. Caraway, and reviewed her medical records.

6. In preparing this supplemental report, I rely on my scientific education and training, my research experience, my knowledge of the scientific literature in the pertinent fields and my 38 years of clinical experience in evaluating, treating, and conducting research with patients with gender dysphoria and other issues related to gender identity.

7. The materials I have relied upon in preparing this supplemental report are the same types of materials that experts in my field of study regularly rely upon when

forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

B. Evaluation of Ms. Caraway

8. **Section B of this report is designated ATTORNEYS EYES ONLY pursuant to the Stipulated Protective Order in this matter. ECF No. 70.**

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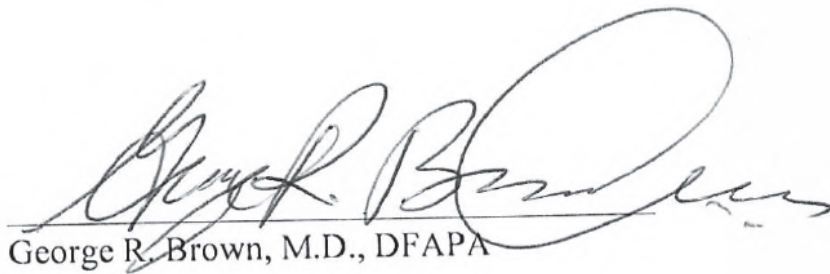
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CONCLUSION

14. In summary, my evaluation of Ms. Caraway confirms that she has been properly diagnosed with Gender Dysphoria, and that the care discussed above that she has been denied pursuant to the exclusion is medically necessary for her, consistent with national standards of care for the diagnosis of Gender Dysphoria. I may supplement these opinions in response to information produced by Defendants in discovery or in response to Defendants' expert disclosures.

I declare under penalty of perjury that the foregoing is true and correct. Executed this second day of April, 2021.


George R. Brown, M.D., DFAPA

CERTIFICATE OF SERVICE

I hereby certify that on April 5, 2021, I caused a copy of the foregoing document and all attachments to be served upon the following parties via email:

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Dated: April 5, 2021

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Exhibit 23(d)

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, *et al.*,

Defendants.

No. 1:19-cv-00272-LCB-LPA

**EXPERT REBUTTAL DISCLOSURE REPORT OF
GEORGE RICHARD BROWN, M.D., DFAPA**

I, George R. Brown, declare as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated and would so testify if called as a witness. I reserve the right to supplement or amend this report based on any future information that is provided to me, including but not limited to information produced by Defendants in discovery or in response to Defendants' expert disclosures.

3. I previously submitted an expert report that was served on March 1, 2021 setting forth my opinions on: (1) the medical condition known as Gender Dysphoria; (2) the prevailing treatment protocols for a diagnosis of Gender Dysphoria, their efficacy, and the cost-effectiveness of this care; (3) whether there is a legitimate medical basis for the exclusions in the health plans offered by the North Carolina State Health Plan for Teachers

and State Employees (“NCSHP”), which I understand to exclude “[t]reatment or studies leading to or in connection with sex changes or modifications and related care”; and (4) for each transgender individual named as a Plaintiff at that time, the results of my evaluation of their Gender Dysphoria diagnosis, and the medical necessity of the care for which they have been and are being denied coverage under NCSHP. I supplemented my report on April 5, 2021 to provide the results of my evaluation of the Gender Dysphoria diagnosis for an additional Plaintiff, Dana Caraway, and the medical necessity of the care for which she was denied coverage under NCSHP.

4. I submit this rebuttal report to respond to the declarations of Patrick W. Lappert, M.D. (“Lappert Decl.”), Stephen B. Levine, M.D. (“Levine Decl.”), Paul W. Hruz M.D. (“Hruz Decl.”), and Paul R. McHugh, M.D. (“McHugh Decl.”), provided by the Defendants in this matter.

5. In preparing this rebuttal report, I considered the materials disclosed in the body of and bibliography attached to my initial expert report, as well as the materials described in my supplemental report and attached exhibits. I also reviewed the declarations from Defendants described above and the accompanying exhibits, and the rebuttal reports submitted in this matter by Drs. Schechter, Karasic, and Olson.

6. I also rely on my scientific education and training, my research experience, my knowledge of the scientific literature in the pertinent fields and my 38 years of clinical experience in evaluating, treating, and conducting research with patients with gender dysphoria and other issues related to gender identity. This experience is detailed in the

updated curriculum vitae attached as Exhibit A. I also attach an updated bibliography reflecting additional sources I have considered to prepare this rebuttal report, some of which are specifically referenced within the text below.

7. The materials I have relied upon in preparing this rebuttal report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

I. Defendants’ Experts Dr. Hruz and Dr. Lappert Have Limited Training and Experience with Treatment of Gender Dysphoria in Adults and Adolescents, and the Opinions of All Four Experts Are Far Outside the Medical Consensus.

8. I have reviewed the declarations of Defendants’ experts, as well as their curriculum vitae, and statements regarding their training, experience, and research with patients with a diagnosis of Gender Dysphoria (the diagnosis and treatment of which are the issues in this litigation).

9. As a preliminary point, I note that throughout their reports, all four of Defendants’ experts use a term that appears to have little traction even on the unregulated internet: Transgender Treatment Industry. (*See, for example*, Hruz Decl. at 62 ¶ 65; Lappert Decl. at 6 (referring to “the highly controversial field of the Transgender Treatment Industry”); McHugh Decl. at 10 ¶ 9 (referring to the “Transgender Treatment Industry” as “another Psychiatric Misadventure” similar to lobotomies or recovered memory therapy); Levine Decl. at 10 ¶ 8.1 (referring to “the ‘affirmation’ treatment industry” which he says

is “often referred to as the Transgender Treatment Industry”).) Defendants’ experts even give this new, unused term an acronym, implying that it is in wide use (TTI).

10. Nothing could be further from the truth. The terms TTI or “Transgender Treatment Industry” are not commonly-known or commonly-accepted in the field of psychology or in the field of treatment of Gender Dysphoria more specifically. The use of this term (with the pejorative suggestion of the word “industry”) in fact appears to be idiosyncratic to Defendants’ experts, and it also appears to be part of the concerted attacks by Defendants’ experts on the dedicated clinicians who provide care for the marginalized community of transgender people—many of whom are evaluated and treated *pro bono* or nearly so.

11. These and other *ad hominem* attacks on Plaintiffs’ experts (some of which I address further below) are improper. Indeed, it is unfortunate that Defendants’ experts accuse well-meaning and hard-working clinicians of malfeasance and unethical conduct simply for following well-accepted and well-settled standard of care guidelines for treatment of Gender Dysphoria. Fortunately, the majority of clinicians do not share the narrow-minded views of these experts, whose opinions (as I describe further below) are far from the mainstream of American medicine.

12. Setting aside the phraseology of Defendants’ experts, I also question their relevant experience in treating adult and adolescent patients with Gender Dysphoria (particularly Dr. Hruz and Dr. Lappert), and I also disagree with the substance of their opinions, as set forth below.

13. Moreover, as explained further below in Section II, the reports of all these four experts inappropriately focus primarily on medical interventions for pre-pubescent children, which are not medically indicated under the Standards of Care. Below, I describe the limitations of the experience of Defendants' experts in the relevant field.

14. **Dr. Hruz.** Dr. Hruz has not provided direct clinical care for adults or adolescents with a diagnosis of Gender Dysphoria. His curriculum vitae does not identify any training, experience, or research with respect to patients with this diagnosis. Of his 50 publications, only two mention gender dysphoria, and one is a Letter to the Editor and one is an opinion piece published in the Catholic Medical Association's journal. Both of these publications are his personal opinions and do not discuss the topic from a clinical or research perspective.

15. Dr. Hruz is also not a reviewer for any relevant professional journals where mainstream literature on gender dysphoria is published. Furthermore, even though he works at a prestigious medical institution in St. Louis (Washington University) which has a well-established and respected transgender clinic since 2016, he has not been involved in this clinic.

16. Finally, despite purporting to offer expert opinions in adolescent and adult psychiatry as part of his report, Dr. Hruz reports no training or experience in these areas.

17. **Dr. Lappert.** Dr. Lappert likewise does not have the requisite training, clinical experience, or research experience to render opinions regarding the medical and psychiatric treatment of adolescents and adults with a diagnosis of gender dysphoria.

Instead, his training and experience is as a surgeon. Moreover, the bulk of his experience as a surgeon was in the United States Navy, during which he could not have performed transition-related surgeries, as these were not authorized in the Department of Defense until after he left the Navy.

18. Dr. Lappert does not appear to have provided any professional presentations on transgender issues at Category I continuing medical education meetings at the state, regional, national, or international levels. He has no publications regarding research into the topic of Gender Dysphoria in adolescents or adults. He has not had any apparent University affiliation in 19 years. In sum, from my review of Dr. Lappert's curriculum vitae and experience, I see no evidence that he has the requisite training, experience, or research expertise that would qualify him as an expert in any type of transgender health, let alone the treatment of a diagnosis of Gender Dysphoria in adolescents and adults.

19. **Dr. McHugh.** Dr. McHugh likewise does not have the requisite training, clinical experience, or research experience to render opinions regarding the medical and psychiatric treatment of adolescents and adults with a diagnosis of Gender Dysphoria. He focuses his opinions on long-since-addressed controversies that existed over four decades ago (like lobotomy, repressed memory syndrome, and multiple personality disorder), and he does not appear to have any significant experience with respect to the modern, accepted, clinical practices in transgender health. Although he was successful at influencing the closure of the gender clinic at Johns Hopkins in 1979, "nearly 4 decades after he derailed a pioneering transgender program at Johns Hopkins Hospital with his views on 'guilt-

ridden homosexual men,' psychiatrist Paul McHugh is seeing his institution come full circle with the resumption of gender reassignment surgeries.” (Washington Post, 4/15/17.) When he co-authored a paper in a conservative Catholic publication, *The New Atlantis*, over 600 students, faculty, alumni, and others at Johns Hopkins medical school signed a petition calling on the hospital to disavow any connection between their institution and Dr. McHugh.

20. **Dr. Levine.** Indeed, of these four experts, only Dr. Levine appears to have any relevant training or limited recent clinical experience in the management of adolescents or adults with a diagnosis of Gender Dysphoria. Despite that, the views expressed in his report are outliers in the community, and they do not comport with the prevailing standards of care or its extensive evidentiary base. Dr. Levine’s own institution, Case Western Reserve University, follows the prevailing standards of care and provides gender-affirming care to transgender people.

21. Below, I provide responses to the substantive opinions of these four experts. There is substantial overlap, almost to the point of “cut-and-paste,” of some of the exact statements and opinions proffered by these physicians. Therefore I will not always provide my rebuttal responses in an individualized fashion, since a number of them apply to more than one declaration.

II. Defendants’ Experts Contravene the Scientific Consensus Around the Medical Necessity, Safety, and Efficacy of Gender-Affirming Care.

A. Defendants’ Experts Improperly Conflate the Appropriate Medical Treatment of Gender Dysphoria in Pre-Pubertal Children Versus Adolescents and Adults.

22. The declarations from Defendants’ experts largely fail to respond to the opinions and body of peer-reviewed literature described in my initial report, focusing instead on issues such as the appropriateness of hormonal intervention and other medical treatments for pre-pubescent children. To the extent Defendants’ experts suggest that I have opined in favor of providing medical or surgical interventions to pre-pubescent children, that is not the case. There is wide agreement that medical and surgical interventions are not indicated or appropriate in pre-pubescent children with gender incongruence, and I have not opined otherwise. Beyond that, I have not been asked to offer affirmative opinions about the appropriate course of treatment for Gender Dysphoria for pre-pubescent children, and I do not intend to offer such opinions in this case.

23. Moreover, the supposedly “key” literature on which all four of Defendants’ experts rely (*e.g.*, NICE review for Great Britain 2020, the Swedish review, the 2020 COHERE Finland reviews, etc.) focus exclusively on pre-pubertal children and thus do not bolster Defendants’ arguments about medical care for adolescents and adults at all. In the Finnish reviews, for example, the recommendations are largely in line with the World Professional Association of Transgender Health (“WPATH”) Standards of Care (“SOC”), and with modern clinical practice for adults with Gender Dysphoria:

“Treatment measures that modify the body to be more congruent with the person’s gender identity can be carried out if the person can reasonably justify them and is aware of the risks associated with them.” (pg 1, COHERE, Finnish review, at www.palveluvalikoima.fi/en). “Surgical procedures are carried out in line with the principles of promoting a good outcome and reducing adverse events . . .”

24. There are in fact, three separate reports published by COHERE in Finland, and they divide minors into pre-puberty and post-puberty. They indicate in their recommendations “puberty suppression treatment may be initiated on a case-by-case basis . . .” for post-pubescent adolescents. *See Medical treatment methods for dysphoria associated with variations in the gender identity of minors*, <https://palveluvalikoima.fi/sukupuolidysforia-alaikaiset>. In summary, Defendants’ experts misrepresent the three Finnish COHERE 2020 reports, again confusing pre-pubertal children with post-pubertal adolescents and adults, while it clearly states in the Finnish guidelines that appropriately diagnosed patients can be treated.

25. I am aware of no standards of care followed by any mainstream clinicians who are experts in transgender healthcare that recommend medical or surgical treatments for pre-pubertal children with gender incongruence/gender dysphoria of childhood. Defendants’ experts’ conflation of this group of children with post-pubertal/late adolescents and adults is misleading, inappropriate, and confusing for the readers of their reports.

26. Defendants’ experts offer no references or literature to support the denial of routine transgender healthcare for adolescents or adults diagnosed with Gender Dysphoria,

following the WPATH Standards of Care (SOC). This is likely because, in my understanding and experience, no such scientifically-reliable literature has been published in at least the last 15 years.

27. Defendants' experts also erroneously generalize about the appropriate course of treatment for Gender Dysphoria in adults or adolescents based on data about pre-pubertal children. This is inappropriate. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5") recognizes separate criteria for diagnosing Gender Dysphoria in children, on the one hand, and adults and adolescents on the other. The WPATH Standards of Care (SOC) have distinct standards of care for pre-pubertal children, adolescents and adults. As noted in my original report, the WPATH SOC, version 7 (Coleman, et al, 2011), are the nationally and internationally accepted standards of care for the evaluation and treatment of a diagnosis of Gender Dysphoria in adolescents and adults. These standards of care are also specifically followed by the largest healthcare systems in the United States (Department of Veterans Affairs, Kaiser-Permanente) as well as most major insurers of healthcare in the United States, including the corporate policy for Blue Cross and Blue Shield which specifically references these WPATH standards. *See Blue Cross Blue Shield of North Carolina, Corporate Medical Policy, Gender Affirmation Surgery and Hormone Therapy* (2021). They are also utilized as standards of care by many Departments of Corrections, the Federal Bureau of Prisons, the National Health Service of the UK, and many other countries as well. Coverage for transgender health care has been considered medically necessary for appropriately diagnosed individuals suffering from

Gender Dysphoria for more than a decade. The opinions of Defendants' experts to the contrary are therefore significantly out of step with the rest of the medical, scientific, and insurance industry communities.

28. Defendants' experts also premise their opinions on the assumption that Gender Dysphoria in post-pubertal adolescents and adults is very likely to "disappear" if left untreated. I disagree. For example, in one follow-up study of adolescents treated at a gender clinic, 100% of the 70 individuals treated ultimately underwent hormone therapy, and continued to identify with a gender different than the one assigned to them at birth. (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011.)

29. My personal experience treating patients is consistent with studies like these. For example, in my personal experience, I have had no adult or late adolescent patients with Gender Dysphoria report a resolution of these clinical symptoms without one or more interventions. I have had no adults under my care "detransition" after medical and/or surgical interventions for a diagnosis of Gender Dysphoria, and whose care has followed the WPATH Standards of Care.

30. Drs. Hruz and Levine also misquote a publication by Exposito-Campos (2020) that they say cites a figure of "60,000" people on the internet that they claim have "detransitioned." The Exposito-Campos paper says nothing of the kind. The authors of this paper only allude to a so-called "subreddit" on Reddit (a social news aggregation and discussion website that anyone can join), that claims to have 16,000 members who may have some interest in this topic.

31. That subreddit (www.reddit.com/r/detrans) shows 20,100 posters. This group includes health care providers, those who claim they have detransitioned or are detransitioning, those who claim to have “desisted,” and those who are “questioning.” There are no limitations to joining as a poster on this subreddit, and “membership” on this group is widely open and poorly defined. It is therefore unknown how many of those 20,100 posters are actually appropriately classified as “detransitioners” (*i.e.*, post-pubertal people who had socially, medically and/or surgically transitioned from their birth sex and “original” gender to some other gender and then reversed that transition). Moreover, there is no indication how many posters may have detransitioned because of true feelings of regret, as opposed to external pressures related to stigma and discrimination. Regardless, even if the number of posters were a reliable measure of regret, in comparison to the population of transgender people this would indicate that regret is a rare phenomenon. It is also noteworthy that Dr. Levine (¶ 99) states there are “misleading reports of clinical experience, publications that misreport evidence, and the unregulated content of the Internet” as problems associated with providing transgender healthcare, while at the same time misquoting the Exposito-Campos publication and relying on an unregulated Internet website to support his misguided opinions on withholding standard-of-care treatments for patients with a diagnosis of gender dysphoria.

B. Randomized Control Trials Are Not the Only Accepted Basis for Medically Necessary and Generally-Accepted Treatment Protocols.

32. Defendants’ experts assert that there is a lack of evidence demonstrating the effectiveness of the accepted protocols for the treatment of Gender Dysphoria – primarily

because, they argue, these protocols are not supported by randomized control trials. (*See, for example*, Hruz ¶ 58 (“The most notable deficiencies of existing research are the absence of proper control subjects and lack of randomization in study design.”); McHugh ¶ 10(C) (criticizing the “Transgender Treatment Industry” for failing to “conduct competent randomized clinical trials”).) They also argue that because these protocols are not supported by randomized controlled trials, such treatments are by definition “experimental” and not generally accepted by the relevant scientific community. (*See, for example*, Hruz ¶ 26(B) (“In my opinion, the relevant scientific community agrees that Transition Treatments are controversial, unproven, untested, and experimental . . .”).)

33. Implicit in these opinions from Defendants’ experts is the assumption that *only* those treatments that are supported by randomized control trials are generally accepted, non-experimental, and medically appropriate. I disagree with Defendants’ experts’ opinions that transgender healthcare for appropriately diagnosed adolescents and adults with Gender Dysphoria is either experimental or controversial, and I further disagree with their position that randomized clinical trials are either necessary, ethically permissible, or scientifically feasible for many aspects of the medical and surgical treatment of adolescents and adults with Gender Dysphoria.

34. First, randomized controlled studies are not the only type of evidence upon which scientists and doctors rely. Studies demonstrating that patients’ conditions improved after treatment can be very informative, whether or not there are matched control groups. (Manieri, Castellano, Crespi, et al., 2014.) Clinicians routinely rely on other types of

evidence to guide their practice. Case reports, case series, cohort studies, observational studies, lengthy clinical experience with a condition, and the consensus of national and international experts in a given field are all brought to bear in the compassionate clinical care of individuals with any given diagnosis.

35. A randomized clinical trial, while possible for some conditions and for some treatments, is not possible for others. For example, it is impossible to randomize or do blinded studies for most established surgical treatments. It is obvious to both the research subject and the researchers whether an individual has had a surgery that is visible to the naked eye. Likewise, for medications that have significant physical effects that are obvious to the casual observer (for example, puberty-suppressing drugs and cross-sex hormones), it is impossible to do a randomized, blinded trial as well.

36. These are just scientific considerations that do not take into account the ethics of conducting such trials if they were scientifically feasible in the first place. For example, once a clinical treatment is well established as a standard of care (for example, the use of cross-sex hormones in late adolescents and adults with a diagnosis of Gender Dysphoria), it is ethically impermissible to decide to go backwards and design a trial where patients suffering from Gender Dysphoria are randomized to receive standard of care treatment or no treatment. The Royal College of Psychiatrists pointed these issues out as long ago as 2013 (Royal College of Psychiatrists, 2013). It is the case across psychiatry, medicine, and surgery that the randomized clinical trial is not the basis for the majority of standard treatments in widespread use by mainstream clinicians worldwide. I will refer to this in

much greater detail in a later paragraph regarding the quality of evidence for treatments for Gender Dysphoria and other diagnoses.

37. Second, Defendants' experts ignore another critically important source of evidence—the clinical experience of generations of clinicians who have treated patients with Gender Dysphoria. There is abundant clinical experience going back 60 years that establishes the effectiveness of social transition, hormone therapy and surgeries as treatments for Gender Dysphoria, utilized on an individualized basis and in collaboration with patients, parents (when indicated), and other clinicians.

38. Third, it is very common for medical professionals to make choices about treatment protocols that are not based on matched control group studies or randomized, placebo-controlled trials. For example, many aspects of the treatment protocols for common psychiatric conditions such as bipolar disorder, depression, post-traumatic stress disorder, and schizophrenia (the bulk of patients seen in outpatient psychiatric clinics) are not matched with control group studies or double-blind clinical trials, but rather have been accepted by the profession as the standard of care based on clinical experience, limited published data, case series, or other types of evidence available.

39. Another common example is a physician's decision to select one drug over another in treating a particular condition. In many cases, the decision to select drug A over drug B or drug C is not validated by a control group study demonstrating that drug A produces results superior to drug B or drug C. Instead, the physician makes a decision among available drugs based on the unique characteristics of the patient in the office,

his/her clinical experience and his/her overall assessment of a patient's situation at that point in time. That decision does not lack an evidentiary basis simply because there is not a matched control group study to support it.

40. A corollary argument posited by Defendants' experts is that medical treatments for Gender Dysphoria are somehow experimental because they are not FDA-approved (*e.g.*, Hruz Decl. ¶ 63; Lappert Decl. at 21). For example, Dr. Hruz misleadingly states that if medications are used "off label" and are not "FDA approved," there must be ethical problems with the medication treatments.

41. This is incorrect. The FDA does not regulate the practice of medicine, and it does not state that medications used without formal FDA approval are necessarily problematic. In fact, the FDA states on their website: "When you don't have the labeling directions to guide you, you need the medical knowledge of your doctor, nurse practitioner, or other health professional" (*see* FDA.gov).

42. These opinions from Defendants' experts also fail to acknowledge that the practice of medicine routinely involves "off label" use of medications as standard-of-care treatments. For example, the most effective drug for nightmares associated with posttraumatic stress disorder is prazosin, a medication that is FDA approved for hypertension but not for any psychiatric indication. Nonetheless, this is standard of care treatment in psychiatry.

43. Defendants' experts also ignore the fact that the majority of medications used every day in the pediatric population in particular are used off-label and without FDA-

approval, because the fact that a drug is FDA-approved for a particular indication for the adult population does not mean that it is also approved for use in the pediatric population, and such approval requires separate evidence of drug efficacy and safety in the pediatric population.

44. Moreover, there is often no financial incentive for companies to go through the expensive, lengthy process of applying for an FDA-approved indication, especially once a medication is available as a generic (as are almost all medication treatments for Gender Dysphoria). Garden-variety aspirin, taken by millions of people worldwide every day, for example, has no FDA approval simply because no one has applied for an FDA indication for generic aspirin.

C. The Practice of Medicine Does Not Require Withholding Treatment Until There Is Perfect Knowledge About the Medical Condition at Issue.

45. Defendants' experts seem to suggest that clinicians must know virtually everything about a condition that causes substantial human suffering before being able to treat or relieve the symptoms of that condition (*e.g.*, Lappert Decl. at ¶ 11; Hruz Decl. at ¶45). They also seem to opine that the physician must know the exact etiology for a diagnosis of Gender Dysphoria in adolescents and adults, before any treatments other than “watchful waiting” or some type of conversion therapy can be utilized.

46. The standard posited by Defendants' experts is not generally accepted in the medical field, and it contravenes the way that clinicians operate every day. The exact etiologies of many conditions treated across the spectrum of psychiatry, medicine, and surgery are at best hypotheses. What are the etiologies of all human cancers? What causes

chronic fatigue syndrome? What causes complex autoimmune disorders? Why do some people exposed to combat situations develop posttraumatic stress disorder while the majority do not? All of these are valid, heuristic questions that are worthy of further clinical research. However, in the meantime, patients with all of these conditions present themselves to competent, well trained clinicians who bring to bear the best scientific information available, in combination with their clinical experience and training, in order to collaboratively develop an individualized treatment plan to improve the well-being of these patients.

47. This is the routine, daily, standard of care experience for clinicians and patients in all fields of medicine, including in transgender healthcare. It is logically inconsistent and cruel to state that because one does not know the precise etiology of a condition that one cannot relieve the suffering of individuals who have it, hiding behind a misapplication of the Hippocratic Oath. (*See, for example*, Levine Decl. ¶ 100; Hruz Decl. ¶ 50 (arguing that the “an essential tenet of medical practice is to avoid doing harm,” and that supposedly “the current Gender Transition Industry violates this essential principle by using experimental treatments on vulnerable populations . . .”).

48. Defendants’ experts also state or imply that essentially doing nothing, what they call “watchful waiting,” should suffice for adolescents and adults legitimately diagnosed with DSM-5 Gender Dysphoria. For one, these opinions seem to be premised on Defendants’ experts’ assumption that withholding clinical treatment will eventually result in most patients no longer experiencing Gender Dysphoria. (*See, for example*,

Levine Decl. ¶ 28 (opining that most studies show that “the large majority of children who present with gender dysphoria will desist from desiring a transgender identity by adulthood if left untreated”); Hruz Decl. ¶ 52 (opining that in most cases, “the vast majority of affected children if left alone are likely to eventually realign their reports of gender identification with their sex.”).) For reasons I describe above, this is incorrect. (*See, for example, de Vries 2011* (follow-up study of adolescents treated at a gender clinic, which found that 100% of the 70 individuals treated ultimately underwent hormone therapy and continued to identify with a gender different than the one assigned to them at birth), and the above summary of my clinical experience treating adult or late adolescent patients with Gender Dysphoria.)

49. Moreover, given the substantial physical and mental health disparities associated with untreated Gender Dysphoria in these populations, following the advice of Defendants’ experts would essentially constitute malpractice in the majority of cases relevant to this litigation. “Doing nothing” does not constitute “do no harm” in most of these clinical situations, contrary to what Defendants’ experts say clinicians must do. (Levine Decl. ¶ 100 (“the physician must ‘do no harm’”); Hruz Decl. ¶ 50 (“the ethical foundations of medicine – first do no harm”).)

50. Defendants’ experts also cite sources such as the Cochrane Reviews and the Endocrine Society’s Guidelines, which rate certain literature as “low quality evidence,” to argue that well-accepted standard of care treatments for Gender Dysphoria in adolescents and adults are unproven. (Levine Decl. at 50 ¶ 127; Lappert Decl. at 26 ¶ 14.) It is not

uncommon for standard, routine interventions in psychiatry, medicine, and surgery to have reviews that conclude that the quality of evidence for such treatments is “low” or “very low” based on the rigid, limited definitions of “evidence” used by these reviewing organizations, and based on the evidence available at a given point in history.

51. In fact, the Cochrane Database of Systematic Reviews on which Defendants’ experts rely as a reason *not* to provide hormonal treatments for adults with a diagnosis of Gender Dysphoria has a number of reviews with similar qualities of evidence for treatments and procedures that are nonetheless considered standard of care and are in routine practice on a daily basis. For example:

1. **Rotator cuff surgery for documented tears with symptoms.** This is a common orthopedic surgery that about 460,000 Americans undergo yearly for symptomatic tears of one or more of the muscles/tendons that enable the shoulder to function normally (<https://idataresearch.com/over-460000-rotator-cuff-surgeries-per-year-reported-in-the-united-states-by-idata-research/>). A 2019 Cochrane review stated “we are uncertain whether rotator cuff repair surgery provides clinically meaningful benefits to people with symptomatic tears.” Further, similar to Defendants’ experts’ complaints about standard treatments for Gender Dysphoria, the report concluded that “trials included have methodology concerns and none included a placebo control.” “There are nine trials with 1007 participants through 2019.” (Cochrane Database, 2019.)
2. **Early versus delayed appendectomy for abscess.** Appendectomy is one of the most common surgical procedures completed on children in the United States. Over 250,000 Americans are operated on for appendicitis annually (<https://www.medscape.com/answers/773895-14426/what-is-the-incidence-of-appendicitis-in-the-us>). One might expect that given all the important decisions regarding this common procedure that has been done for at least 150 years (first reported in 1735) there would be well-settled, high quality evidence supporting its efficacy. That is not the case according to the Cochrane review, however. The Cochrane review included evidence from 1950 through 2016, in all languages. They found just two studies with 80 total patients deemed

acceptable for their review. They concluded “it is unclear whether early appendectomy prevents complications compared to delayed appendectomy for people with appendiceal phlegmon or abscess.” “Evidence is of very low quality.” They also noted “data are sparse.” And finally, “further trials on this topic are urgently needed.” (Cochrane Database, 2017.) Needless to say, clinical decisions regarding immediate treatment of appendiceal abscesses are made on a daily basis in thousands of patients with the intent to relieve suffering and mortality in those emergently presenting for care with this condition, notwithstanding the Cochrane’s review which criticizes such treatments as lacking randomized controls and having “very low quality” evidence.

3. **Review of exercise-based cardiac rehabilitation for adults after a heart valve surgery.** (Cochrane Database, 2021.) It is common, standard-of-care practice for patients who have undergone a variety of cardiac procedures, including valve replacement, to be prescribed a course of exercise-based cardiac rehabilitation. The 2021 Cochrane review of evidence in support of this routine practice found six trials with 364 participants. The reviewers stated “due to lack of evidence and the very low quality of available evidence, this updated review is uncertain about the impact of exercise cardiac rehabilitation in this population . . .”

52. As these several examples (from dozens that are readily available) show, there are many clinical practices that have been developed over years or decades that may not have any randomized clinical trials or “high-quality” evidence to support their use as determined by the reviewers of such procedures, but that are nonetheless in routine clinical practice today (including those that also receive routine insurance coverage). This highlights the fact that there are many types of evidence, not just randomized clinical trials, which are relevant in practicing standard-of-care medicine. These include cohort trials, controlled comparison trials (*e.g.*, van der Miesen, 2020, that showed “transgender adolescents show poorer psychological well-being before treatment but show similar or better psychological functioning compared with cisgender peers from the general

population after the start of specialized transgender care involving puberty suppression.”), retrospective studies based on medical records databases, case series, case reports, clinical consensus reports from experts in a field, etc. The treatments described in the WPATH SOC for adolescents and adults suffering from Gender Dysphoria have similar, or in some cases better, evidence bases than other common treatments in routine clinical practice today.

53. Next, Defendants’ experts erroneously apply the concept of “error rates” to terminology, procedures, and the evidence cited in Plaintiffs’ expert reports. There are eight types of error rates (Bayes, Bit, Per-Comparison, Residual, Soft, Human performance, Viterbi, and Word), and none of them have validity when applied in the manner used by Defendants’ experts. Error rates are generally applied to repeated observations and other nonmedical applications. Experts and practitioners in the field do not apply this concept to terminology as Defendant’s experts attempt to do throughout their declarations.

III. Defense Experts Improperly Conflate Sex and Gender.

54. Defendants’ experts offer various opinions about the nature of sex, but to the extent they suggest that sex is determined solely by “DNA” or other isolated characteristics, they rely on outdated notions that do not reflect the scientific consensus.

55. In most cases, the sex assigned at birth to newborns on their birth certificate is based solely on a cursory examination of their external genitalia. However, this method of assigning sex amounts to nothing more than a “best guess” of a child’s sex. It is true

that this “best guess” is accurate the vast majority of the time, but not all of the time. At birth, sex can usually be recorded as only “male” or “female” and, as such, is an administrative binary terminology that does not take into account the complexity of human experience. “Sex” is much more complicated, as it involves biological constructs that may or may not be readily observed, and includes the important component of gender identity (Richardson, 2013).

56. A person’s “sex” is not exclusively or solely defined by one’s anatomy or ability to procreate as was often believed in the past (Ovesey & Person, 1973). “Biological sex” is a broad and complex concept that consists of a number of variables that includes gender identity, genital anatomy (internal and externally visible), secondary sexual characteristics, brain anatomy, hormonal levels in the brain and body, and chromosomal complement.

57. Primary sexual characteristics are a factor when determining a person’s sex. Genital anatomy, which includes both internal (not observable) and external (observable) components, is an example of a primary sexual characteristic. The appearance of the observable external genitalia is usually the sole basis for determining whether a baby’s sex is recorded on a birth certificate as either “male” or “female.” As a general category, however, primary sexual characteristics include those features that are not subject to the hormonal changes associated with puberty: *e.g.*, testes, prostate, seminal vesicles, penis, ovaries, vagina, uterus, fallopian tubes, clitoris, and labia.

58. Secondary sexual characteristics are yet another factor in determining a person's sex. Secondary sexual characteristics are those physical features that develop under the influence of rising levels of sex steroid hormones beginning at puberty. Examples include breasts in women; "Adam's Apple" (enlargement of the front part of the laryngeal cartilage) in men; facial hair in men; widening of the pelvis in women; deepening of the voice in men; and hip to waist measurement ratios that are higher in adult females, on average, compared to adult males. The development of secondary sexual characteristics is dependent on production of adequate amounts of estrogens in females and testosterone in males.

59. Brain anatomy is another determinant of a person's sex. As discussed in greater detail below, many areas of the brain are different between males and females ("sexually dimorphic" areas of the brain) due to genetics and the amounts of sex steroid hormones present in the developing fetal brain (*i.e.*, hormones from any source, including from the woman carrying the fetus).

60. The relative levels of the hormones estrogen and testosterone (and their metabolites, or what is left after they are processed by the body) present in the brain and body are also factors that determine a person's sex. Both the brain and the body have receptors for estrogen and testosterone, which means that the brain and various organs in the body are changed by the presence, or absence, of these two major hormone classes. For example, both testosterone and estrogen are present in all people, but the relative amount of estrogen compared to testosterone is typically far, far higher in female bodies than in

male bodies, whereas the amount of testosterone is typically far greater in male bodies than in female bodies.

61. Variability in the amount of these sex hormones, both before and after birth, can have major consequences on the primary and secondary sexual characteristics and the gender identity of people with these differences. Different, non-normative, prenatal sex hormone production can result in ambiguously appearing genitalia at birth, or misassignment of sex at birth (MacGillivray and Mazur 2005). For example, babies with much higher levels of androgens early in life (*e.g.*, congenital adrenal hyperplasia, a genetic absence of an important sex steroid enzyme) may appear to have male genitalia at birth even though they have typically female chromosomes (46XX; see below) and a female gender identity. There are many such conditions, which collectively are referred to as “intersex” conditions, disorders/differences of sex development, or “atypical sexual development” (Mazur et al., 2007).

62. Chromosomes are also a determinant of sex. Typically, most people have 46 total chromosomes, two of which are “sex chromosomes” known as X and Y. Babies assigned the female sex at birth based on the appearance of external genitalia typically have a 46XX pattern; likewise, babies assigned the male sex at birth based on the appearance of their external genitalia typically have a 46XY pattern. Uncommonly (but not rarely), there are genetic abnormalities in the fertilized egg that lead to chromosome patterns that are different from either 46XX or 46XY. Examples are numerous and can be found in Mazur et al., 2007. Classic examples include Turner’s Syndrome, estimated at 1:2500 live births

(46XO, where one sex chromosome is missing), and Klinefelter's Syndrome, where extra chromosomes are present (for example, 47XXY, 48XXYY). This nonheritable genetic abnormality is present in 1:600 live births (Nielsen and Wohlert, 1991).

63. Some, but not all, disorders of the sex chromosomes are associated with atypical sexual organ appearance and higher rates of homosexuality, bisexuality, or asexuality (that is, little to no sexual attraction to anyone or interest in having sexual relations). Some people with disorders of the sex chromosomes, but not all, may have atypical gender identity and/or gender role development as well. The key point is that the presence of a typical 46XX or 46XY chromosome pattern is relevant for determining a person's sex, but not sufficient, in and of itself, to determine a person's sex (Richardson, 2013).

64. As I explained in my original report, gender identity is an internal sense of oneself as a particular gender. From a medical perspective, gender identity is a critical determinant of a person's sex. From a social perspective (which is also relevant when considering the appropriate medical approach to these issues), the appropriate determinant of sex is gender identity and associated gender expression/role, as that is the underlying basis for how one presents oneself to others in society in ways that typically communicate what sex one is in our culture. Dr. Hruz incorrectly states (paragraph 16) that "gender identity" is controversial. It is not. The American Psychiatric Association (DSM-5, p. 451) defines gender identity as a "category of social identity and refers to an individual's identification as male, female, or occasionally, some category other than male or female."

Standard definitions are well accepted in the relevant medical and psychiatric communities, and gender identity falls within this category.

65. Dr. Hruz's conception of gender and sex as inextricably related to "reproductive purposes" is not rooted in current, appropriately nuanced understandings of these concepts in medicine or science. He conflates sex and gender, and appears to treat these concepts as the same in animals and humans. His use of a definition of gender that relies on participation "in activities related to reproduction" is also not only incorrect but fails to account for the diversity in procreative capacity among people. A notable segment of the population chooses not to, or may be incapable of, reproducing, but this does not determine their sex or gender identity.

66. Although the precise etiology of transgender phenomena is unknown (Ettner, 2007; Lev, 2004), most experts agree that there is likely a biological, rather than a psychological, basis for gender identity in general, including transgender identity (Korpaisarn & Safer, 2019, for a current review).

67. Much of the evidence in support of a biological basis for gender identity is based on comparison studies of the brains of persons identified as transsexual¹ using imaging techniques with live subjects or measurements taken post-mortem (after death). Such techniques were not possible a short time ago, but nonetheless, the concept of a "critical period effect" during fetal brain development was espoused decades ago as an

¹ Although the terms "transsexual," "MtF," "FtM," "transwoman," and "transman" are no longer widely used, I use those terms in this report where needed to accurately describe the underlying literature.

explanation for why some individuals experience gender nonconformity (Kimura 1992). Although it is not possible to directly study the developing human brain before birth, it was proposed that the hormones present in the bloodstream surrounding the developing brain at certain, undetermined critical periods in brain sexual differentiation were altered to the extent that the “brain sex” did not match the otherwise “normal” anatomic/genital sex at birth. This theory more recently received support in a study of fetal testosterone exposure, which showed that amniotic fluid levels of testosterone for “birth sex” male and female fetuses correlated positively with male-typical play patterns in both “birth sex” male and female children (Auyeung, et al, 2009).

68. It is well known that the brains of cisgender men and women differ in size in many regions of the brain (Korpaisarn & Safer, 2019). These include specific parts of the brain (called “sexually dimorphic”) that are visible on MRI studies, including the hippocampus, caudate nucleus, and anterior cingulate gyrus, to name a few, that are larger in “birth sex” women and the amygdala and gray matter volumes that are larger in “birth sex” men. Most studies of gender-typical male and female brains also indicate that the right hemisphere is larger in men than in women.

69. Zhou and others reported in 1995 that areas of the brain known to differ in size between men and women generally could be studied in persons who had been identified as transsexual. At least one of these sexually dimorphic brain regions in male-to-female transsexual subjects was consistent with the size seen in “birth sex” females, and not males.

70. Additional support for a biological basis for gender identity was reported by Luders and colleagues, who analyzed MRI data of 24 people identified as male-to-female (MtF) transsexuals not yet treated with cross-sex hormones in order to determine whether gray matter volumes in the brains of MtF transsexuals more closely resemble people who share their “birth sex” (30 control men), or people who share their gender identity (30 control women). Results revealed that MtF transsexuals showed a significantly larger volume of regional gray matter in the right putamen compared to the control group of non-transsexual, “birth sex” men. These researchers concluded that their findings provided new evidence that transsexualism is associated with a distinct cerebral pattern, which supports the assumption that brain anatomy plays a role in gender identity.

71. Savic and Stefan (2011) studied the brains of persons identified as male-to-female transsexuals compared to “birth sex” controls of the same sexual orientation. The brains of the transgender female subjects differed from controls in several regions (*e.g.*, smaller volumes in the putamen and thalamus in transgender women). They concluded: “Gender dysphoria is suggested to be a consequence of sex atypical cerebral differentiation.”

72. Additional studies in support of the hypothesis that gender dysphoria is caused by sex atypical differentiation of parts of the brain before birth due to genetic and/or an early organizational effect of testosterone levels during fetal brain development include: Giedd J., Castellanos F., et al., 1997; Green R. and Keverne E., 2000; van Goozen S., Slabbekoorn D., et al., 2002; and Swaab D., 2007.

73. Finally, several other studies have also found distinctive brain patterns in subjects identified as transsexual that differ from what would be expected to be seen in non-transsexual subjects of the same “birth sex” in post-mortem studies. *See* Kruijver F., Zhou J., et al., 2000; Berglund H., Lindstrom P., et al., 2008.

74. The evidence for gender identity arising from strictly, or mostly, postnatal influences (such as family interactions, social factors, maternal/paternal rearing styles) is not persuasive; for this reason, the suggestion by three of the Defendants’ experts that being transgender is a result of “social contagion” or exposure to the Internet is wholly unsupported by the science. “Social contagion” as defined by the American Psychological Association (APA Dictionary, 2020) is “the spread of behaviors, attitudes, and affect through crowds and other types of social aggregates from one member to another. Early analyses of social contagion suggested that it resulted from the heightened suggestibility of members and likened the process to the spread of contagious diseases.”

75. Dr. Hruz (¶¶ 41, 70) and the other defense experts proffer this untested theory as the explanation for the decade or more increases in requests for transgender health services. Dr. Hruz suggests that this social contagion is a result of nefarious Internet-based influences promulgated by transgender activists seeking to increase their numbers. This is an unproven concept that disregards what can readily be explained by objective, observed, and well-known phenomenon. Zucker (2019) lists four “likely interconnected” explanations that may explain this observed increase in requests for care: (1) the increased visibility given to transgender issues and print media, television, etc.; (2) access to Internet

sites where anyone can read about gender dysphoria and transgender healthcare; (3) the gradual reduction in stigma associated historically with gender dysphoria and transgender identity; and (4) the increased availability of medical treatments for gender dysphoria, including pubertal suppression. I served as the only psychiatrist on the early committees within the Department of Veterans Affairs (2010-2016) that established a new benefits package for transgender veterans with a diagnosis of Gender Dysphoria, an updated name for that diagnosis which was adopted by the American Psychiatric Association in 2011. I conducted research on the changes in prevalence and diagnoses of Gender Dysphoria and tracked the predicted increases in this diagnosis in the years subsequent to 2011 (Blosnich, et al, 2014). Once these treatments were made available nationally and this information was publicized, eligible veterans reported to hospitals and clinics to access this care in increasing numbers. None of these new patients were adolescents. The average age of these “new” patients with a diagnosis of Gender Dysphoria ranged between 40 and 70 years. There was no “social contagion” involved in this predictable increase.

76. Indeed, Defendants’ experts all but acknowledge that their theories about “social contagion” increasing the number of persons who experience gender dysphoria are essentially speculation. They cite no scientific studies to support these opinions, and they admit they do not know to what extent (if at all) this supposed phenomenon actually occurs. (*See, for example*, Lappert Decl. at 40 (“A currently unknown percentage and/or number of patients reporting gender dysphoria are being manipulated by a . . . social contagion and social pressure process”) (emphasis added); McHugh Decl. ¶ 11 (same, verbatim); Hruz

Decl. ¶ 29 (“Social medical ‘influencers’ are *reportedly* training patients to fabricate symptoms to gain rapid access to ‘transition’ interventions”) (emphasis added).

IV. Defendants’ Experts Ignore and Misconstrue Relevant Scientific Literature, and Their Opinions About Appropriate Treatment for Gender Dysphoria Is Far Outside of the Scientific Consensus.

A. Defendants’ Experts Misconstrue Scientific Literature.

77. The opinions offered by Defendants’ experts are not reliable for an additional reason: they misconstrue the work of others in the field in substantive ways. A nonexhaustive list of examples includes the following:

a) misrepresentation of the conclusions of the three COHERE studies from Finland as noted above (Lappert Decl. at 2).

b) Dr. Lappert asserts that Plaintiffs’ experts have undisclosed conflicts of interest because their income is “derived from the experimental, unproven, potentially harmful methods and procedures of affirmation treatments.” (Lappert Decl. at 8). As a psychiatrist employed by the Department of Defense and the Department of Veterans Affairs for well over 30 years, none of my income was derived from the sources he alleges. Moreover, experts in the field naturally will include those who treat the population at issue, which is how practitioners develop clinical expertise.

c) Dr. Lappert misrepresents the 2013 sources about the alleged lack of support for DSM-5 by the National Institute of Mental Health (“NIMH”). As described further below, the actual primary source information shows that NIMH did not discontinue funding for research on the DSM-5, and in fact recognizes it as authoritative.

d) Drs. Levine (¶ 98) and Hruz (p. 18) misquote Exposito-Campos, et al. (2021) by stating that there are “60,000” detransitioners on an internet site, whereas the authors mention “16,000” in their publication, which is not necessarily a count of “detransitioners.” As described above, their discussion of this source reference significantly misrepresents our scientific understanding of the low rates of regret for treatment of Gender Dysphoria.

B. Defendants' Experts Ignore the Fact that Treatment for Gender Dysphoria Has Long Been Accepted as Appropriate and Medically Necessary.

78. Defendants' experts claim that treatments for Gender Dysphoria are experimental and not medically necessary. These opinions are far out of step with mainstream medicine and the standard approaches of most healthcare systems in the United States. There is a wide availability of psychiatric, medical, and surgical treatments for transgender people suffering from Gender Dysphoria. Those treatments have been recognized as medically necessary care by the largest healthcare systems in the United States, and by being covered by the largest third-party insurance companies in the United States. This further underscores that Defendants experts are out of step with the relevant medical community and accepted standards of care for the treatment of Gender Dysphoria in adolescents and adults.

79. Although no medical, surgical, or psychiatric treatments are without risks or side effects, the treatments for adolescents and adults with diagnosed Gender Dysphoria have been found to be generally safe and effective, with favorable outcomes on a variety of outcome measures (Kuper, et al., 2019; Carmichael, et al., 2021; Bustos, et al., 2021; van der Miesen, et al., 2020; Simonsen, et al., 2015; Murad, et al., 2010; Almazan and Keuroghlian, 2021). Defendants' experts criticize my opinions and the opinions of other of Plaintiff's experts for supposedly ignoring relevant scientific literature, but notably, they fail to acknowledge these recent and highly relevant studies. These studies confirm what experts in the field have long known: the widely accepted standard-of-care treatments for

adolescents and adults diagnosed with Gender Dysphoria are medically necessary and associated with a favorable risk/benefit ratio for most patients who are deemed appropriate for these interventions.

80. Defendants' witnesses further situate themselves outside the mainstream of the medical field by rejecting well-accepted treatment protocols recognized by the major medical and mental health professional associations in the United States. As set forth in my original report, the World Professional Association of Transgender Health publishes Standards of Care for treating Gender Dysphoria. WPATH is an internationally recognized association comprising nearly 2,500 medical, surgical, mental health, and other professionals who specialize in the evaluation and treatment of transgender and gender non-conforming people. The WPATH Standards of Care, which are in their seventh revision, represent the evidence-based consensus of experts in the field and have been recognized as the authoritative treatment protocols by the major medical and mental health associations in the United States, including the American Psychiatric Association, the American Medical Association, the American Psychological Association, and the American Academy of Pediatrics.

81. The Veterans Health Administration ("VHA")—the largest integrated health care system in the United States—treats transgender veterans largely based on the guidelines set forth in the current version of the WPATH SOC, and references these standards in their national training programs. I have been directly involved with the

national VHA training program since its inception in 2011 and I co-wrote the national formulary for medications used in the treatment of Gender Dysphoria in VHA.

82. The corporate policy of Blue Cross and Blue Shield also recognizes the WPATH SOC, by not only providing insurance coverage for transgender health treatments but by specifically referencing the SOC in their corporate benefits documentation. Blue Cross Blue Shield of North Carolina, Corporate Medical Policy, *Gender Affirmation Surgery and Hormone Therapy* (2021).

C. Defendants' Experts Mischaracterize the WPATH and Its Functions.

83. Defendants' experts also characterize WPATH as an advocacy organization with a social and political agenda, as opposed to a professional medical association that uses evidence-based standards. (*See, for example*, Hruz at para 56, page 54 (referring to WPATH as “an advocacy-political, consensus seeking organization, whose positions are based on voting and not a scientific, evidence-based process”); McHugh at para 11, page 14) (similarly referring to WPATH as an organization that relies on “consensus-seeking methodologies including voting rather than careful, prudent, evidence-based” methodologies).)

84. I am well familiar with the WPATH and the SOC that it publishes. I continue to serve as a coauthor of the WPATH SOC, including on the evolving draft of Version 8, likely to be released this year approximately 10 years after the release of Version 7.

85. Defendants' characterizations of WPATH are incorrect. WPATH is a medical association in the same mold as every other medical association dedicated to the

treatment of a particular condition—it creates a community of experts to share research and clinical experience; it establishes best practices for treatment based on experts in the field engaging in a robust review of the available evidence; and it supports policies that enhance the well-being of its patient population. There is ample scientific evidence supporting the WPATH SOC, which are in widespread use throughout the United States and other countries. Any psychiatrist or other clinician trained in or with experience in this field would be aware of this.

D. The Defendants’ Experts’ Criticisms of the DSM-5 Are Incorrect.

86. Defendants’ experts also criticize the DSM-5, supposedly because it is created using a “political-voting process” and “controversial consensus seeking,” rather than being the result of reliable science. (Hruz Decl. at 8 ¶ 13A; *see also, for example*, McHugh Decl. at 7 ¶ 7 (similarly criticizing the DSM-5 for being “created using a consensual, political process of committees and voting methodologies”); Levine Decl. at 15 ¶ 13 (opining that his criticisms of the DSM-5 are supposedly “generally accepted by the relevant scientific community”).)

87. I disagree with these criticisms as well. Far from using some supposedly unreliable methodology, as Defendants’ witnesses suggest, the DSM-5 is the authoritative source for psychiatric diagnoses in the United States and many other countries. The process of determining the diagnoses and diagnostic criteria included in the DSM involves a robust review of available evidence by hundreds of experts with varying perspectives in the relevant field over the course of many years of research, planning, field testing, and

debate. There is no sound basis for concluding that its contents are politically-driven rather than the product of scientific research and assessment. The process by which this 947-page document was developed was well publicized, was interactive with thousands of clinicians and researchers, and well described in the literature (DSM-5, pp. 5-10, 897-916).

88. I find Dr. Lappert's critiques of the DSM-5 (Lappert at page 17) particularly unavailing. Dr. Lappert is a plastic surgeon by training, with no specialized training or expertise in either transgender health or psychiatry that I am aware of. He does not explain what bases he has to criticize the DSM-5 or the process by which the DSM-5 was created.

89. Dr. Lappert also claims that in 2013, just prior to the publication of DSM-5, the National Institute of Mental Health stopped funding projects that use the DSM-5. He inaccurately cites Dr. Thomas Insel, director of the NIMH, as having made these statements, and having rendered a supposed "deathblow" to DSM-5 in 2013 (which has obviously never materialized to date). Other Defendants' experts provide similar opinions. (*See, for example*, Hruz Decl. at 30 ¶ 34(C) ("The DSM has become increasingly controversial in recent years – including being 'dumped' by the National Institute of Mental Health as a key basis for research funding"); McHugh Decl. at page 7-8 ¶ 7 ("In a humiliating blow to the American Psychiatric Association," Dr. Insel of the NIMH "made clear the agency would no longer fund research projects that rely exclusively on DSM criteria".))

90. This is an inaccurate recitation of the facts. In fact, on May 14, 2013, Drs. Insel and Lieberman (then President of the American Psychiatric Association, the publisher

of DSM-5) issued a joint public statement stating “they acknowledged that along with the International Classification of Diseases, DSM represents *the best information currently available* for clinical diagnosis of mental disorders and that the two publications remain the contemporary consensus standard on how mental disorders are diagnosed and treated.” (See <https://alert.psychnews.org/2013/05/lieberman-insel-issue-joint-statement.html> and <https://dxrevisionwatch.files.wordpress.com/2013/05/13-37-joint-apa-and-nimh-statement.pdf>) (emphasis added). Moreover, this statement also made clear that the NIMH was *not* discontinuing funding for DSM-5-based research, stating, “The National Institute of Mental Health (NIMH) has not changed its position on DSM-5.” (T. Insel & J. Lieberman, *DSM-5 and RDoC: Shared Interests*, <https://dxrevisionwatch.files.wordpress.com/2013/05/13-37-joint-apa-and-nimh-statement.pdf>). The statement from Defendants’ experts to the contrary are inaccurate, and they do not provide any reasonable basis to reject the use of DSM-5 as a well-accepted and authoritative source for psychiatric diagnoses.

E. Defendants’ Experts Ignore the Relevance of Patients’ Reporting of Symptoms for Many Psychiatric Conditions, Including Gender Dysphoria.

91. In some of their opinions, Defendants’ experts (particularly the non-psychiatrists Dr. Hruz and Dr. Lappert) seem to question the entire field of psychiatry, the normally-accepted bases for diagnoses in that field, and the standard techniques employed by specialists in that field, such as evaluation of a patient’s reported symptoms. (See, for example, Lappert Decl. at 53-54 ¶ 17; Hruz Decl. ¶ 27). Again, it is not clear on what basis

Dr. Hruz and Dr. Lappert can offer these opinions, given their lack of training and experience in this field.

92. Regardless, I disagree with these opinions. For example, Dr. Lappert considers the reports of patients and parents of their symptoms and lived experiences to be worthless in the diagnosis of Gender Dysphoria, or potentially any other condition. (*See* Lappert Decl. at 15 (criticizing reliance on “unverified self-reports (conversations) of often disturbed patients).) Dr. Hruz provides similar opinions, opining about the supposed “hazards of relying on unverified patient self-report data with no objective evidence.” (Hruz Decl. at 18 ¶ 27.) Dr. Hruz in fact goes so far to describe patients’ accounts of their own lives as “alleged memories.” (Hruz Decl. ¶ 28.)

93. These opinions are far afield of the scientific consensus in the field of psychiatry. Indeed, it is stunning to me that a physician would discount the importance of accurate history taking from patients and family members as a critical part of the diagnostic assessment for *all* medical, psychiatric, and surgical conditions. We routinely teach our medical students that gathering a detailed history is the single most important component in developing a diagnosis in most conditions. Even in conditions where laboratory assessment or imaging techniques may be of use, the history guides the selection, or the lack of selection, of such ancillary diagnostic procedures.

94. Dr. Lappert also seems to suggest that mental health clinicians are charlatans and that patients are essentially liars who cannot be trusted to give an accurate history of their lived experience because they are somehow trying to scam clinicians to access

treatment for gender dysphoria. These assumptions, again, are inconsistent with my professional experience, and with well-accepted diagnostic techniques in the field of psychiatry. In addition to a detailed history, which may take place over multiple appointments, the collection of collateral information from parents, when appropriate, other family members, employers, coworkers, and spouses may all play an important role in developing a differential diagnosis. The availability of past medical and psychiatric records, clinical/objective observations of the patient, observing longitudinal behaviors after the initial engagement in mental health care, and assessments for other psychiatric comorbidities are all components of arriving at a diagnosis of Gender Dysphoria, or any other psychiatric condition.

95. Nor is the diagnosis of Gender Dysphoria unique in this respect. For instance, the diagnosis of chronic fatigue syndrome, PTSD, irritable bowel syndrome, migraine headaches, and many other common maladies are approached with much the same diagnostic procedures as utilized in the diagnosis of Gender Dysphoria.

V. The Suggestion That the Only Appropriate Treatment for Gender Dysphoria is to Align Gender Identity with Birth Sex Falls Outside the Standards of Care and Medical Consensus.

A. Defendants’ Experts’ Opinions Are Inconsistent with the Standards of Care from the WPATH, the Endocrine Society, the American Academy of Pediatrics, and the Royal College of Psychiatrists Treatment Guidelines.

96. Defendants’ experts assert that the so-called “Gender Transition Industry/Transgender Treatment Industry” and its treatments are not generally accepted by the relevant scientific community.” (Hruz Decl. at 17 ¶ 26(E); *see also* Lappert Decl. at 5

¶ 11 (opining that “affirmation treatments” are “not generally accepted by the relevant scientific community”).) Again, I disagree. As described below and also in more detail in my opening report, there is in fact broad scientific consensus about appropriate and generally-accepted treatments for Gender Dysphoria. And the opinions of Defendants’ experts—who seem to suggest that rather than follow these professional standards, clinicians who treat patients with Gender Dysphoria should try to help them change their gender identity to align with their birth-assigned sex—place them well outside these well-accepted norms.

97. The WPATH Standards of Care emphasize the importance of access to medical care for transgender people with Gender Dysphoria, as does the American Academy of Pediatrics (Rafferty, et al, AAP Position Statement, 2018) among other mainstream medical organizations.

98. As I noted in my original report, attempts to try to help patients change their gender identity to align with their birth-assigned sex this have been found to be ineffective, and in fact are recognized as potentially harmful by professional associations (*see* Royal College of Psychiatrists, 2018 as one example). I agree that psychotherapy (*not* in the form of conversion or reparative therapy) should be included as a covered benefit for persons with a diagnosis of Gender Dysphoria, which is consistent with the WPATH SOC. Such psychotherapy, although not mandated, should be aimed at helping persons with Gender Dysphoria understand their gendered self where there remains turmoil about that issue, as

well as to support them on their individualized treatment plan, which may or may not include any medical or surgical treatments.

99. From my review of the opinions of Defendants’ experts, however, it is apparent that they have a different use of “psychotherapy” in mind. Specifically, rather than using psychotherapy *in addition* to other treatment for Gender Dysphoria, Defendants’ expert seem to suggest that psychotherapy should be used *alone* as an “alternative” treatment for Gender Dysphoria. (*See, for example*, Lappert Decl. at 50 (criticizing use of “affirmation” treatments, instead of using “proven effective psychotherapy (e.g. Cognitive Behavioral Therapy)”; Hruz Decl. 50 ¶ 52 (favoring “neutral” approach that may “include the use of scientifically validated treatments (e.g. CBT)”)).)

100. These suggestions that psychotherapy can be used as an “alternative” treatment, rather than a complementary treatment are dangerous, misguided, and unsupported by any evidence. A statement from the Royal College of Psychiatrists (2018, page 3) addresses this issue:

“The term ‘conversion therapy’ has also been used to describe treatments for transgender people that aim to suppress or divert their gender identity – i.e. to make them cisgender – that is exclusively identified with the sex assigned to them at birth. Conversion therapies may draw from treatment principles established for other purposes, for example psychoanalytic or behaviour therapy. They may include barriers to gender-affirming medical and psychological treatments. There is no scientific support for use of treatments in such a way and such applications are widely regarded as unacceptable.”

101. The only treatment approaches for a diagnosis of Gender Dysphoria in adolescents and adults that are supported by evidence and, thus, represent the medical consensus, are the protocols set forth in the WPATH Standards of Care and in the Endocrine Society's guidelines (as applied to the hormonal aspects of multimodal treatment for this condition).

102. The Royal College of Psychiatrists treatment guidelines are substantially similar, and they also reference the WPATH SOC. (Royal College of Psychiatrists, 2013; 2018.)

103. I note that Dr. Hruz is a member of the Endocrine Society, but his statements about Gender Dysphoria place him completely out of step with his own professional society in this regard. He is likewise not a member of any of the other national medical associations that he criticizes as political and activist in nature, for example the American Medical Association, the American Psychiatric Association, the American Psychological Association, American Academy of Pediatrics, etc.

104. Dr. Hruz is, however, a member of the American College of Pediatricians. That organization, established in 2002, was described by the Southern Poverty Law Center as: "a fringe anti-LGBTQ hate group that masquerades as the premier U.S. association of pediatricians to push anti-LGBTQ junk science, primarily via far-right conservative media and filing amicus briefs in cases related to gay adoption and marriage equality." (<https://www.splcenter.org/fighting-hate/extremist-files/group/american-college->

Pediatricians). Indeed, leaders of this fringe “College” have made the following public statements of relevance to this litigation:

“Your public library may have a drag queen story hour where books like I am Jazz are read to children by trans activists eager to groom the next generation of victims.” (Andre Van Mol, co-chair of American College of Pediatricians’ Committee on Adolescent Sexuality, “Reinforcing Children’s Sexual Identity: A Review of Ellie Klipp’s ‘I Don’t Have to Choose,’ Aug. 27, 2019)

and

“The transgender movement is an opening for a totalitarian government.” (Michelle Cretella, American College of Pediatricians executive director, speaking at Illinois Family Institute Worldview Conference, Oct. 2019).

105. Given Dr. Hruz’ membership in such a fringe group (the American College of Pediatricians only has a few hundred members, versus the mainstream American Academy of Pediatrics, which has over 67,000 members), it is not surprising that the views he has expressed in his declaration are far from mainstream.

106. Contrary to the dangerous, unscientific, and misguided statements promulgated by the American College of Pediatricians, the mainstream American Academy of Pediatrics has extensively published positions that are the exact opposite of those from the American College of Pediatricians noted above. For example:

“The AAP works toward all children and adolescents, regardless of gender identity or expression, receiving care to promote optimal physical, mental, and social wellbeing.” (Rafferty, et al, AAP Policy Statement, 2018, page 1)

and

“the AAP recommends the following: that insurance plans offer coverage for health care that is specific to the needs of youth who identify as TGD, including coverage for medical, psychological, and, when indicated, surgical gender affirming interventions.” (Rafferty, et al, AAP Policy Statement, 2018, page 10).

VI. Defendants’ Experts Inappropriately Misgender Plaintiffs and Downplay the Pain and Challenges of Being Denied Care for Gender Dysphoria.

107. Defendants’ experts seem to assume that a transgender person’s gender identity is not based in reality, and is related to mental health issues that can somehow be ameliorated by psychotherapy to change their gender identity. Dr. Lappert, in particular, appears to believe that patients who experience Gender Dysphoria are “disturbed” (Lappert Decl. at 15), and he refuses to use pronouns consistent with Plaintiffs’ gender identity (*i.e.*, misgendering). *See, e.g.*, Lappert Decl. at 51 (referring to one of the male Plaintiffs as a “girl,” and calling him “profoundly psychologically disturbed”).

108. Just as problematic, Dr. Levine dismisses the suffering of the Plaintiffs in this matter as experiencing the “relatively minor pain of gender dysphoria.” (Levine Decl. at 70 ¶ 81.)

109. These attitudes are inappropriate and further reflect Defendants’ experts’ lack of experience in working with transgender people. Anyone who works extensively with transgender people should be well aware of the importance of consistent and appropriate pronoun use, and the psychological pain and disrespect that most transgender people report experiencing when pronouns consistent with their identity are repeatedly not utilized (Brown, 1990; Lev, 2004).

110. I find it troubling that Defendants' experts do not appear to have palpable concern or empathy for what patients with Gender Dysphoria diagnoses experience. Their dismissal of the pain of patients with Gender Dysphoria who must struggle to access affirming care, and their refusal to refer to Plaintiffs by the pronouns consistent with their identity disregard basic clinical conventions and decency, and are likewise far outside the clinical mainstream.

VII. The *Ad Hominem* Attacks of Defendants' Experts Are Improper.

111. Throughout their reports, Defendants' experts also make various improper *ad hominem* attacks on Plaintiffs' experts, including myself. For example, Dr. Hruz argues that "Plaintiffs' Expert Dr. Brown's Methodological Failures Should be Investigated," and he accuses me of "misconduct." (Hruz Decl. at 40 ¶ 40.) Dr. Lappert similarly argues that physicians who treat Gender Dysphoria "should be properly investigated as unethical, misconduct, and an abuse of a vulnerable patient population." (Lappert Decl. at 15.)

112. There is no basis for these inflammatory accusations. As explained in my original report and in this rebuttal report, my opinions on appropriate clinical care for adolescents and adults with a diagnosis of Gender Dysphoria are squarely within the scientific mainstream, and are consistent with standards of care and treatment guidelines from various organizations like WPATH. Dr. Hruz's and Dr. Lappert's own reports, on the other hand, omit relevant and modern scientific literature related to the efficacy and outcomes of such standard clinical care, and opine extensively about topics that are irrelevant to this case.

VIII. Additional Responses to the Opinions of Dr. Levine.

113. In addition to addressing several of Dr. Levine's opinions above, I address several of his other opinions more specifically here.

114. Dr. Levine opines that adolescents with Gender Dysphoria also have psychiatric comorbidities at elevated rates. (Levine Decl. at 24-26.) While this may possibly be the case, the presence of such conditions is unremarkable given the discrimination and stigma they experience in society. The availability of care for adolescents and adults with Gender Dysphoria should not be denied or restricted on this basis, but rather the treatments should be sequenced or individualized to the patient based on the totality of their conditions. This is addressed in the WPATH SOC and also makes good clinical sense. Clinicians and health care plans do not deny access to treatments for diabetes, for example, just because the same patient has arthritis, hypothyroidism, or depression.

115. Dr. Levine offers the false choice of "competing therapies" for Gender Dysphoria: psychotherapy *versus* all other therapies currently utilized in the treatment of Gender Dysphoria. (Levine Decl. at 29-34.) He offers no evidence, weak or otherwise, that any form of psychotherapy in adolescents or adults, adequately treats Gender Dysphoria in any, let alone a majority of such patients.

116. Like Dr. Levine (with whom I worked with side-by-side on the development of the WPATH SOC Version 5 more than 20 years ago), I too offer and provide psychotherapy (exploratory; psychodynamic) as part of my treatment armamentarium for

adults with Gender Dysphoria. I am in support of psychotherapy being included as part of an overall benefits package that also includes medically necessary medications and surgeries for the treatment of Gender Dysphoria in late adolescents and adults. I do not, however, view psychotherapy as an “alternative” therapy in the sense that Dr. Levine and other defense witnesses suggest without evidence.

117. Dr. Levine also claims that treatment protocols for cross-sex hormones, also known as gender-affirming hormones, are “not generally accepted by the relevant scientific community.” (Levine Decl. at 27.) This is incorrect. The guidelines published by WPATH, the Endocrine Society, UCSF Center of Excellence for Transgender Health (all appreciably the same in the areas where they overlap) are in widespread use in the largest health care systems in the United States (Department of Veterans Affairs, Kaiser Permanente, Departments of Corrections, Federal Bureau of Prisons, Department of Defense, etc.) and in dozens of academic medical center-based gender programs nationwide, including Dr. McHugh’s Johns Hopkins Hospital, Dr. Hruz’s Washington University hospital system, and Dr. Levine’s Case Western Reserve University (<https://case.edu/lgbt/resources/transgender-resources>).

118. Dr. McHugh, Dr. Hruz, and Dr. Levine are each affiliated with major, well-respected universities. (The fourth expert, Dr. Lappert, does not appear to be university-affiliated in any way since 2002.) All of those universities offer transgender healthcare following the WPATH SOC for adolescents and adults with a diagnosis of Gender Dysphoria. This again shows that Defendants’ experts are out of step with their own

institutions, as well as the larger medical community, in their misguided attempts to argue that adolescents and adults with Gender Dysphoria should not have access to the same care that their own institutions provide.

119. Dr. Levine misleadingly cites my original research work (as he has done with others, including Djehne et al, 2011) when he states that treatments for Gender Dysphoria are not associated with improved outcomes. (Levine Decl. ¶ 74.) That is not what my research (which constitute some of the largest studies published to date on patients with a diagnosis of Gender Dysphoria (Brown and Jones, 2015; 2016)) shows. To the contrary, the negative health and mental health associations in our controlled studies of transgender veterans compared to matched, non-transgender veterans were done in the context of the vast majority of the gender dysphoric veterans not having had access to treatment(s) for their gender dysphoria. Our studies were not a “pretreatment” and “posttreatment” study, such as that conducted by van der Miesen (2020) which did, in fact, show a post-treatment benefit for those who got hormonal treatments.

120. Next, Dr. Levine also argues in favor of transgender beneficiaries having lifelong access to coverage for psychotherapy services. (Levine Decl. ¶ 93.) I could not agree more. Just as any other beneficiaries of a health care plan with mental health parity, beneficiaries who are either cisgender or transgender should have equal access to these services over their lifetimes.

121. Dr. Levine also argues (without evidence) that “regret following transition is not an infrequent phenomenon.” (Levine Decl. at 76.) All that he offers in support of this

point are a couple of personal anecdotes from his 47 year long career as a psychiatrist. That alone seems “infrequent” to me, based on his experience with gender dysphoric patients.

122. Moreover, there are publications that actually address this issue, and that are remarkably convergent in their consistent conclusions that the frequency of regrets after surgical transition is very low. Bustos et al (2021) summarized the literature on a pooled analysis of 27 studies involving 7,928 patients who had undergone one or more gender affirming surgical procedures (“GAS”). There were a total of 77 patients who reported regretting having had GAS, which was about 1%. This is consistent with reports going back as far as 30 years ago. The Swedish group (Djehne, 2011) has reported 2%. The Dutch group reports less than 1% (Wiepjes, et al, 2018; 0.6% of transwomen, 0.3% of transmen). Narayan (2021) reported “low regrets.” In summary, one need not rely on clinical anecdotes to determine whether or not patients in large numbers have regretted receiving medically necessary care for Gender Dysphoria when there are data that address this question.

IX. Lappert’s Summary Conclusions Based on a Review of Plaintiffs’ Medical Records are False and Misleading.

123. Dr. Lappert indicates that he reviewed the medical records of each Plaintiff but did not interview any of them. Based on his assessment of their records, Dr. Lappert condemns all clinicians involved in the care of Plaintiffs, including the mental health clinicians, for supposedly providing or recommending medically unnecessary treatment. He further concludes, again without having interviewed any of the Plaintiffs, that none of them received medically necessary transgender health care.

124. To start, given that Dr. Lappert is trained only as a Plastic/Cosmetic surgeon and not as a mental health clinician, it is unclear what expertise or basis he has to criticize the clinicians' treating decisions and recommendations.

125. Dr. Lappert appears to take the position that no one (let alone Plaintiffs in this case) can receive transgender health care that is medically necessary, because he does not accept DSM-5 diagnoses or value the importance of obtaining a good patient history in the development of a diagnosis. Dr. Lappert argues (paragraph 22) that since he believes there is no "objective" basis for the diagnosis of Gender Dysphoria, it therefore follows (in his view) that the medical care that Plaintiffs received must be inappropriate, experimental, "cosmetic," and not medically necessary. This reasoning is unsupported and illogical. Following Dr. Lappert's logic, patients suffering from Major Depressive Disorder (DSM-5, page 160), Bipolar Disorder (DSM-5, page 123), Post-traumatic Stress Disorder (DSM-5, page 271), and a host of other legitimate diagnoses could never receive medically necessary care for their conditions, simply because there is no so-called "objective" basis for those diagnoses either. This is simply incorrect and inconsistent with well-accepted standards of treatment in this field.

126. **[The following paragraph of this report is designated ATTORNEYS EYES ONLY.]** [REDACTED]

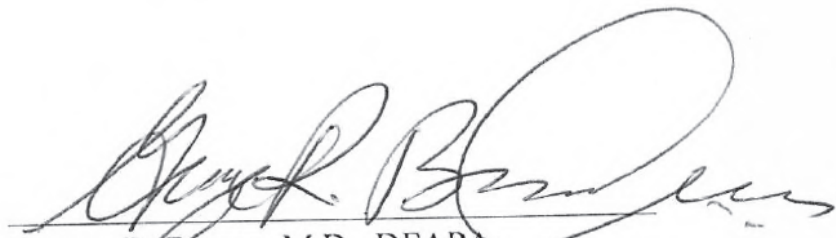
[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

I declare under penalty of perjury that the foregoing is true and correct. Executed this 10th day of June, 2021.


George R. Brown, M.D., DFAPA

CERTIFICATE OF SERVICE

I hereby certify that on June 11, 2021, I caused a copy of the foregoing document and all attachments to be served upon the following parties via email:

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Dated: June 11, 2021

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Exhibit 23(e)

Exhibit A

CURRICULUM VITAE

GEORGE RICHARD BROWN, MD, DFAPA

Professor of Psychiatry and
Associate Chairman for Veterans Affairs
Quillen College of Medicine, Department of Psychiatry
East Tennessee State University

Research, Teaching, and Consulting Psychiatrist
James H. Quillen VAMC
Mountain Home
Johnson City, TN

Email: BrownGR@etsu.edu

Date of Preparation: June 1, 2021

EDUCATION:

Undergraduate: University of Rochester, Rochester, New York, 1975-1979;
Bachelor of Science with Highest Honors and Distinction in Research, Summa Cum Laude.
Double major, with BS in both biology and geology

Medical School: University of Rochester School of Medicine, Early Acceptance Program
(Rochester Plan), 1979-1983; Doctor of Medicine with Honors; Health Professions Scholarship
Program.

Internship: United States Air Force Medical Center, Wright-Patterson Air Force Base, Ohio,
1983-1984.

Residency: Wright State University - United States Air Force Integrated Residency in Psychiatry,
Dayton, Ohio, 1984-1987.

CREDENTIALS:

FLEX, December, 1983 (Behavioral Sciences, 94%; Psychiatry, 93%).

Full licensure to practice medicine, State of Ohio, December, 1983 to April, 2017; license
#50119; allowed to expire in 2017 with no intent of practicing in Ohio.

Full licensure to practice medicine, State of Texas, August, 1989 to present; license
#H5847

Full Licensure to practice medicine, Commonwealth of Kentucky, 1993 to 1995,
#30100; allowed to expire with no intent of practicing in Kentucky.

Full licensure to practice medicine, State of Tennessee, 1994-present, license #25192

Psychiatry Resident In-Training Examinations;

1986: 98th percentile - all U.S. residents, psychiatry.

1985: 90th percentile - all U.S. residents, psychiatry.

1984: 98th percentile - all U.S. residents, psychiatry.

1983: 98th percentile - all U.S. residents, psychiatry.

American Board of Psychiatry and Neurology, Part I, April 1988 (92nd percentile); Part II,
June 1989; ABPN Certificate #31377.

Electroconvulsive Therapy Administration Certification,
1985-1990.

Courtesy Staff Privileges, Charter Real Hospital, San Antonio, Texas, 1990-1994.

Courtesy Hospital Staff, Bexar County Hospital District, San Antonio, Texas, 1988-1994.

Full Admitting Privileges, Wilford Hall Medical Center, San Antonio, Texas, 1987-1993.

Full Admitting Privileges, James H. Quillen VAMC Hospital, Johnson City, TN, 1994-2016

Basic Life Support Certification, renewed March 2017-2019.

Research and Teaching Privileges, James H. Quillen VAMC Hospital, Johnson City, TN, 2016-present.

World Professional Association for Transgender Health Certification (grandparenting by examination)

PROFESSIONAL EXPERIENCE:

Current Positions:

Professor and Associate Chairman for Veterans Affairs, Department of Psychiatry and Behavioral Sciences, Quillen College of Medicine, East Tennessee State University. 1995-present. Advisory duties to the Chairman, signature authority in absence of the Chair, contributing to administrative, teaching, and research missions of the Department, liaison between the VAMC and ETSU psychiatry administrations.

Research, Teaching, and Resident supervision appointment, James H. Quillen VAMC. February 1, 2016-present. Responsibilities include providing teaching, research services, clinical consultation, and resident supervision/mentoring in the Psychiatry Service.

Past Positions:

Clinical Professor of Psychiatry (Adjunct), University of North Texas Health Sciences Center. 2017-2019. Clinical privileges at Carswell Federal Correctional Institution in association with UNTHSC appointment. Responsibilities include teaching and consultation with UNTHSC and Federal Bureau of Prisons staff about transgender health issues.

Staff Psychiatrist, Mental Health Outpatient Clinic, James H. Quillen VAMC. December, 2014-January 31, 2016. Responsibilities included treating veterans with chronic, persistent, mental illnesses in an outpatient setting and providing consultation services to junior staff and residents in psychiatry. Direct supervision of third year psychiatry residents in the Mental Health Clinic.

Transgender Health Care Facility Lead, Mountain Home Health Care System. 2014-January 31, 2016. Responsibilities included providing direct patient care for transgender veterans, providing national training for VHA health care providers learning how to provide transgender health care, direct supervision of other health care providers in teaching evaluation and treatment techniques, leading a multidisciplinary team of health care providers assigned to provide transgender health care in our 70,000 patient health care system.

Program Officer, Health Care Outcomes, Office of Health Equity (10A6), VA Central Office, Washington, D.C. December, 2012, to December, 2014. Responsibilities included researching medical and psychiatric health disparities in vulnerable populations of Veterans treated by the Veterans Health Administration, and assisting top officials in VHA in the development of policies that lead to elimination of health care outcome disparities in these subpopulations. Continued to see patients at Mountain Home VAMC throughout this appointment.

Chief of Psychiatry, James H. Quillen VAMC. November 22, 1995-December 16, 2012. Responsibilities included direct supervision of a staff of 34-42 professional staff, including 24-28 psychiatrists, 2 Clinical Nurse Specialists, and 9-12 psychiatric nurse practitioners. Represented the Department in all meetings requiring the input of the Chief of Service. Attended executive meetings in the Medical Center and University. Contributed to long range planning of services in the Medical Center.

Research Appointment (WOC), VHA Center of Excellence for Suicide Prevention, Canandaigua, New York. 2011-2014. Responsibilities of this position included developing research protocols collaboratively with CoE staff that have national implications related to suicide in VHA.

Director of Psychiatric Research, James H. Quillen VAMC Dept. of Psychiatry. 1994-2012. Responsibilities included creating a research program de novo and leading a research team at the VAMC, teaching resident seminars, didactics, research electives, providing direct patient care for inpatients on research protocols (usually those with severe mental disorders), traveling to conferences to present research findings and providing Grand Rounds to other institutions and medical schools. Major focus of research activities has been working with stigmatized/disenfranchised populations and addressing mental health care aspects and disparities in care.

Staff psychiatrist, Another Chance Recovery Program, Morristown, Tennessee. March 1995-1996. This is an intensive outpatient drug and alcohol treatment program with a heavy emphasis on dual diagnosis patients, outpatient detoxification from chemical dependency, and a blend of the medical and 12-Step approaches to treatment of the chemically dependent patient. One evening clinic per week.

Senior Research Scientist and Director of Psychiatric/Neuropsychiatric HIV Research, Wilford Hall Medical Center, Henry M. Jackson Foundation for the Advancement of Military Medicine, San Antonio, Texas. 1 July 1991 to 1 October 93. Responsibilities included hiring and then directing a team of approximately 15 civilian and military psychiatric researchers conducting HIV-related psychiatric research; Principal Investigator on longitudinal psychiatric natural history study of early HIV infection (males and females), 1989-1993; preparing manuscripts, presenting research findings at national and international meetings; designing and implementing new protocols; interviewing and assisting in the hiring of personnel; managing administrative and personnel issues.

Private practice of adult psychiatry. 1991-November 1993. Part-time practice primarily focusing on sexuality and gender concerns, including endocrine care, and adult psychodynamic psychotherapy.

Consulting Psychiatrist for Quality Assurance and Continuing Quality Improvement Programs:

- 1) Charter Real Partial Hospitalization Program, San Antonio, Texas. 1990 to 12/93. Responsibilities of this part time position included designing and implementing a medical quality assurance program and assisting Utilization Review personnel with implementing efficient resource utilization procedures.
- 2) Colonial Hills Hospital Inpatient Services and Adult Partial Hospitalization Program, San Antonio, Texas. 1992. Responsibilities of this part time position included custom designing a four part program to address QA/CQI concerns on all inpatient units, coordinating the implementation of the program with hospital QA/UR personnel, and quantifying/ databasing physician charting performance to analyze trends.

Staff Psychiatrist, Wilford Hall Medical Center, Lackland Air Force Base, San Antonio, Texas:

1987-1989: Primary responsibility for inpatient ward of 25-33 patients, resident and medical student teaching, and professional presentations. 1040 admissions; average length of stay 13 days.

1989-1991: Outpatient Clinic service, responsible for evaluations and treatment of adult outpatients; supervision of PGY-3 residents in psychiatry and other staff working in the clinic (social workers, psychologists, and mental health technicians). Medical support for comprehensive Smoking Cessation Clinic.

1989-1991: Director of Psychiatric Research, half-time position; developed a research program primarily targeting psychiatric resident involvement with research and related activities, including presentations at regional and national professional meetings. Active in conducting research, reviewing and approving protocols, research design, editing publications submitted from the Department of Psychiatry, and organizing symposia; interviewing and selecting official for research personnel for multicenter collaborative HIV research grant.

ACADEMIC APPOINTMENTS:

Professor of Psychiatry (1998-present), East Tennessee State University, Quillen College of Medicine. VA Academic Faculty appointment.

Clinical Professor of Psychiatry (Adjunct), University of North Texas Health Sciences Center, Fort Worth, Texas (2017-2020).

Adjunct Professor of Psychology, University of Tennessee at Knoxville (1997). Served on doctoral dissertation committee as supervisor and mentor for doctoral candidate in clinical psychology.

Associate Professor of Psychiatry (1994-1998), East Tennessee State University, Quillen College of Medicine. Full time geographic faculty appointment. Renewal of previously awarded academic ranking. Activities include serving on numerous committees (see below), teaching residents, providing electives, working collaboratively with staff to conduct new research projects, interviewing residency and faculty candidates.

Clinical Associate Professor of Psychiatry (1992-1994), University of Texas Health Science Center at San Antonio, San Antonio, Texas. 1987 to 1994. Primary responsibility of this position was teaching medical students and residents in individual, group, and lecture settings; provision of psychodynamic psychotherapy supervision. Lectures and seminars include core material on sexual dysfunction, treatment of paraphilias, gender identity disorders, homosexuality, and psychiatric aspects of HIV infection.

Clinical Associate Professor of Psychiatry (1992-1996), Uniformed Services University for the Health Sciences, School of Medicine, Bethesda, Maryland. Primary responsibility of this position was teaching medical students from the University who travel to San Antonio for clinical rotations in psychiatry and serving as a visiting lecturer for USUHS.

Full time faculty, Department of Psychiatry, Wilford Hall Medical Center, Lackland Air Force Base, San Antonio, Texas, 1987 to 1991. Adjunct clinical faculty, Department of Psychiatry, 1991 to 1993. Responsibilities included supervising psychiatric residents involved in research activities, sponsoring Distinguished Visiting Professors in conjunction with the Department, and teaching core didactic lectures and seminars.

Assistant Clinical Instructor, Wright State University School of Medicine, 1983-1987. Primary responsibility of this position was teaching medical students during clinical rotation in psychiatry.

Chief Resident in Psychiatry, November, 1986 to March, 1987, with administrative, teaching, and research responsibilities.

CONSULTATION EXPERIENCE:

Psychiatric Liaison and Consultant to Oncology Unit, Good Samaritan Hospital, Dayton, Ohio, 1985.

Clinical Supervisor and Psychiatric Consultant to Montgomery County Juvenile Court Diversion Program, Dayton, Ohio, 1986-1987.

Consultation/Liaison Rotation, Keesler AFB, MS, 1986.

Psychiatric Consultant to the United States Air Force Child Abuse Task Force (convened by the Surgeon General of the Air Force), 1989-1991.

Lorain Correctional Institution, psychiatric consultant for inmate mental health evaluations and treatment, July-August 1993.

State of Tennessee Mental Health and Mental Retardation, appointed as consultant to develop Best Practice Guidelines for all State programs for Bipolar Disorder.

Health Ed, The Patient Education Agency: consultant for development of patient education materials for chronic mental illnesses, 2006-2007.

Consultant to Batavia Independent School District in assisting on-the-job gender transition for a transgender high school teacher, 2006.

Consultant to Port Ewan/Kingston BOCES School Program in assisting on-the-job transition for a transgender principal, 2007.

Consultant to the Federal Bureau of Prisons on policies relating to medical management of transgender inmates, 2009, 2014.

Consultant to Department of Defense on policy and medical issues related to transgender service members, 2016-2018.

Faculty consultant to Carswell Federal Correctional Institution, Fort Worth, Texas, on transgender health issues, 2017-present.

Research Consultant to Michael Goodman, MD, Principal Investigator, PCORI Grant to study transgender health issues (STRONG protocol), Emory University, 2014-2016.

Department of Justice, National Institute of Corrections, 2017-2018.

Department of Veterans Affairs, LGBT Veterans Program, Washington, DC, 2016-present

Consultant to the Idaho Department of Corrections, April 10, 2019.

SPECIALIZED TRAINING EXPERIENCES:

School of Aerospace Medicine, Course I, Brooks AFB, San Antonio, Texas, 1981.

Administrative Course for Chief Residents, Tarrytown, New York, June, 1985.

Combat Casualty Care Course, San Antonio, Texas, 1985.

Consultation and Liaison Psychiatry, Keesler AFB, Biloxi, Mississippi, 1986.

Center for the Treatment of Impotence, Case Western Reserve University, Cleveland, Ohio, July, 1986.

Forensic Psychiatry Course and associated clinical work, 6 months, 1986-87; ongoing case work in forensic psychiatry as expert witness and legal consultant, 1987-present.

Gender Identity Clinic, Case Western Reserve University, Cleveland, Ohio, July, 1986.

Paraphilias Clinic, Case Western Reserve University, Cleveland, Ohio, July, 1986.

Chemical Dependency Program, Samaritan Hall, Dayton, Ohio, August, 1986.

Advanced Study of Gender and Sexual Disorders, Institute of Living, Hartford, Connecticut, April, 1987.

Electroconvulsive Therapy Administration Training, Jan-June, 1985; June, 1987.

SCID training seminar, September, 1989.

American Board of Psychiatry and Neurology Examiner, 1991-present.
Administrative psychiatry and leadership training, James H. Quillen VAMC, 1996 to 2012.
Physician Executive Training, American College of Physician Executives, (PIM-I Course, 31 hours; PIM-II Course, 31 hours, PIM-III Course, 31 hours), 1998-1999.
Masters and Johnson workshop on trauma, sexual compulsivity/addiction treatment, 11 hours, December, 2003.
Forensic Workshop on sex offenders, National Council on Sexual Addiction and Compulsivity, October, 2002
Forensic workshops, including PREA implementation, managing hunger strikes, mental health issues in prison, sponsored by National Commission on Correctional Health Care, 2010, 2012.
Forensic workshops, including 3 hours of training on medical and legal aspects of providing health care for transgender inmates, sponsored by National Commission on Correctional Health Care, 2015.
Lexipol Training Certificate, Managing Manipulation by Inmates, 10/17/19.

COMMITTEE AND BOARD ACTIVITIES:

Mohonasen Public School Board Member, Schenectady, New York, 1974-1975.
Social Chairman, Wright State University Psychiatry Residency, 1984.
Dayton Representative to the Member-in-Training Committee of the Ohio Psychiatric Association, 1984-1986.
Chairman, Member-in-Training Committee, Ohio Psychiatric Association, 1986-1987.
Chairman, Member-in-Training Committee, Dayton Psychiatric Society, 1985-1987.
Peer Review Committee, Ohio Psychiatric Association, 1986-1988.
Long Range Planning Committee, Ohio Psychiatric Association, 1986-1987.
American Psychiatric Association, Area IV Resident Caucus, Ohio Representative, 1987.
American Psychiatric Association, Committee of Residents of the Council on Medical Education and Career Development, Ohio Representative, 1986-1987.
Ohio Psychiatrist's Political Action Committee, Board of Directors, 1987.
Bexar County Psychiatric Society Committee on AIDS, 1990-1993.
World Professional Association for Transgender Health (WPATH) Committee to Revise the Standards of Care, 1990-present; Cochairman of Standards of Care Revision Committee, 2001-2005.
Psychiatric Consultant to the Board of Directors, Boulton and Park Society, San Antonio, Texas, 1988-1998.
President-elect, Society of Air Force Psychiatrists, 1990-1991.
Board of Directors, Alamo Area Resource Center (AIDS/HIV Service Organization), 1991-1992.
Board of Advisors, American Educational Gender Information Service (Atlanta, Georgia), 1992-1998.
Quality Assurance Committee, Texas Society of Psychiatric Physicians, 1992-1993.
Professional Standards Committee, Texas Society of Psychiatric Physicians, 1992-1993.
Board of Directors, Harry Benjamin International Gender Dysphoria Association (WPAth), 1993-1997; 2001-2007
Ethics Committee, Tennessee Psychiatric Association, 1994-present.
Advisory Committee on Publications and Advertising, Southern Medical Association, 1994-1996.
Councilor to the Executive Committee, Tennessee Psychiatric Association, East Tennessee Region, 1995-2005.
Vice-Chairman, Section on Neurology and Psychiatry, Southern Medical Association, 1995-1996.
President, New Health Foundation, 2001-2003.
Secretary of the Section on Neurology and Psychiatry, Southern Medical Association, 1997-2000.
American Psychiatric Association PKSAP and Medical Education Committees, appointed by

Herb Sachs, M.D. and Harold Eist, M.D. (APA Presidents), 1997-2001.
Scientific Affairs Committee, Southern Medical Association, 1997-1999.
Consultant to the Joint Commission on Public Affairs, American Psychiatric Association, appointed by Rod Munoz, M.D. (APA President), 1998-1999.
Scientific Program Committee, Southern Psychiatric Association, 1999-2000.
Resident Award Committee, Southern Psychiatric Association, 1997-2009.
Ethics Committee; HIV Committee; Harry Benjamin International Gender Dysphoria Association, 1999-2005
Board of Directors, New Health Foundation, Chicago, IL, 2000-present.
Tennessee Department of Mental Health and Retardation Adult Committee on Best Practices (responsible for recommending guidelines for treatment of bipolar disorder), 2000-2003.
Associate Counselor for Tennessee, Southern Medical Association, 2000-2008.
Resident Award Committee, Southern Psychiatric Association, 2003-2009.
Board of Directors, James H. Quillen VAMC Research Corporation, 2003-2010.
HBIGDA Biennial Symposium Scientific Meeting Committee, 2006-2007.
Board of Regents, Southern Psychiatric Association, 2006.
Southern Medical Association, Section Secretary for Psychiatry and Neurology, 2004-2008.
Scientific Review Committee, World Professional Association for Transgender Health Symposium, 2007-2009; 2015-2018.
Board of Regents, Second Year, Southern Psychiatric Association, 2007.
Chairman, Board of Regents, Southern Psychiatric Association, 2009.
WPATH Board of Directors, 3 terms totaling 13 years, with last term 2014 (mandatory rotation off the board).
Secretary-Treasurer, World Professional Association of Transgender Health, 2007-2009.
DSM-V workgroup on Gender Identity Disorders (WPATH advisory work group to American Psychiatric Association DSM-V GID task force), 2009.
World Health Organization advisory committee for ICD-11 (gender identity disorders), 2011-present.
Department of Veterans Affairs Transgender Directive Communication Plan Education Group, 2011-2012.
VHA Transgender Training Workgroup, Patient Care Services, 2012- present.
Numerous VA Central Office national workgroups and committees, including the workgroup to add birth sex and gender identity data fields to all VA medical records, 2012-2019.
Commissioner, Palm Center Commission on Transgender Military Service, Appointed by Joycelyn Elders, MD, 2013-2014.

PROFESSIONAL ORGANIZATIONS:

American Psychiatric Association (1983-2015); #044933, Fellow, 1998; Distinguished Fellow, 2003
Association for the Advancement of Psychotherapy (1985-1993)
World Professional Association for Transgender Health (1986-present)
Ohio Psychiatric Association (1983-1987)
Texas Society of Psychiatric Physicians (1988-1994)
Tennessee Psychiatric Association (1994-2015)
American Medical Students Association (1977-1987)
American Medical Association (1983-1988; 2015-2019)
Ohio State Medical Association (1983-1987)
Montgomery County Medical Society (1983-1987)
Dayton Psychiatric Society (1983-1987)
Society of United States Air Force Psychiatrists (1983-1991)
Bexar County, Texas, Psychiatric Society (1987-1990)
Southern Medical Association (1994-2010)
Southern Psychiatric Association (1997-2009)

New Health Foundation (advocacy organization for transgendered health care; 1996-present)
American Psychological Association Society for the Psychological Study of Men and Masculinity, Division 51, 1996-2000.

AWARDS AND SPECIAL RECOGNITION:

Valedictorian, Mohonasen High School, Schenectady, New York, 1975.
New York State Regents Scholarship, 1975-1979.
Bausch and Lomb Science Award and Scholarship, 1975-1979.
Phi Beta Kappa, junior year selection, 1977.
Donald Charles Memorial Award for Research in Biology, 1978.
Recognition for Highest Grade Point Average, Department of Biology-Geology, University of Rochester, 1979.
Dean's Letters of Commendation for Academic Achievement, University of Rochester, 1975-1983.
Letter of Commendation for Excellence in Pathology, University of Rochester, 1981.
Alpha Omega Alpha Medical Honor Society, University of Rochester, 1983.
Wright State University Department of Psychiatry selectee for fellowship in the Group for the Advancement of Psychiatry (GAP), 1984.
Wright State University Department of Psychiatry nominee for Laughlin Fellowship of the American College of Psychiatrists, 1985, 1986.
Physician's Recognition Award of the American Medical Association, 1986 to present.
President's Award of the Ohio Psychiatric Association for outstanding service to the organization, 1987.
Chairman's Recognition Award For Scholarship and Research, Wright State University Department of Psychiatry, 1987.
Air Force Training Ribbon, 1980.
Air Force Outstanding Unit Decoration, 1987; first oak leaf cluster additional award, 1990.
Air Force Expert Marksman Ribbon, 1988.
Air Force Achievement Medal for research accomplishments, 1990.
1990 American Academy of Psychosomatic Medicine Dlin Fischer Award for Significant Achievement in Clinical Research; corecipient.
Who's Who Among Human Services Professionals, 1990 to present.
West's Who's Who in Health and Medical Services, 1991 to present.
Marquis Who's Who of Board Certified Medical Specialists, 1992-present.
Bexar County Medical Society Certificate of Appreciation, 1991.
Air Force Meritorious Service Medal for distinguished clinical and research service to the Department of Psychiatry, Wilford Hall Medical Center, 1991.
Air Force National Defense Ribbon, Desert Storm Campaign, 1991.
Mohonasen High School Hall of Fame for Lifetime Achievement, 1992 inductee.
Health Care Professional of the Year Award, Boulton and Park Society, San Antonio, Texas, 1992-93.
Special Citation Award, Society of Behavioral Medicine, with Coyle C, et al., for presentation at 1993 Society of Behavioral Medicine Annual Meeting, 1993.
Institute for Legislative Action, 1995 Honor Role.
Sterling Who's Who of Health Care Professionals, 1995.
Southern Medical Association 1995 Award for Medical Excellence (Best Scientific Oral Presentation in Neurology and Psychiatry), \$1,000 Scholarship prize, 1995.
Janssen Clinical Scholar, 1995.
Mountain Home VAMC Group Special Contribution Award, 1995, 1997.
Marquis Who's Who in the South and Southwest, 1996-1998.
Marquis Who's Who in Medicine and Healthcare, 1997-1998.
Certificate of Appreciation, ETSU Psychiatry Residents, 1997, 1998, 1999.
Fellow, American Psychiatric Association, 1998-2002.

Resident Special Recognition Award, June, 2000.
Distinguished Fellow, American Psychiatric Association, January, 2003
Special Group Contribution Award, VAMC, 2003
Secretary of Defense Certificate of Recognition, Cold War Military Service, 2003
VA Performance Award, 2005
First Annual Irma Bland Award for Excellence in Teaching Residents, presented by the American Psychiatric Association, May, 2005
Special Contribution Award, Mountain Home VAMC, for assisting in obtaining over 2.5 million in new program monies from VA Central Office RFP process, April 26, 2006
Top Psychiatrists of 2006, Consumer Research Council selectee
ETSU Resident Recognition Award for "dedication to the Resident's Journal Club", 2006
Fellow, Southern Psychiatric Association, 2006
ETSU Psychiatry Faculty Mentor of the Year Award, 2007
Cambridge Who's Who, Executive and Professional Registry, 2007
Southern Medical Association, Third Place Award for Scientific Poster Presentation, Dallas, Texas, December 5, 2009
Twenty-five year U.S. Government service award, January 10, 2010
Joint Commission recognition : "Top Performers on Key Quality Measures" (contributor), 2011
Robert W. Carey Quality Performance Excellence Award (contributor), 2011; Department of Veterans Affairs award using Baldrige criteria
James H. Quillen VAMC selected as VA to be featured in the Commonwealth Fund's article on successful efforts to improve patient safety (contributor), 2011
Gender Identity Research and Education Society (GIREs) 2011 award to the 34 members of the Standards of Care Revision Committee for their work on the WPATH Standards of Care, 7th Version.
Robert W. Carey Quality Trophy Award, Mountain Home VAMC. This is the highest level of the Carey Award for those VAMC's seeking performance excellence using the Baldrige Criteria. Awarded by the Secretary of the VA to the leadership team of which I was a Part, 2012.
Recognized by LGBT Health journal in March, 2016 as having first-authored the #1 and #3 most read articles in that journal since its inception.
Lifetime Achievement Award for Distinguished Research, awarded by the World Professional Association for Transgender Health for a lifetime of transgender research contributions, November 5, 2018.
Southern Trans Health and Wellness Research Award, 2019, presented by the Mountain Area Health Education Center, Wake Forest University, NC, March 7, 2019.

UNIVERSITY/VA COMMITTEE ACTIVITIES:

Learning Resources Advisory Committee (ETSU), 1995-1996.
Psychiatric Residency Training Committee /Educational Policy Committee (ETSU), 1993-2017.
Peer Review Committee (VAMC), 1995-1996.
Chairman and Founder, Psychiatric Grand Rounds and Visiting Professor Program (ETSU), 1993-1997; 2003-2004.
Clinical Executive Board (VAMC), 1995-2012.
Research and Development Committee, Dean's Appointment (VAMC), 1996-1998.
Chairman, VAMC Research and Development Committee, 1999-2000.
Co-Chairman, Mental Health Council (VAMC), 1995-2009.
Academic Partnership Committee (ETSU), member, 1995-2012.
Facility Master Plan and Space Utilization Committee (VAMC), 1995-2010.
Professional Standards Board (VAMC), 1995-2012.
Safety Committee, Department of Psychiatry, Chairman (VAMC)
ETSU Psychiatry Promotion and Tenure Committee, 1998-present.
Resident Selection Committee, ETSU Psychiatry Program, 1998-2012.
Chairman, VAMC Research and Development Committee, 2001-2002.

Veterans Health Affairs, VISN 9, Budget and Finance Committee, 2002-2004.
 Institutional Review Board (ETSU/VAMC), member, 1996-2003; served as acting chair as needed.
 Cameron University Department of Psychology, Dissertation Committee Consultant for Beth Ryan, Masters Thesis, 2004-2005 (gender identity disorder research).
 VISN 9 Mental Health Leadership Committee, 2002-2012.
 ETSU/VAMC Subcommittee on Graduate Medical Education, 2008-2012.
 Vanderbilt University Department of Nursing, Dissertation Committee member and consultant for Gerald Meredith, 2009-2010.
 VA Transgender Directive Education Workgroup; VACO workgroup to advise the Undersecretary, VHA, on how to educate and implement the 2011 and 2013 Directives on providing Healthcare to transgender and intersex Veterans, 2011-present.
 Office of Health Equity (VACO), Health Equity Coalition, 2013-2014.
 Numerous research committees and advisory panels for health equity research projects being conducted in VA, 2012-2015.
 Chairman, Educational Policy Committee (Residency Training Committee), East Tennessee State University Department of Psychiatry, 2015-2016.
 Self-Identified Gender Identity Data Field Training Workgroup (National VA work group to change electronic medical records data collection to include self-identified gender identity), 2012-present.
 Research Committee, East Tennessee State University Department of Psychiatry, 2015-2017.
 Promotion and Tenure Committee, East Tennessee State University, Quillen College of Medicine, Department of Psychiatry and Behavioral Sciences, 1999-present.
 WPATH International Awards Committee, 2020.

FORENSIC PSYCHIATRY ACTIVITIES:

1. Military court proceedings, two occasions as expert witness at trial; U.S. Air Force, U.S. Army, c.1990-1992.
2. Military Physical Evaluation Board Proceedings, expert testimony, 2/8/02.
3. Farmer v. Hawk, United States District Court for the District of Columbia, expert opinion by affidavit on behalf of plaintiff, 1999.
4. Yolanda Burt v. Federal Bureau of Prisons/Moritsugu, United States District Court for the District of Columbia, deposition testimony on behalf of plaintiff, 2000.
5. Kosilek v. Maloney, 221 F.Supp 2d 156,186 (D.Mass. 2002), expert witness by trial testimony on behalf of plaintiff, 2001.
6. Family Court expert witness trial testimony, Missouri, (custody issues for transgendered parent),1993.
7. Thompson v. Idaho Department of Corrections (prison medical care Issues), consultant on behalf of plaintiff, 2002 (citation: Linda Patricia Thompson v. Dave Paskett, et al., Case No. CV00-388-S-BLW).
8. State of Missouri Medical Board, expert opinion by affidavit on behalf of physician, 10/2001.
9. State of Tennessee Medical Board, expert opinion by affidavit on behalf of physician, 5/2002.
10. Military Administrative Hearing, consultant, U.S. Army, December, 2002.
11. Oiler v. Winn-Dixie Louisiana, Inc; USDC, Eastern District of Louisiana, No. 00-3114 "L" (3); consultant on behalf of defendant, 2001-2002.
12. Moore v. State of Minnesota, consultant and expert opinion by deposition testimony on behalf of defendant, Attorney General's Office, State of Minnesota, 2003.
13. Woods v. US Air Force, administrative discharge board, consultant, San Antonio, TX, 2003.
14. Ophelia Azriel De'Lonta vs. Ronald Angelone and Prison Health Services, Inc. (Virginia Department of Corrections) United States District Court, Western District of Virginia, 330 F.3d 630,635 (4th Cir 2003) expert opinion by deposition testimony on behalf of plaintiff, 2003.
15. Malpractice case, Tennessee, consultant for defendant (primary care physician), 2004-

- 2005.
16. Josef v. Ontario Minister of Health, Attorney General of Ontario representing Her Majesty the Queen in Right of Ontario; Ontario Superior Court of Justice; expert opinion by affidavit and consultant on behalf of plaintiff, 2004-2007.
 17. Nubel v. New Jersey Board of Nursing, consultant and expert opinion by deposition testimony for defendant, 2004-2005.
 18. Malpractice case, Tennessee, consultant for defendant (psychiatrist), 2004-2005 .
 19. Malpractice case, Kentucky, consultant for defendants (psychiatrists), 2005-2006.
 20. Kosilek v. Mass. Department of Corrections/ Kathleen Dennehy, expert witness by trial testimony and consultant on behalf of plaintiff, 2005-2006 (Kosilek v. Spencer, 889 F.Supp.2d 190 (D. Mass. Sept. 4, 2012); "Kosilek II."
 21. Gammett v. Idaho Department of Corrections, expert opinion by affidavit and consultant for plaintiff, 2005-2007 (Gammett v. Idaho State Bd. of Corrections, No. CV05-257-S-MHW, 2007 WL 2186896 (D. Idaho July 27, 2007).
 22. Isaak v. Idaho Department of Corrections, consultant, and expert opinion by deposition testimony on behalf of plaintiff, 2006-2008.
 23. May v. State of Tennessee and multiple codefendants; consultant on behalf of defendant, Attorney General's Office, State of Tennessee, 2006.
 24. Fields/Sundstrom v. Wisconsin Department of Corrections, consultant and expert opinion by deposition testimony on behalf of plaintiff, 2007 (Fields v. Smith, 653 F.3d 550 (7th Cir. 2011).
 25. Palmer v. State of TN; malpractice case; consultant and expert opinion by deposition testimony for defendant, Attorney General's Office, State of Tennessee 2007.
 26. Spray v. Temp Agency, consultant and expert opinion by affidavits on behalf of plaintiff, 2007.
 27. O'Donnabhain v. Internal Revenue Service/Department of the Treasury, expert witness by trial testimony on behalf of plaintiff, 2007 (O'Donnabhain v. Commissioner, 134 T.C. No. 4 (Feb. 2, 2010).
 28. Battista v. Mass. Department of Corrections/Kathleen Dennehy, consultant and expert opinion by affidavit for plaintiff, 2008-2011.
 29. Plumley v. State of TN; malpractice case; consultant for defendant, 2009.
 30. Kolestani v. State of Idaho, capital murder case, consultant and expert opinion by affidavit for public defender's office, 2009.
 31. Smith v. St. Mary's Medical Center, medical malpractice case, consultant for defendant, 2009-2011, expert witness by jury trial testimony, 2011.
 32. Finch aka Destiny v. Idaho Department of Corrections, consultant for plaintiff, 2010-2011.
 33. Soneeya v. Clarke, Civil Action No. 07-12325 (NG), Massachusetts, consultant for plaintiff, 2011. (see also Soneeya v. Spencer, 851 F.Supp.2d 228 (D. Mass. 2012)
 34. Hoyle v. Saha, malpractice case; consultant for defendant, 2011- 2014.
 35. Champouillon v. State of TN; malpractice case; consultant for defendant, 2012-2014.
 36. Equivel v. State of Oregon; access to transgender health care for Oregon State employees; consultant to Lambda Legal, 2012.
 37. Kosilek v. MA DOC, consultant for plaintiff, 2012-2014.
 38. Binney v. South Carolina DOC, consultant and expert opinion by affidavit for plaintiff (death row case), 2013-2015.
 39. De'Lonta v. Harold W. Clarke et al. (Virginia Department of Corrections), consultant and expert opinion by affidavit for plaintiff, 2013-2014 (inmate paroled).
 40. U.S. and Tudor v. Southeastern Oklahoma State University, expert consultant for plaintiff and the Department of Justice (Title VII discrimination case), by declaration for plaintiff, 2015-2018. (Case decision 2018)
 41. Mott v. State of Kansas, consultant and expert opinion by affidavit for plaintiff (birth certificate change), 2015-2016.
 42. Fuller v. MA Department of Corrections; expert opinion by affidavit and deposition, for plaintiff, 2015-2016.
 43. Franklin v. Hardy, et al. (Illinois Department of Corrections); expert opinion by affidavit, for plaintiff, 2015-2016.

44. Dunn et al. v. Dunn et al. (Alabama Department of Corrections), expert consultant for plaintiff, 2016-2017.
45. Keohane v. Jones (Florida Department of Corrections), Case No.4:16-cv-511-MW-CAS, N. D. Fla, expert opinion by affidavit, deposition, and bench trial testimony for plaintiff, 2016-2017.(Case decision August, 2018)
46. Rodgers v. State of Florida, Case #1998CF274, expert opinion by affidavits for plaintiff (death row case) 2016-present.
47. U.S. v. State of North Carolina, North Carolina Department of Public Safety, & University of North Carolina (HB2); 1:16-CV-00425, expert opinion by affidavits, for plaintiff (DOJ, Civil Rights Division, and ACLU), 2016-2017. Case dropped by Attorney General Sessions.
48. Hicklin v. Lombardi, et al., File No. 3587.53, (Missouri Department of Corrections, Corizon), consultant for defendants (Corizon only), expert opinion by videotaped deposition, 2017-2018 (settled).
49. U.S. v. John Patrick Price, expert opinion by affidavit for defendant (Federal Public Defender, Western NC), 2017.
50. Jane Does 1-5 v. Donald J. Trump, James Mattis, et al, case number 17-cv-1597, District of Columbia, expert opinion by declarations and deposition for plaintiffs, 2017-present.
51. Stockman et al. v. Donald J. Trump, James Mattis, et al., case number 17-CV-6516, United States District Court, Central District of California, expert opinion by declarations and deposition for plaintiffs, 2017-present.
52. Karnoski, et al. v. Donald J. Trump, James Mattis, et al., case number 2:17-cv-01297-MJP, Unites States District Court, Western District of Washington, expert opinion by Declarations and depositions for plaintiffs, 2017-present.
53. Stone, et al. v. Donald J. Trump, James Mattis, et al., case number 1:17-cv-02459 (MJG), United States District Court, District of Maryland, expert opinion by declarations and deposition for plaintiffs, 2017-present.
54. Hampton v. Baldwin et al, CIVIL NO. 17-cv-936-DRH (S.D. Ill. Nov. 29, 2017), Illinois, expert opinion by deposition for plaintiff, 2017-present.
55. Roy Trost aka Daisy Meadows v. Brian Sandoval, et al, case number 3:14-cv-00611-MMD-WGC, United States District Court, Nevada, expert opinion for plaintiff, 2018-present.
56. Bruce v. South Dakota, case number 5:17-cv-05080-JLV, expert opinion by affidavit and deposition for plaintiff, 2018-2019 (death of plaintiff).
57. Edmo v. Idaho Department of Corrections, Corizon, Inc., et al; case number 1:17-cv-151-BLW, expert opinion by declaration for defendant, 2017-present.
58. Radan v. Colorado Department of Corrections, Rick Raemisch, and Darren Lish, case numbers 1:16-cv-01717-STV and 16-cv-01717-MSK-STV, expert opinion by declaration for defendants, 2017-2018 (settled).
59. EEOC v. A&E Tire, Inc, case number 1:17-cv-02362-RBJ, expert opinion by declaration on behalf of plaintiff, 2018-2019 (settled).
60. Jamison Rigby v. University of Michigan, et al; expert opinion by deposition (malpractice case), on behalf of plaintiff, 2018-present.
61. Monroe (aka Patterson) v. Baldwin, Illinois Department of Corrections et al, Case No. 1:19-cv-01060 consultant for plaintiff, 2019-present.
62. Tate (aka Ms. Tay Tay) v. Wexford Health Services, Baldwin, Illinois Department of Corrections, et al; Case 3:16-cv-00092-NJR-MAB; declarations on behalf of plaintiff, 2019-present.
63. Jannah Monroe (aka Andre Patterson), Marilyn Melendez, et al v. Bruce Rauner, Bruce Baldwin, et al; Case No.3:18-cv-156; consultant for plaintiffs, class action suit, 2018-present.
64. Kadel v. Folwell, et al., Case No. 1:19-cv-00272-LCB-LPA (M.D.N.C.); consultant for plaintiffs (class action lawsuit), 2019-present.
65. Hoffner v. United States, consultant for plaintiff (death row case, Ohio), 2019-present.
66. State of TN v. Carlton Brown, Docket No. 114791, expert opinion by declaration on behalf of defendant, 2019-present.
67. Lt. Jane Doe v. Esper, Trump, et al. Consultant for plaintiff; declaration; 2020-present.
68. United States v. Anthony Eugene Long, DKT. 0649 2:19CR00030-001, consultant for Federal

- Public Defender on behalf of defendant; expert opinion by declaration on behalf of defendant; 2020-present.
69. Drain v. State of Ohio, consultant on behalf of plaintiff (death row case, Ohio), 2021-present.
70. U.S. v. James David Rogers, LA CR 19-700-JAK, consultant on behalf of the defendant (Federal Public Defender, Los Angeles office), 2021-present.

PUBLICATIONS:

1. Brown G R: Morphologic complexity and its relationship to taxonomic rates of evolution. J Undergrad Res, 3:139-168, 1978.
2. Brown G R: Stadol dependence: another case. JAMA, 254(7):910, 1985.
3. Brown G R: Letter to the Editor. Newsletter of the Ohio Psychiatric Association, 10(1):8, 1986.
4. Brown G R: Resident Rounds. Column for Newsletter of the Ohio Psychiatric Association. 10(2), 10(3), 11(1), 11(2), 1986-1987.
5. Brown G R: Anorexia nervosa complicated by Mycobacterium xenopi pulmonary infection. J Nerv Ment Dis, 175(10):629-632, 1987.
6. Brown G R: Mycobacterium xenopi infection complicating anorexia nervosa. Proceedings of the 29th Annual Meeting of American College of Physicians (Air Force Regional Meeting), 22-25 March, 1987.
7. Brown G R: Buspar, a new anxiolytic. Letter to the Editor, Journal of the Ohio State Medical Association, Spring, 1987.
8. Brown G R: Transsexuals in the military: flight into hypermasculinity. Abstract. Proceedings of the 10th International Symposium on Gender Dysphoria (Amsterdam, The Netherlands) 7 June, 1987.
8. Brown G R: Transsexuals in the military: flight into hypermasculinity. Arch Sex Behav, 17(6):527-537, 1988.
10. Brown G R: Therapeutic effect of silence: application to a case of borderline personality disorder. Current Issues in Psychoanalytic Practice, 4(3-4):123-131, 1988.
11. Brown G R: Bioethical issues in the management of gender dysphoria. Jefferson J Psychiatry, 6(1):33-44, 1988.
12. Brown G R, Rundell J R: Psychiatric disorders at all stages of HIV infection. Proceedings of the 1988 Annual Session of the Texas Medical Association (San Antonio, Texas), May, 1988.
13. Brown G R, Rundell J R: Suicidal tendencies in HIV-seropositive women. Am J Psychiatry, 146(4):556-557, 1989.
14. Brown G R, Collier L: Transvestites' women revisited: a nonpatient sample. Arch Sex Behav, 18(1):73-83, 1989.
15. Brown G R, Pace J: Hypoactive sexual desire disorder in HIV-seropositive individuals. JAMA, 261(17):2305, 1989.
16. Brown G R: Prospective study of psychiatric morbidity in HIV-seropositive women. Psychosom Med, 51:246-247, 1989.
17. Brown G R: Current legal status of transsexualism in the military. (Letter) Arch Sex Behav, 18(4):371-373, 1989.
18. Rundell J R, Brown G R: Use of home test kits for HIV is bad medicine. JAMA, 262(17):2385-2386, 1989.
19. Rundell J R, Brown G R, Paolucci S L: Psychiatric diagnosis and attempted suicide in HIV-infected USAF personnel. Abstract. Proceedings of the Fifth International Conference on AIDS (Montreal, Canada), June, 1989.
20. Brown G R: Current legal status of transsexualism in the military. Abstract. Proceedings of the Eleventh Inter-national Symposium on Gender Dysphoria (Cleveland, Ohio), September, 1989.
21. Brown G R: A review of clinical approaches to gender dysphoria. J Clin Psychiatry, 51(2):57-64, 1990.
22. Pace J, Brown G R, Rundell J R, et al.: Prevalence of psychiatric disorders in a mandatory

- screening program for infection with human immunodeficiency virus: A pilot study. Milit Med, 155:76-80, 1990.
23. Rundell J R, Brown G R: Persistence of psychiatric symptoms in HIV seropositive persons. Am J Psychiatry, 147(5):674-675, 1990.
 24. Praus D, Brown G R, Rundell J R, et al.: Associations between CSF parameters and high degrees of anxiety or depression in USAF personnel infected with HIV. J Nerv Ment Dis, 178(6):392-395, 1990.
 25. Brown G R, Rundell J R: Prospective study of psychiatric morbidity in HIV-seropositive women without AIDS. Gen Hosp Psychiatry, 12:30-35, 1990.
 26. Brown G R: The transvestite husband. Med Aspects Human Sexuality, 24(6):35-42, 1990.
 27. Drexler K, Brown G R, Rundell J R: Psychoactive drug use and AIDS. JAMA, 263(3):371, 1990.
 28. Brown G R, Rundell J R: Psychiatric morbidity in HIV-seropositive women without AIDS. Proceedings of the 143rd Annual Meeting of the American Psychiatric Association, pages 75-76 (New York, New York), May, 1990.
 29. Rundell J R, Ursano R, Brown G R: HIV infection and perception of social support. Proceedings of the 143rd Annual Meeting of the American Psychiatric Association, page 76 (New York, New York), May, 1990.
 30. Rundell J R, Brown G R, McManis S, et al.: Psychiatric predisposition and current psychiatric findings in HIV-infected persons. Proceedings of the Sixth International Conference on AIDS (San Francisco, California), June, 1990.
 31. Drexler K, Rundell J R, Brown G R, et al.: Suicidal thoughts, suicidal behaviors, and suicide risk factors in HIV-seropositives and alcoholic controls. Proceedings of the Sixth International Conference on AIDS (San Francisco, California), June, 1990.
 31. Brown G R: The inpatient database as a technique to prevent junior faculty burnout. Acad Psychiatry, 14(4):224-229, 1990.
 32. Rundell J R, Wise M, Brown G R, et al: Relative frequency of HIV disease as a cause of mood disorder in a general hospital. Proceedings of the 1990 Update on Neurological and Neuropsychological Complications of HIV Infection, page PSY-4 (Monterrey, California), June, 1990.
 33. Rundell J R, Praus D, Brown G R, et al: CSF parameters, immune status, serum viral titers, anxiety, and depression in HIV disease. Proceedings of the 1990 Update on Neurological and Neuropsychological Complications of HIV Infection, page PSY-5 (Monterrey, California), June, 1990.
 34. Brown G R: Clinical approaches to gender dysphoria. Abstract. Psychiatry Digest, 5:9-10, 1990.
 35. Brown G R, Rundell J R, Temoshok L, et al: Psychiatric morbidity in HIV-seropositive women: Results of a three year prospective study. Proceedings of the 37th Annual Meeting of the American Academy of Psychosomatic Medicine, 1990.
 36. Rundell J R, Brown G R, Kyle K, et al: Methods employed by and length of knowledge of HIV-seropositivity of HIV-infected suicide attempters. Proceedings of the 37th Annual Meeting of the American Academy of Psychosomatic Medicine, 1990.
 37. Brown G R: Unzufriedenheit mit dem eigenen Geschlecht: Klinische Behandlungsmöglichkeiten. Abstract for European readership. Psychiatry Digest, 10:3-4, 1990.
 38. Brown G R, Anderson B W: Credibility of patients in psychiatric research. Amer J Psychiatry, 148(10):1423-1424, 1991.
 39. Brown G R, Anderson B: Psychiatric morbidity in adult inpatients with childhood histories of physical and sexual abuse. Amer J Psychiatry, 148(1):55-61, 1991.
 40. Plotnick E, Brown G R: Use of intravenous haloperidol in nonviolent severely regressed adult psychiatric inpatients. Gen Hosp Psychiatry, 13:385-390, 1991.
 41. Brock I, Brown G R, Jenkins R: Affect and health locus of control in early HIV infection. Proceedings of the 144th Annual Meeting of the American Psychiatric Association, 79, 1991.
 42. Brock I, Brown G R, Jenkins R: Early HIV infection and health locus of control. Proceedings of the 144th Annual Meeting of the American Psychiatric Association, 79, 1991.

43. Brown G R, Pace J, Brock I, et al: Psychiatric morbidity in HIV-seropositive military women. Proceedings of the 144th Annual Meeting of the American Psychiatric Association, 208, 1991.
44. Pace J, Brown G R: Factors associated with length of inpatient psychiatric hospitalization in a military medical center. Proceedings of the 144th Annual Meeting of the American Psychiatric Association, 95, 1991.
45. Plotnick E, Brown G R: Sexual functioning in HIV-positive women without AIDS. Proceedings of the 144th Annual Meeting of the American Psychiatric Association, 80-81, 1991.
46. Hicks D, Stasko R, Rundell J, Norwood A, Brown G R: Psychiatric treatment in early HIV disease. Proceedings of the 144th Annual Meeting of the American Psychiatric Association, 208, 1991.
47. McManis S, Brown G R, Rundell J, et al: Subtle, early cognitive impairment in HIV disease. Proceedings of the 144th Annual Meeting of the American Psychiatric Association, 77-78, 1991.
48. McManis S, Brown G R, Rundell J, et al: Cognitive impairment and CSF values in HIV disease. Proceedings of the 144th Annual Meeting of the American Psychiatric Association, 78, 1991.
49. McManis S, Brown G R, Zachary R, et al: Cognitive impairment and gender in HIV-positive persons. Proceedings of the 144th Annual Meeting of the American Psychiatric Association, 78, 1991.
50. Carey M, Jenkins R, Brown GR, et al: Gender differences in psychosocial functioning in early stage HIV patients. Proceedings of the 7th International Conference on AIDS, M.B. 4230, 1:447, 1991.
51. McManis S, Brown G R, Zachary R, et al: Neuropsychiatric impairment early in the course of HIV infection. Proceedings of the 7th International Conference on AIDS, M.B. 2064, 1:198, 1991.
52. Brown G R, Rundell J, Pace J, et al: Psychiatric morbidity in early HIV infection in women: results of a 4 year prospective study. Proceedings of the First International Conference on Biopsychosocial Aspects of HIV Infection, p 22, 1991.
53. Brown G R, Kendall S, Zachary R, et al: Psychiatric and psychosocial status of US Air Force HIV-infected personnel. Proceedings of the First International Conference on Biopsychosocial Aspects of HIV Infection, p 121, 1991.
54. Brown G R, Zachary R, McManis S, et al: Gender effects on HIV-related neuropsychiatric impairment. Proceedings of the First International Conference on Biopsychosocial Aspects of HIV Infection, p 125, 1991.
55. Temoshok L, Smith M, Brown G R, Jenkins R: Perceptions of zidovudine (AZT) and cooperation with treatment or clinical trials. Proceedings of the First International Conference on Biopsychosocial Aspects of HIV Infection, p 198, 1991.
56. Jenkins R, Patterson T, Brown G R, Temoshok L: Social functioning in early stage HIV patients. Proceedings of the First International Conference on Biopsychosocial Aspects of HIV Infection, p P12, 1991.
57. Zachary R, Coyle C, Kendall S, Brown G R: Living with HIV: Mechanisms for coping with psychological distress. Proceedings of the First International Conference on Biopsychosocial Aspects of HIV Infection, p P13, 1991.
58. Brown G R, Rundell J, McManis S, Kendall S, Jenkins R: Neuropsychiatric morbidity in early HIV disease: Implications for military occupational function. Proceedings of the Aerospace Medicine Symposium on Allergic, Immunological, and Infectious Disease Problems in Aerospace Medicine, NATO Advisory Group for Aerospace Research and Development, AGARD-CP-518, (paper 16):1-14, 1992.
59. Brown G R: Single USAF AIDS center offers unique opportunity to research biopsychosocial aspects of HIV infection. San Antonio, M.D., 1(4):8-9,14-15, 1991.
60. Rundell J, Mapou R, Temoshok L, Brown G R: An overview of the U.S. military HIV testing policy. Proceedings of the American Psychological Association Annual Meeting, August, 1991, page 277.
61. Brown G R: The transvestite husband. J Gender Studies, 13(1):14-19, 1991.

62. Rundell J R, Kyle K, Brown G R, Thomasen J: Factors associated with suicide attempts in a mandatory HIV-testing program. Psychosomatics, 33(1):24-27, 1992.
63. Beighley P, Brown G R: Medication refusal in psychiatric inpatients in the military. Military Med, 157:47-49, 1992.
64. McManis S, Brown G R, Zachary R, et al: Screening for subtle neuropsychiatric deficits early in the course of HIV infection. Psychosomatics, 34(5):424-431, 1993.
65. Brown G R, Kendall S, Ledsky R: Sexual dysfunction in HIV-seropositive women without AIDS. J Psychol Human Sexuality, 7(1-2):73-97, 1995.
66. Brock I, Brown G R: Psychiatric length of stay determinants in a military medical center. Gen Hosp Psychiatry, 15(6):392-398, 1993.
67. Brown G R, Rundell J, McManis S, Kendall S, Jenkins R: Neuropsychiatric morbidity in early HIV disease: Implications for military occupational function. Vaccine, 11(5):560-569, 1993.
68. Brown G R, Rundell J: Prospective study of psychiatric aspects of early HIV infection in women. Gen Hosp Psychiatry, 15:139-147, 1993.
69. Brown G R, Rundell J, McManis S, Kendall S, Zachary R, Temoshok L: Prevalence of psychiatric disorders in early stages of HIV infection in United States Air Force Personnel. Psychosomatic Medicine, 54:588-601, 1992.
70. Beighley P, Brown G R, Thompson J: DSM-III-R brief reactive psychosis among Air Force recruits. J Clin Psychiatry, 53(8):283-288, 1992.
71. Brown G R: Letter to the editor. Amer J Psychiatry, 149(4):541, 1992.
72. Lothstein L M, Brown G R: Sex reassignment surgery: current concepts. Integ Psychiatry, 8(1):21-30, 1992.
73. Brown G R, Zachary R, Rundell J R: Suicidality before and after HIV seroconversion in men with early stage disease. Proceedings of the 50th Anniversary International Meeting of the American Psychosomatic Society, 43, 1992.
74. Brock I, Brown G R, Butzin C: Predictors of psychiatric inpatient length of stay. Proceedings of the 145th Annual Meeting of the American Psychiatric Association, New Research Volume, 101, 1992.
75. Rundell J R, Brown G R, Jenkins R, Temoshok L: Social support, psychiatric morbidity, and HIV disease. CME Syllabus and Proceedings of the 145th Annual Meeting of the American Psychiatric Association, 281, 1992.
76. Plotnick E, Brown G R: IV haloperidol in severe nonviolent psychosis. Psychiatry Drug Alerts, 6(5):40, 1992.
77. Goethe K, Richie D, Brown G R, Kendall S: Longitudinal neuropsychological findings in HIV-positive males. Proceedings of the 8th International AIDS Conference, Vol. 2, Abstract PuB 3770, Amsterdam, The Netherlands, 1992.
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Reviewer, Psychosomatics, 1989 to present
Reviewer, Journal of AIDS, 1990 to 2001
Reviewer, Psychology and Health, 1992
Editorial Board, San Antonio M.D., 1991-1993
Reviewer, International Journal of Psychiatry in Medicine, 1994-2006
Reviewer, CNS Drugs, 1995-2002.
Reviewer, Southern Medical Journal, 1995-2013
Reviewer, AIDS Patient Care, 1996-2003
Editorial Board, International Journal of Transgenderism, 1997-present
Reviewer, Federal Practitioner, 2000-present
Reviewer, Journal of the American Geriatrics Society, 2000-2003
Reviewer, Bipolar Disorders, 2005-2017
Reviewer, Journal of Sexual Medicine, 2009-present
Reviewer, European Psychiatry, 2010-present
Reviewer, International Journal of Sexual Health, 2011-present
Reviewer, American Journal of Public Health, 2011-present
Editorial Board, LGBT Health, 2013-present
Reviewer, Canadian Medical Association Journal, 2013-present
Reviewer, Suicide and Life-Threatening Behavior, 2015-present

Editorial Board, Transgender Health, 2015-present
Reviewer, Journal of Correctional Healthcare, 2017-present
Reviewer, Breast Cancer Research and Treatment, 2017-present
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PRESENTATIONS:

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"The Difficult Patient: Recognition, Understanding, and Management", The Marriott Hotel, Dayton, Ohio. March 6, 1985, (Category I, CME credit).

"Transsexualism: Literature Review and Case Report", Wright State University, Dayton, Ohio. March 19, 1985.

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"Anxiety Disorders: New Treatment Approaches", Wright State University, Department of Family Practice, Dayton, Ohio. January 29, 1987.

"Gender Dysphoria", Wright State University Medical School, Dayton, Ohio. February 10, 1987.

"Bioethical Issues in Sex Reassignment", Good Samaritan Hospital, Dayton, Ohio. February 2, 1987.

"Mycobacterium xenopi Pulmonary Infection Complicated by Anorexia Nervosa", presentation at the 29th Annual Meeting of the Society of Air Force Physicians, New Orleans, Louisiana. March 23, 1987.

"The Transsexual Flight into Hypermasculinity", presentation at the Tenth International Symposium on Gender Dysphoria, Amsterdam, The Netherlands. June 10, 1987.

"Grand Rounds: Gender Disorders", Institute of Living, Hartford, Connecticut, April 30, 1987.

"Affective Disorders", three hour lecture series, Wilford Hall Medical Center, San Antonio, Texas, September, 1987.

"Grand Rounds: Transsexualism", Maine Medical Center, Portland, Maine, November 4, 1987.

"Opportunistic Infection in Anorexia Nervosa", 34th Annual Meeting of The Academy of Psychosomatic Medicine, Las Vegas, Nevada, November 14, 1987.

"Grand Rounds: Gender Disorders, An Overview", Wilford Hall Medical Center, San Antonio, Texas, December 17, 1987.

"Women Who Marry Transvestites", accepted for presentation at XXI Annual Meeting of AASECT, San Francisco, California, April 26, 1988 (no funding available).

"Psychiatric Manifestations of HIV Infection", Texas Medical Association Annual Session, San Antonio, Texas, May 13, 1988.

"Introduction to Gender Disorders", University of Texas Health Science Center, San Antonio, Grand Rounds, September 27, 1988.

"Transsexualism and Gender Disorders", Bexar County Psychiatric Society, San Antonio, Texas, October 18, 1988.

"Psychiatric Diagnoses in HIV-seropositive Air Force Personnel", Maine Medical Center, Portland, Maine, November 5, 1988.

"Symposium on HIV-seropositivity and Psychiatry", Program Coordinator, Behavioral Health Sciences Symposium, Sheppard AFB, Wichita Falls, Texas, November 8, 1988.

"Childhood Gender Disorders", Laurel Ridge Hospital, San Antonio, Texas, January 24, 1989.

"Prospective Study of Psychiatric Morbidity in HIV-seropositive Women", Annual Meeting of the American Psychosomatic Society, San Francisco, California, March 10, 1989.

"Psychiatric Findings in HIV-seropositive Air Force Women", Walter Reed Army Institute of Research, Bethesda, Maryland, March 31, 1989.

"Psychiatric findings in HIV-seropositive persons in a mandatory HIV screening program", (abstract and poster session, with J Rundell, S Paolucci), Fifth International Conference on AIDS, Montreal, Canada, June 5, 1989.

"Alcohol Use and HIV-seropositivity", (poster presentation, with K Drexler, J Rundell), American Psychiatric Association Annual Meeting, San Francisco, California, May, 1989.

"Current Legal Status of Transsexualism in the Military Setting", Eleventh International Symposium on Gender Dysphoria, Cleveland, Ohio, September, 1989.

"Grand Rounds: Transsexualism in the Military", Wilford Hall Medical Center, December 14, 1989 (videotape available on request).

"Psychosexual and Gender Disorders", 6 session advanced seminar for psychiatric residents, University of Texas Health Science Center, San Antonio, January to February, 1990.

"Update on HIV Psychiatric Research in the USAF: 1990", Behavioral Health Sciences Symposium, Wichita Falls, Texas, 25 April, 1990.

"Psychiatric Morbidity in HIV-seropositive Women without AIDS", 143rd Annual Meeting of the American Psychiatric Association, New York, May 14, 1990.

"HIV Infection and Perception of Social Support", (Rundell, Ursano, Brown), 143rd Annual Meeting of the American Psychiatric Association, New York, May 14, 1990.

"Relative Frequency of HIV Disease as a Cause of Mood Disorder in a General Hospital", (Rundell, Brown), Neurological and Neuropsychological Complications of HIV Infection Conference, Monterrey, California, June 17, 1990.

"CSF Parameters, Immune Status, Serum Viral Titers, Anxiety, and Depression in HIV Disease", (Rundell, Praus, Brown), Neurological and Neuropsychological Complications of HIV Infection Conference, Monterrey, California, June 17, 1990.

"CSF Findings and Request for Psychiatric Examination in HIV-Infected Patients", (Rundell, Brown, et al.), poster presentation, Neurological and Neuropsychological Complications of HIV Infection Conference, Monterrey, California, June 17-19, 1990.

"Methods Employed by and Length of Knowledge of HIV-Seropositivity of HIV-infected Suicide Attempters", (Rundell, Brown, Kyle, et al.), 37th Annual Meeting of the Academy of Psychosomatic Medicine, Phoenix, Arizona, November 18, 1990.

"Psychiatric Morbidity in HIV-seropositive Women: Results of a Three Year Prospective Study", (Brown, Rundell, Temoshok, et al.), 37th Annual Meeting of the Academy of Psychosomatic Medicine, Phoenix, Arizona, November 16, 1990.

"Psychiatric Issues in the Evaluation of Spouses of Cross-dressers," Fairfax Hospital, Falls Church, Virginia, November 30, 1990.

"Measurement of Negative Affect in HIV-seropositive Individuals," (Jenkins, Carey, Temoshok, Brown, et al.), 12th Annual Meeting of The Society of Behavioral Medicine, Washington, D.C., March 20, 1991.

"Psychiatric and Neuropsychiatric Morbidity in Early HIV Disease," Grand Rounds presentation with S. McManis, University of Texas Health Science Center, San Antonio, Texas, April 30, 1991.

"Neuropsychiatric Impairment Early in the Course of HIV Infection," (McManis, Brown, Zachary, et al.), 7th International Conference on AIDS, Florence, Italy, June 17, 1991.

Nine presentations/new research posters/symposia presented at the 144th Annual Meeting of the American Psychiatric Association, New Orleans, Louisiana, May 11-15, 1991 (see Publications section, #50-58, for titles).

Two presentations at the 7th International Conference on AIDS, Florence, Italy, June 15-17, 1991 (see Publications section, #59-60, for titles).

"Methodological Advantages of Comprehensive Multidisciplinary Consultation-Liaison Psychiatry Research: HIV Research as a Model," (Rundell, Temoshok, Brown, et al.), Annual Meeting of the Academy of Psychosomatic Medicine, Atlanta, Georgia, October 17, 1991.

"HIV Psychiatric Research in the Air Force," Grand Rounds presentation, Mayo Clinic, Rochester, Minnesota, July 9, 1991.

"Neuropsychiatric Morbidity in early HIV Disease: Implications for Military Occupational Function," (Brown, Rundell, McManis, Kendall), Aerospace Medicine Symposium on Allergic, Immunological, and Infectious Disease Problems in Aerospace Medicine, NATO Advisory Group for Aerospace Research and Development Conference, Rome, Italy, October, 1991; presented by J. Rundell in my absence due to lack of funding.

Four oral presentations and two poster presentations at the First International Conference on the Biopsychosocial Aspects of HIV Infection, Amsterdam, The Netherlands, 22-25 September, 1991 (see Publications section, #61-66, for titles).

"Biopsychosocial HIV Research in the U.S. Military," Invited Grand Rounds presentation, University of South Dakota School of Medicine, Sioux Falls, South Dakota, October 25, 1991.

"Biopsychosocial Issues in Treating HIV-seropositive Women," Fairfax Hospital Evening CME Lecture Series, Falls Church, Virginia, December 11, 1991.

"Psychiatric Issues in Women with HIV," Fairfax County Health Department, Falls Church, Virginia, December 12, 1991.

"Suicidality in Men with Early HIV Disease," American Psychosomatic Society 50th Annual Meeting, New York, New York, April 1, 1992.

USAF HIV "Train-the-Trainer" Course; course organizer, presenter, and comprehensive course assessment (pretest, posttests), San Antonio, Texas, April 7-9, 1992.

"Clinical Utility and Diagnostic Sensitivity of the Michigan Alcoholism Screening Test in Patients with HIV Disease," (Rundell, Brown), Annual Meeting of the Academy of Psychosomatic Medicine, San Diego, CA, October 31, 1992.

"Longitudinal Neuropsychological Findings in HIV Positive Males," (Goethe, Richie, Brown, et al), 8th International AIDS Conference, Amsterdam, The Netherlands, July 20, 1992.

- "HIV and Women: Challenge for the 90's," Grand Rounds presentation, Geisinger Medical Center, Danville, PA, August 6, 1992.
- "Psychosocial Dimensions of Depression in Early HIV Disease," (Jenkins R, Rundell J, Brown G, Law W, Temoshok L), Annual Meeting of the American Psychological Association, Washington, D.C., August 15, 1992.
- "Psychiatric Presentations of HIV Disease," AIDS and Mental Health Program sponsored by San Antonio VA and UTHSC-SA, Corpus Christi, TX, September 18, 1992.
- "Major Depression in HIV Disease Before AIDS: Clinical Features and Associated Factors," (Rundell J, Brown G, Jenkins R, Kendall S, Temoshok L), Annual Meeting of the Academy of Psychosomatic Medicine, San Diego, CA, 29 October, 1992.
- "HIV Risk Behavior Surveys in the U.S. Military -- What Have We Learned?," Wilford Hall Medical Center Scientific Group Meeting, San Antonio, TX, 16 November 1992.
- "Biopsychosocial Aspects of Early HIV Disease in Women," Grand Rounds, Michigan State University/St. Lawrence Hospital, Lansing, MI, 18 December 1992.
- "Methodological Issues in Assessing Risk Behaviors in an HIV Sero-positive Military Sample," (Coyle C, Blake S, Brown GR, Ledsky R, Temoshok L), Special Citation Poster Presentation, Proceedings of the Fourteenth Annual Meeting of the Society of Behavioral Medicine, San Francisco, CA, March 10, 1993.
- "Gender differences in transmission risk behavior, affect, and social support in HIV-positive individuals," (Nannis E, Temoshok L, Jenkins R, Blake S, Sharp E, Jenkins P, Brown G, Patterson T, Coyle C, Brandt U, Johnson C), Proceedings of the Fourteenth Annual Meeting of The Society of Behavioral Medicine, San Francisco, CA, March 10, 1993.
- "Psychosocial stressors and vulnerability to psychiatric distress in early-stage HIV," (Zachary R, Brown GR, Kendall S, Coyle C, McManis S), Proceedings of the Fourteenth Annual Meeting of The Society of Behavioral Medicine, San Francisco, CA, March 10, 1993.
- "Establishing databased research in an academic department of psychiatry," invited address to the Department of Psychiatry, Jefferson Medical College, College of Physicians, Philadelphia, PA, April 30, 1993.
- Two Workshops, three poster sessions, 1993 Annual Meeting of the American Psychiatric Association, San Francisco, CA, May 22-24, 1993.
- "Treating Depression in Early HIV Disease," Grand Rounds, Oklahoma University School of Medicine, Oklahoma City, OK, December 1, 1993.
- "Diagnosis and Treatment of Transvestism," Tulane University School of Medicine, Department of Psychiatry presentation, December 2, 1993.
- "Psychiatric Disorders in Early HIV Disease," Grand Rounds, Tulane University School of Medicine, New Orleans, LA, December 3, 1993.
- "Diagnosis and Treatment of Gender Identity Disorders," invited presentation at Keesler Air Force Base Medical Center, Biloxi, MS, January 13, 1994.
- "Personality Disorders in HIV-positive Persons: Association with Other Measures of Psychiatric Morbidity," poster presentation, (Richards J, McManis S, Brown G), Annual Meeting of the American Psychiatric Association, Philadelphia, PA, May 23, 1994.
- "Psychiatric Issues in HIV/AIDS," invited presentation, Huntsville Mental Health Community, Huntsville Space and Science Center, Huntsville, AL, November 12, 1994.
- "Diagnosis and Treatment of Gender Identity Disorders," Grand Rounds, Tulane University School of Medicine, New Orleans, LA, April 29, 1994.
- "Management of Depression in Early HIV Disease," Upper East Tennessee Psychiatric Association Meeting, Kingsport, TN, June 2, 1994.
- "Sertindole in the Treatment of Chronic Schizophrenia: a Phase III Controlled Trial," Grand Rounds, East Tennessee State University, Johnson City, TN, September 30, 1994.
- "New Onset of Sexual Dysfunction in HIV-seropositive Women: Results of a Prospective Study,"

88th Annual Scientific Assembly of the Southern Medical Association, Orlando, Florida, November 3, 1994.

"Gender Identity Disorders in the VAMC Setting," Grand Rounds, Atlanta VAMC, December 13, 1994.

"Managing Depression in Early Stage HIV Disease," Grand Rounds, Salem VAMC, December 22, 1994.

"Biopsychosocial Aspects of HIV Disease in Men," Invited Speaker, Mississippi Pharmacists Association MidWinter Meeting, Jackson, MS, February 12, 1995.

"Biopsychosocial Aspects of HIV Disease in Men," Invited Speaker, Mississippi Pharmacists Association MidWinter Meeting, Oxford, MS, February 19, 1995.

"Biopsychosocial Aspects of HIV Disease in Women," Grand Rounds, East Tennessee State University, Johnson City, TN, March 17, 1995.

"Managing Insomnia," primary care provider educational meeting, Bristol, TN, May 22, 1995.

"Diagnosis and Treatment of Gender Identity Disorders: DSM-IV Approach," Grand Rounds, Geisinger Medical Center, Danville, PA, June 15, 1995.

"Psychosocial Characteristics of 739 Transgendered Men," (Brooks G, Brown GR, Askew J), 41st Annual Meeting of the Southeastern Psychological Association, Savannah, GA, March 12, 1995.

"Personality Characteristics and Sexual Functioning of 188 American Transgendered Men: Comparison of Patients with Nonpatients." 14th Harry Benjamin International Gender Dysphoria Symposium, Irsee/Ulm Germany, September 9, 1995.

"Sertindole HCl: A Novel Antipsychotic With a Favorable Side Effect Profile." 89th Scientific Assembly of the Southern Medical Association, Kansas City, Missouri, November 17, 1995.

"Long term Safety of Treatment with Sertindole, a Novel Antipsychotic." (Radford M, Brown GR, Matthew H) poster, 89th Scientific Assembly of the Southern Medical Association, Kansas City, Missouri, November 17, 1995.

"Diagnosis and Newer Treatments for Schizophrenia." Invited Presentation. Central Appalachia Services, Kingsport, TN, December 7, 1995.

"Personality and Sexuality in Transvestism." Grand Rounds, University of Texas Health Sciences Center, San Antonio, Texas, December 12, 1995.

"HIV/AIDS and Sexuality." Grand Rounds, Wilford Hall Medical Center, San Antonio, Texas, December 14, 1995.

"How Research Can Enhance Your Career." Invited Presentation to Department of Psychiatry, Wilford Hall Medical Center, San Antonio, Texas, December 13, 1995.

"Conducting Research With Stigmatized Populations." Journal Club Presentation, University of Texas Health Sciences Center, Department of Psychiatry, San Antonio, Texas, December 12, 1995.

"Sexuality in HIV/AIDS." Grand Rounds, Bowman Gray Medical School, Department of Psychiatry, Wake Forest University, Winston-Salem, North Carolina, January 19, 1996.

"Gender Identity Disorders." Grand Rounds, Lakeshore Mental Health Institute, Knoxville, Tennessee, February 14, 1996.

"New Approaches to the Management of Schizophrenia," Helen Ross McNabb Center, Knoxville, Tennessee, February 14, 1996.

"Diagnosis and Management of Gender Dysphoria," Grand Rounds, University of Alabama at Birmingham, March 5, 1996.

"Depression and Primary Care," Morristown, TN Primary Care Provider's CE Group, Morristown, TN, June 27, 1996.

"Personality and Sexuality in Transgendered Men," paper presentation, American Psychological Association, Toronto, Canada, August 13, 1996.

"Gender Identity Disorders," paper presentation at Southern Psychiatric Association Annual Meeting, Santa Fe, New Mexico, September 25, 1996.

"Sleep Disorders," Grand Rounds, Salisbury VAMC, Salisbury, North Carolina, August 21, 1996.

"Depression in Primary Care Settings," Nurse Practitioner-Physician Assistant Association of Northeast Tennessee, Johnson City, Tennessee, September 11, 1996.

Visiting Professorship, Menninger Clinic and Foundation; included Grand Rounds, case presentation and discussion, meetings with residents and staff; Topeka, KS, October 10-11, 1996.

"New Approaches to the Treatment of Schizophrenia," Grand Rounds, Lakeshore Mental Health Institute, Knoxville, Tennessee, October 30, 1996.

"HIV Disease in Women: Sexual Manifestations," symposium presentation at Academy of Psychosomatic Medicine Annual Meeting, San Antonio, Texas, November 14, 1996.

"HIV and Sexuality," Grand Rounds, Atlanta VAMC/Emory University, Atlanta, Georgia, December 3, 1996.

"Santa Claus is a Cross-Dresser (and so are his little elves)," invited address for the Upper East Tennessee Psychiatric Association, a component of the Tennessee District Branch of the American Psychiatric Association, Johnson City, TN, December 9, 1996.

"Depression and Sexuality," Tazewell County Medical Society, Richlands, Virginia, March 25, 1997.

"Identifying and Treating Depression in Primary Care," Annual Meeting of the Nurse Practitioner's and Physician's Assistants of East Tennessee, Johnson City, TN, March 25, 1997.

"Managing Sexual Side Effects of Antidepressant Treatment," Harlan County Medical Society, Harlan, Kentucky, March 11, 1997.

"Depression and Intimacy," Chatanooga Psychiatric Society, Chatanooga, TN, April 21, 1997.

"Depression and Sexuality," Lakeshore Mental Health Institute Grand Rounds, Knoxville, TN, April 9, 1997.

"Managing Sexual Side Effects of Antidepressants," Southern Highlands Pharmacist's Society, Abingdon, Virginia, April 29, 1997.

"Transgendered Families," Lakeshore Mental Health Institute Grand Rounds, Knoxville, TN, April 30, 1997.

"Depression and Intimacy," Buchanan County Medical Society, Grundy, VA, May 8, 1997.

"Depression, Sexuality, and Treatment," Highlands Psychiatric Society, Abingdon, VA, May 9, 1997.

"Managing Sexual Side Effects of Antidepressants in Primary Care," Chatanooga Family Practice Association, Chatanooga, TN, May 20, 1997.

"Double Trouble: Depression and Anxiety in Primary Care," LeFlore County Medical Center, Greenwood Mississippi, May 29, 1997.

"HIV and Sexuality," ETSU Medicine and Sexuality Symposium, Johnson City, TN, June 13, 1997.

"Depression and Sexuality," ETSU Medicine and Sexuality Symposium, Johnson City, TN, June 13, 1997.

"Transgenderism," Grand Rounds, Overlook Mental Health Center, Knoxville, TN, June 25, 1997.

"Managing Sexual Side Effects of Antidepressants in Primary Care," Wise County Medical Society, Norton, Virginia, July 11, 1997.

"APA Guideline on the Treatment of Schizophrenia," Smoky Mountain Chapter of the Tennessee Psychiatric Association, Knoxville, TN, July 22, 1997.

"Nicotine Dependence: Kicking the Habit," August Monthly Meeting of the Tricities Nurse Practitioner-Physician Assistants Association, Johnson City, TN, August 14, 1997.

"Biopsychosocial Issues in Women with HIV Disease," Monthly Meeting of OB-GYN Society of Tricities, Johnson City, TN, August 26, 1997.

"Revision of the HBGDA Standards of Care: Opportunities and Controversies," Biannual Meeting of the Harry Benjamin International Gender Dysphoria Association, Vancouver, British Columbia, Canada, September 11, 1997.

"Anxiety and Depression in Primary Care: Double Trouble," Primary Care Grand Rounds, Fort Campbell, KY, October 1, 1997.

"Treatment Guidelines for Schizophrenia," Psychiatry Grand Rounds, Lexington VAMC, Lexington, KY, September 17, 1997.

"Gender Dysphoria in the Military Setting," Grand Rounds, Wilford Hall Medical Center, San Antonio, TX, December 18, 1997.

"Clinical Issues in Transgendered Families," Grand Rounds, University of Texas Health Sciences Center, San Antonio, December 16, 1997.

"Depression and Sexuality," Southwest Virginia Counsel of Nurse Practitioners, Abingdon, Virginia, November 1, 1997.

"Depression and Anxiety Disorders in Primary Care," Annual Meeting of the Nurse Practitioner Physician Assistant Association of Northeast TN, Johnson City, TN, February 23, 1998.

"Differentiating SSRI's in Clinical Practice," Richmond Psychiatric Society Meeting, Richmond, VA, January 22, 1998.

"Gender Identity Disorders," Grand Rounds, University of VA, Roanoke, VA, February 19, 1998.

"Smoking Cessation: Modern Approaches," Monthly Meeting of the East TN Hospital Pharmacists Association, Kingsport, TN, February 24, 1998.

"Identification and Treatment of Gender Dysphoria Syndromes," Grand Rounds, University of Mississippi, Jackson, MS, February 27, 1998.

"Gender Dysphoria Syndromes in Primary Care," Nurse Practitioner Physician Assistant Association of Northeast TN, Kingsport, TN, March 19, 1998.

"Treatment Guidelines for Schizophrenia," Grand Rounds, University of Kentucky, Louisville, KY, April 23, 1998.

"Gender Identity Disorders," Grand Rounds, University of Alabama at Huntsville, Huntsville, AL, May 21, 1998.

"Nicotine Reduction Strategies," Grand Rounds, Southwest Virginia Mental Health Institute, Marion, VA, May 27, 1998.

"Depression and Anxiety Management in Primary Care," East Tennessee State University Dept. of Psychiatry Symposium on "Psychiatry in the Trenches", Johnson City, TN, June 12, 1998.

"Managing Depression in Primary Care," Grand Rounds, Internal Medicine Department, East Tennessee State University, Johnson City, TN, June 16, 1998.

"Mood Disorders in Women," Roanoke Psychiatric Society, Roanoke, VA, June 17, 1998.

"Gender Identity Disorders," Grand Rounds, Loyola University Strich School of Medicine, Chicago, IL, June 18, 1998.

"Standards of Care for Gender Identity Disorders," Grand Rounds, University of Louisiana, Baton Rouge, LA, July 21, 1998.

"Depression and Sexuality," Fall Symposium of the Mental Health Association of Knoxville, September 11, 1998.

"Pharmacotherapy of Agitation in the Elderly," Kentucky Pharmacists' Association, Lexington, Kentucky, September 20, 1998.

"Women and Mood/Anxiety Disorders," monthly meeting of the Nurse Practitioners-Physician Assistants, Johnson City, TN, October 1, 1998.

"Killing the Bore: How to Give Effective Medical Presentations That Keep an Audience Awake," Grand Rounds, ETSU Dept. of Psychiatry, Johnson City, TN, October 16, 1998.

"Pharmacologic Management of Agitation in the Elderly," Detroit Psychiatric Society, Detroit, Michigan, December 22, 1998.

"Nicotine Dependence: Kicking the "Habit," Wise County Medical Society, Wise, Virginia, January 14, 1999.

"Mood Disorders in Women," Chatanooga Psychiatric Society, Chattanooga, TN, January 18, 1999.

"From Menarche to Menopause: Mood and Anxiety Disorders in Women," Greene County

Medical Society, Greeneville, TN, February 2, 1999.

"From Menarche to Menopause: Mood and Anxiety Disorders in Women," Annual Meeting of the TriCities Nurse Practitioner-Physician Assistant Association, Johnson City, TN, February 23, 1999.

"Comparison of Risperidone and Olanzapine: RIS-112 Study," Upper East TN Psychiatric Society, Johnson City, TN, March 4, 1999.

"New Directions in Treating Schizophrenia," CME, Inc. sponsored faculty member, Los Angeles, California, March 27, 1999.

"Pharmacologic Management of Agitation in Dementia," University of Alabama Pharmacotherapeutics Conference, Huntsville, AL, April 24, 1999.

"Mood and Anxiety Disorders in Women," University of Alabama Pharmacotherapeutics Conference, Huntsville, AL, April 24, 1999.

"Behavioral Problems in Dementia," Grand Rounds, Alvin York VAMC, Murfreesboro, TN, April 29, 1999.

Pharmacological Management of Agitation in Dementia," Grand Rounds, Lakeshore Mental Health Institute, Knoxville, TN, May 7, 1999.

"Psychiatric Disorders in Women," Women's Health Symposium, University of Alabama, Huntsville, AL, May 14, 1999.

"Loxitane: A New Look at an Old Drug," Lakeshore Mental Health Institute, Knoxville, TN, June 4, 1999.

"Psychiatric Disorders in Women," University of Tennessee at Knoxville, OB-GYN Grand Rounds, June 4, 1999.

"Working With Transgendered Clients," workshop presented at A Search for New Understanding of Lesbian, Gay, and Bisexual Issues, East Tennessee State University, Johnson City, TN, September 24, 1999.

"Optimizing Treatment for Schizophrenia", CME, Inc. Symposium, Cleveland, Ohio, September 25, 1999.

"Diagnosis and Treatment of Depression in Primary Care," Grand Rounds, James H. Quillen VA Medical Center-ETSU Department of Medicine, Johnson City, TN, September 28, 1999

"Gender Identity Disorder," Annual Meeting of the Southern Psychiatric Association, Hot Springs, Virginia, September 30, 1999.

"Management of Insomnia," Annual Meeting of the Tennessee Association of Physicians' Assistants, Gatlinburg, TN, October 12, 1999.

"Sexual Dysfunction in Primary Care Practice," Behavioral Health in Primary Care Symposium, East Tennessee State University, Johnson City, TN, October 16, 1999.

"Management of Insomnia: New Directions," monthly meeting of the Upper East Tennessee Psychiatric Association, Bristol, TN, October 19, 1999.

"Depression and Anxiety in Women Through the Life Cycle," Johnson City Women's Health Center Grand Rounds, Johnson City, TN, October 27, 1999.

"Selecting Antidepressant Treatment," invited presentation and panel discussion, New Orleans Academy of Internal Medicine, January 10, 2000.

"Managing Insomnia in Primary Care," Grand Rounds, Holston Valley Medical Center, Kingsport, TN, January 31, 2000.

"Gender Identity Disorders." Grand Rounds, University of Cincinnati, Cincinnati, OH, January 26, 2000.

"Selecting Antidepressants in Primary Care," Rural Health Cooperative, Kingsport, TN, February 7, 2000.

Visiting Professor, Loyola University Medical School, Chicago, IL (two presentations), February 10, 2000.

"Managing Insomnia in the New Millennium," Annual Meeting of the East TN Nurse Practitioner's and Physicians' Assistants Association, Johnson City, TN, February 22, 2000.

"Sexual Dysfunction in Primary Care," Annual Meeting of the East TN Nurse Practitioner's and Physicians' Assistants Association, Johnson City, TN, February 22, 2000.

"Depression and PTSD in Women," Grand Rounds, Department of OB-GYN, University of Tennessee, Knoxville, March 17, 2000.

"Depression and Anxiety in Primary Care Practice," Grand Rounds, Department of Internal

Medicine, University of Tennessee, Knoxville, March 16, 2000.

"Diabetes, Glucose Regulation, and Schizophrenia," Upper East Tennessee Psychiatric Society, Johnson City, TN, April 13, 2000

"Sexual Dysfunction in Primary Care Practice," Annual Meeting of the Tennessee Osteopathic Medicine Association, Chattanooga, TN, May 7, 2000.

"Diabetes, Weight Gain, and Schizophrenia," Grand Rounds, Lakeshore Mental Health Institute, Knoxville, TN, July 20, 2000.

"Bipolar Disorder: Monotherapy versus Combination Therapy", national CME Category I lecture series sponsored by Medical Education Resources and Curry, Martin, and Schiavelli, to 17 cities between May and November, 2000.

"Managing Depression and Anxiety Disorders," invited presentation to the Annual Meeting of the Tennessee Academy of Family Practice, Jackson, TN, August 19, 2000.

"Managing Insomnia," monthly meeting of the Tazwell County Medical Society, Richlands, Virginia, August 23, 2000.

"Sexual Dysfunction," Grand Rounds, ETSU Department of OB/GYN, Johnson City, TN, September 6, 2000.

"Depression and Sexuality," Grand Rounds, Holston Valley Hospital, Bristol, TN, September 25, 2000.

"Depression and Anxiety in Primary Care: Case Conference/Grand Rounds," Southern Medical Association Annual Meeting, Orlando, Florida, November 2, 2000.

"Depression in Primary Care Settings," Hamblen County Medical Society, Morristown, TN, November 21, 2000.

"Sleep Disorders," Nurse Practitioners-Physicians Assistant Association Monthly Meeting, Johnson City, TN, December 7, 2000.

"CD-ROM Workshop, Anxiety and Depression", Annual Meeting of the Holston Valley Nurse Practitioners-Physicians Assistants Association, Johnson City, TN, February 26, 2001.

"The Harry Benjamin Standards of Care in Prison: Benefits for Transsexual Healthcare," International Foundation for Gender Education Annual Symposium, Chicago, IL, March 24, 2001.

"Why Internists Should Care About Treating Depression," Grand Rounds, Department of Internal Medicine, ETSU, Johnson City, TN, April 3, 2001.

"Antidepressants: Effective Side Effect Management," Annual Meeting of the Tennessee Osteopathic Medicine Association, Memphis, TN, April 21, 2001.

"Gender Identity Disorder: Management," invited presentation, Smokey Mountain Chapter of the Tennessee Psychiatric Association, Knoxville, TN, April 24, 2001.

"Gender Identity Disorder," Grand Rounds, Department of Psychiatry, Memphis VAMC, May 24, 2001.

"Antipsychotic Efficacy Uncompromised by Side Effects," Grand Rounds, Department of Psychiatry, UT Memphis, May 25, 2001.

"Sexual Dysfunctions in Primary Care," International Medical Update Symposium, Johnson City, TN, August 2, 2001.

"Diagnosis and Treatment of Gender Dysphoria," Grand Rounds, Department of Psychology, James H. Quillen VAMC, August 3, 2001.

"Management of Bipolar Disorder," Grand Rounds, Meharry Medical College, Nashville, TN, August 21, 2001.

"Medical Treatment of Agitation in Dementia," Fall Symposium of the Mental Health Association of Knoxville, September 13, Knoxville, TN.

"Monotherapy vs. Combination Therapy in the Management of Mania," Fall Symposium of the Mental Health Association of Knoxville, September 14, Knoxville, TN

"Optimizing Treatment for Bipolar Disorder," quarterly meeting of the Upper East Tennessee Psychiatric Association, Johnson City, TN, September 20, 2001.

"Gender Identity Disorders: Diagnosis and Management," Grand Rounds, Institute of Living/Hartford Hospital Departments of Psychiatry and Psychology, Hartford, CT, October 17, 2001.

"Gender Identity Disorder Complicated by Dissociative Identity Disorder: Report of a Successful Case," XVII Symposium of the Harry Benjamin International Gender Dysphoria

Association, Galveston, TX, November 3, 2001.

"Mood Disorders in Women," monthly meeting of the TriCities Nurse Practitioners Association, Johnson City, TN, December 10, 2001.

"Substance Use Disorders Complicating Common Psychiatric Disorders," Grand Rounds, Holston Valley Hospital, Bristol, TN, December 18, 2001.

"Women's Health Issues in Psychiatry," OB-GYN Grand Rounds, East Tennessee State University, Johnson City, TN, May 8, 2002.

"Matching the Neurotransmitter to the Patient," ½ day CME presentation, World Medical Conferences, Jackson, Mississippi, May 18, 2002.

"Matching the Neurotransmitter to the Patient," ½ day CME presentation, World Medical Conferences, Albany, New York, June 1, 2002.

"Killing the Bore: How to Give Effective Medical Presentations That Keep People Awake," Grand Rounds, Dept. of Psychiatry, ETSU, Johnson City, TN, August 9, 2002.

"Current Issues in Treatment of Dementia," Roanoke Psychiatric Society, Roanoke, VA, June 26, 2002.

"Comfort Foods: Should We Just Surrender Now?," Northeast Tennessee Nurse Practitioner's Association Annual Meeting, Bristol, TN, September 14, 2002.

"Gender Identity Disorders: Diagnosis and Management," Psychiatry Grand Rounds, University of Florida, Gainesville, Florida, September 20, 2002.

"Gender Identity Disorders: Diagnosis and Management," Psychiatry Grand Rounds, Meharry Medical College, Nashville, TN, October 9, 2002.

"New Issues in the Management of Bipolar Disorder," Grand Rounds, Lakeshore Mental Health Institute, Knoxville, TN, October 5, 2002.

"Pharmacological Management of Dementia," Psychiatry Grand Rounds, Western State Hospital, Staunton, Virginia, March 19, 2003.

"Appropriate Use of Antipsychotics in Primary Care Practice," Tricounty Medical Society Meeting, Johnson City, TN, April 3, 2003.

"Appropriate Use of Antipsychotics in Primary Care Practice," 2003 Primary Care Conference, Johnson City, TN, April 1, 2003.

"Pharmacological Management of Dementia," Grand Rounds, Gaston Memorial Hospital, Gastonia, NC, May 13, 2003.

"Brown G R, McBride L, Williford W, Bauer M: Impact of childhood sexual abuse on bipolar disorder. Proceedings of the 5th International Conference on Bipolar Disorders, Pittsburgh, PA, 2003 (poster presented by Dr. Bauer in my absence).

"Aripiprazole Use in Psychiatry," Grand Rounds, Lakeshore Mental Health Institute, Knoxville, TN, August 22, 2003.

"Use of Anticonvulsants in Psychotic Disorders," Tennessee Psychiatric Association, Smoky Mountain Chapter Meeting, Knoxville, TN, August 28, 2003.

"Application of the Harry Benjamin International Gender Dysphoria Association's Standards of Care to the Prison Setting: Recent Victories for Transgender Healthcare in the USA," 18th Biennial Symposium of the HBGIDA, Gent, Belgium, September 11, 2003.

"Family and Systems Aggression Towards Therapists Working with Transgendered Clients," 18th Biennial Symposium of the HBGIDA, Gent, Belgium, September 12, 2003.

"Impact of Childhood Abuse on Disease Course in Veterans with Bipolar Disorder," 97th Annual Meeting of the Southern Medical Association, Atlanta, Georgia, November 8, 2003.

"Gender Dysphoria: Diagnosis and Management," Grand Rounds presentation, Marshall Medical School, Huntington, West Virginia, January 9, 2004.

"Gender Dysphoria: Diagnosis and Management," Grand Rounds presentation, Catawba State Hospital, Roanoke, Virginia, March 17, 2004.

"Treatment Resistant Schizophrenia," Grand Rounds presentation, Broughton State Hospital, Morganton, North Carolina, March 25, 2004.

"Antipsychotic Use in Geriatric Populations," Grand Rounds presentation, Tampa VAMC, Tampa, Florida, April 23, 2004.

"Gender Identity Disorders," Grand Rounds presentation, University of TN College of Medicine, Memphis, TN, May 14, 2004.

"Overcoming Barriers to Treatment Success in Chronic Mental Illnesses," Grand Rounds,

- Salisbury VAMC, Salisbury, NC, June 3, 2004.
- "Dissociative Identity Disorder Comorbid with Gender Identity Disorder: Review of the Literature and Long-term Case Presentation," Southern Psychiatric Association, Savannah, Georgia, October 2, 2004.
- "Bipolar Disorder in Primary Care," CME Cat 1 presentation, Knoxville, TN, December 1, 2004.
- "Bipolar Disorder and Impulsive Aggression in Primary Care Settings," CME Cat 1 presentation to Tricities Nurse Practitioner Association, December 16, 2004.
- "Overcoming Barriers to Treatment in Chronic Mental Illnesses," North Carolina Advanced Practice Nurses Association, Greensboro, NC, February 13, 2005.
- "Bipolar Disorder in the Primary Care Setting: What to do?," 9th Annual Update for Nurse Practitioners, Johnson City, TN, March 21, 2005.
- "Current Controversies in the Use of SSRI's," TriCounty Medical Society, Johnson City, TN, May 5, 2005.
- "Transgender client aggression towards therapists," XIX Biennial Symposium of the Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, April 9, 2005.
- "Gender identity disorder comorbid with dissociative identity disorder: review of the literature and 7 year followup case presentation. XIX Biennial Symposium of the Harry Benjamin International Gender Dysphoria Association, Bologna, Italy, April 9, 2005.
- "Current Controversies in the Use of SSRI's," CME symposium, Southern Medical Association 9th Annual Scientific Symposium, San Antonio, TX, November 12, 2005.
- "Gender Identity Disorder: Diagnosis and Management," Grand Rounds, University of South Florida, Tampa, Florida, January 6, 2006 (Videotaped version of presentation available at www.TheCJC.com).
- "Gender Identity Disorders," East Tennessee State University Women's Health Program, CME Cat 1 symposium, Johnson City, TN, March 24, 2006.
- "Update on Bipolar Disorder," Millennium Center, CME Cat I program, Johnson City, TN, March 31, 2006.
- "Dealing with Chronic Mental Illness: Barriers to Treatment Success," Southside Virginia Psychiatric Society Quarterly Meeting, Richmond, Virginia, April 3, 2006.
- "Management of Gender Identity Disorders," Intermountain Psychological Association, invited presentation, Johnson City, TN, June 8, 2006.
- "Transgender Health Issues," Emory and Henry Lyceum Series, Emory, Virginia, September 18, 2006.
- "Impact of Childhood Abuse in Veterans with Bipolar Disorder," 65th Annual Scientific Meeting of the Southern Psychiatric Association, Baltimore, Maryland, September 29, 2006.
- "Appropriate Use of Antipsychotics in Primary Care Settings," 100th Annual Meeting of the Southern Medical Association, Charlotte, NC, October 14, 2006.
- "Impact of Childhood Abuse on the Course of Bipolar Disorder," Keynote speaker, Perspectives In Health, Texas Department of State Health Services Annual CME Symposium, Austin, Texas, October 27, 2006.
- "Autocastration as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder," Southern Psychiatric Association Annual Meeting, Memphis, TN, August, 2007.
- "Autocastration as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder," XX Biennial Symposium of the World Professional Association for Transgender Health, Chicago, Illinois, September, 2007.
- "Gender Identity Disorders in the Military and VA," Panel discussion and presentation. XX Biennial Symposium of the World Professional Association for Transgender Health, Chicago, Illinois, September, 2007.
- "Diagnosis and Treatment of Gender Identity Disorders," Mountain Update on Psychiatry, ETSU CME Symposium, October 19, 2007.
- "Voice Parameters That Result in Identification or Misidentification of Biological Gender in Male-to-Female Transgender Veterans," poster presentation at the First Annual Gender Spectrum Health Fair, Sponsored by the Alliance for Gender Awareness, Inc and Rutgers Office of Social Justice Education LGBT Communities Rutgers University College, New Brunswick, NJ, November 8, 2007 (with R King et al, coauthors).

- "Voice Parameters That Result in Identification or Misidentification of Biological Gender in Male-to-Female Transgender Veterans," poster presentation at the XX Biennial Symposium of the World Professional Association for Transgender Health, Chicago, Illinois, September, 2007 (with R King, et al, coauthors).
- "Voice Parameters That Result in Identification or Misidentification of Biological Gender in Male-to-Female Transgender Veterans," poster presentation at the Southern Medical Association Annual Scientific Meeting, Nashville, TN, September, 2008 (presented by E McDuffie on behalf of Brown, King, et al, coauthors).
- "Evaluation and Management of Gender Identity Disorders," Cat I, 1.5 hour CME program, Annual Meeting of the Alaska Psychiatric Association, Alyeska, Alaska, April 18, 2009.
- "Forensic Issues and Case Presentations on GID," Cat I, 1.5 hour CME program, Annual Meeting of the Alaska Psychiatric Association, Alyeska, Alaska, April 18, 2009.
- "70 Veterans with Gender Identity Disturbances: A Descriptive Study," XXI Biennial Symposium of the World Professional Association for Transgender Health, Oslo, Norway, June 18, 2009.
- "70 Veterans with Gender Identity Disturbances: A Descriptive Study", Annual Scientific Meeting of the Southern Medical Association, Dallas , Texas, December 4, 2009.
- "Overview of Autocastration and Surgical Self Treatment in Prisons", National Commission on Correctional Healthcare Annual Meeting, October 10, 2010, Las Vegas, Nevada (invited two hour CME CAT I program)
- "Autocastration- Overview and Case Series Presentation," Grand Rounds, East Tennessee State University, Johnson City, TN, April 29, 2011.
- "Providing Healthcare for Transgender and Intersex Veterans," Live Meeting Series broadcast nationally by VA Talent Management System. Co-Presenters Leonard Pogache, MD, Meri Mallard, RN; CME category I credit for each of 3 programs completed, November 22 (2 programs) and November 30, 2011.
- "PBM Guidelines for Providing Care for Transgender and Intersex Veterans," copresenter with Lisa Longo, Pharm.D, Live Meeting Series broadcast nationally by VA Talent Management System, May 10 and May 14, 2012.
- "Providing Culturally Competent Care for Transgender Veterans," invited Keynote address at Houston VAMC for symposium (CEU accredited) on LGBT Veteran healthcare, Houston, TX, August 17, 2012.
- "Update on Version 7 of the WPATH Standards of Care," invited Keynote address for Mountain Area Health Education Center's Southeastern Summit on Transgender Healthcare, Category 1 CME accredited, Asheville, NC, August 24, 2012.
- "History of Transgender Healthcare in the Department of Veterans Affairs," invited Keynote address for Mountain Area Health Education Center's Southeastern Summit on Transgender Healthcare, Category 1 CME accredited, Asheville, NC, August 25, 2012.
- "Qualitative Analysis of Transgender Inmates' Correspondence: Implications for health Services in Departments of Correction", National Commission on Correctional Healthcare Annual Meeting, October 14, 2012, Las Vegas, Nevada (invited one hour CME CAT I program).
- "Cross Sex Hormonal Treatment for Transgender Veterans," national Live Meeting for Women's Health Program, Department of Veterans Affairs, July 16, 2013.
- "Transgender Health Care Training for VA Health Care Providers", 3 hours Category 1 CME accredited , Minneapolis, MN, September 26, 2013.
- "Sex Reassignment Options", national presentation to VA SCAN-ECHO and regional consultation teams responsible for VA transgender health consultations, July 2, 2013.
- "Access to Care for Gender Dysphoric Inmates: Issues and Cases," Invited plenary speaker for the 21st Annual Forensic Rights and Treatment Conference, sponsored by Drexel University College of Medicine, Category 1 CME credit (1.5 hours), Harrisburg, PA, December 5, 2013.
- "Forensic Aspects of Transgender Health Care in Prison," Grand Rounds, East Tennessee State University, Category 1 CME, March 7, 2014.
- "Health Disparities Research: Suicidality in Gender Minorities as a Research Model," Grand Rounds, East Tennessee State University, Category 1 CME credit, May 20, 2014.
- "Sex reassignment surgeries: female-to-male," national presentation to VA SCAN-ECHO and

- regional consultation teams responsible for VA transgender health consultations, Cat I CME, June 24, 2014.
- “Sex reassignment surgeries: male-to-female,” national presentation to VA SCAN-ECHO and regional consultation teams responsible for VA transgender health consultations, Cat I CME, July 8, 2014.; December 2, 9, 16, 23, 2014; February 24, 20-15.
- “Medico-Legal Aspects of Providing Transgender Healthcare for Inmates,” invited 2.5 hour presentation for national training program in LGBT healthcare for the Federal Bureau of Prisons, September 4, 2014.
- “Mental health and medical outcome disparities in 5,135 transgender veterans: a case-control study,” 32nd Annual Conference of the Gay and Lesbian Medical Association, Category 1 CME credit, Baltimore, MD, September 11, 2014.
- “Mental health and medical outcome disparities in 5,135 transgender veterans: a case-control study,” Vanderbilt University Grand Rounds, Department of Psychiatry, Cat 1 CME credit, Nashville, TN, September 26, 2014.
- “Mental health and medical outcome disparities in 5,135 transgender veterans: a case-control study,” Drexel University Grand Rounds, Department of Psychiatry, Cat 1 CME credit, Philadelphia, PA, October 23, 2014.
- “Pharmacotherapy issues with gender dysphoria,” College of Psychiatric and Neuropsychiatric Pharmacists, Annual Meeting, Cat I CME credit, Tampa, FL, April 19, 2015.
- “Lesbian, gay, bisexual, and transgender (LGBT) sociopolitical indicators and mental health diagnoses among transgender Veterans receiving VA care. Blosnich, J.R., Marsiglio, M.C., Gao, S., Gordon, A.J., Shipherd, J.C., Kauth, M., Brown, G.R., Fine, M.J. (2015, July). Department of Veterans Affairs Health Services Research & Development/Quality Enhancement Research Initiative National Conference, Philadelphia, PA, July, 2015.
- “Killing the Bore: How to Give Effective Medical Presentations,” East Tennessee State University Department of Psychiatry and Behavioral Sciences Grand Rounds (Cat I CME), May 1, 2015.
- “Sex reassignment surgeries: male-to-female,” national presentation to VA SCAN-ECHO and regional consultation teams responsible for VA transgender health consultations, Cat I CME, July 21, July 28, 2015
- “Sex reassignment surgeries: female-to-male,” national presentation to VA SCAN-ECHO and regional consultation teams responsible for VA transgender health consultations, Cat I CME, September 15, September 22, 2015.
- “Transgender military service: Moving past ignorance in DoD and VHA,” invited Keynote Address, Rush Medical University, Cat I CME credit, Chicago, IL, October 9, 2015.
- “Health correlates of criminal justice involvement in 4,793 transgender veterans. Poster Presentation at the Annual National Conference on Correctional Health Care, Denver, CO, October 18, 2015.
- “Open Transgender Military Service: Health Considerations,” presentation to medical leadership of the USMC, Washington, DC, by videolink, January 27, 2016.
- “Sex reassignment surgeries; masculinizing and feminizing,” national presentations to VA SCAN-ECHO and regional consultation teams responsible for VA transgender health consultations, Cat I CME, June 7 and 28, 2016.
- “Orange is not the new black—yet,” Symposium on prison transgender mental health care and update on recent court cases supporting access to transgender health care in US prisons, 24th Biennial Scientific Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, Cat I CME (1.5 hours), June 20, 2016.
- “Harry Benjamin Plenary Lecture,” invited Keynote address for the 24th Biennial Scientific Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, Cat 1 CME, June 18, 2016. Available at www.wpath2016.com, timer marker 4:20.
- “Health correlates of criminal justice involvement in 4,793 transgender veterans. Poster

- Presentation at the 24th Biennial Scientific Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, Cat I CME, June 18, 2016.
- "Breast cancer in a cohort of 5,135 transgender veterans over time," 24th Biennial Scientific Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, Cat 1 CME, June 20, 2016.
- "Impact of social determinants of health on medical conditions among transgender Veteran," Blosnich J, Marsiglio M, Dichter M., Gao S., Gordon M, Shipherd J, Kauth M, Brown G, Fine M. VA HSR&D Field-Based Meeting to Engage Diverse Stakeholders and Operational Partners in Advancing Health Equity in the VA Healthcare System. Philadelphia, PA, September, 2016
- "Current and past military context and overview of transgender military service," Caring for Transgender Persons in a Changing Environment, Walter Reed National Military Medical Center and Uniformed Services University of the Health Sciences, Bethesda, MD, Cat I CME, 13 September, 2016.
- "State of the Science: Current VHA research findings, policies, and transgender health care delivery model," Caring for Transgender Persons in a Changing Environment, Walter Reed National Military Medical Center and Uniformed Services University of the Health Sciences, Bethesda, MD, Cat I CME, September 13, 2016.
- "Social determinants of health and their associations with medical conditions among transgender veterans," presented by first author John Blosnich, Ph.D., Field-Based Meeting to Engage Diverse Stakeholders and Operational Partners in Advancing Health Equity in the VA Healthcare System, Philadelphia, PA, September 20, 2016.
- "Update on the Mountain Home Transgender Veteran Research Protocol," Grand Rounds, East Tennessee State University, Johnson City, TN, Cat 1 CME, September 23, 2016.
- "History of transgender people in the military," Southeastern Transgender Health Summit 2016 Overcoming Barriers, Mountain Area Health Education Center, Asheville, NC, Cat 1 CME, September 25, 2016.
- "Update on VA care for transgender veterans and summary of research." Southeastern Transgender Health Summit 2016 Overcoming Barriers, Mountain Area Health Education Center, Asheville, NC, Cat 1 CME, September 25, 2016.
- "Transgender inmates in prison: perspectives from expert witnesses," Symposium Chair and presenter, United States Professional Association for Transgender Health, First Scientific Meeting, Los Angeles, CA, Cat 1 CME (1.5 hours), February 3, 2017.
- "Changes in prescriptions of cross-sex hormones and psychotropic medications for 4,409 transgender veterans receiving services at VHA facilities," United States Professional Association for Transgender Health, First Scientific Meeting, Los Angeles, CA, Cat 1 CME, February 3, 2017.
- "Sex reassignment surgeries; masculinizing and feminizing," national presentations to VA SCAN-ECHO and regional consultation teams responsible for VA transgender health consultations, Cat I CME, 4 hours, February 21, 28; May 9, 16, 2017.
- "Transgender Health Care, Research, and Regulations in the Department of Defense," 4 hour/half day CME Cat I symposium (solo presenter), 2017 USMEPCOM Medical Leadership Training Seminar, San Antonio, TX, May 2, 2017.
- "Transgender Health Care, Research, and Regulations in the Department of Defense," 4 hour CME Cat I symposium (solo presenter), Department of the Army, Fort Knox, KY, July 25, 2017.
- "Transgender Health in the Prison Setting: Medical and Legal Issues," Oklahoma Department of Corrections statewide training workshop, Oklahoma City, OK, August 21, 2017.
- "Role of the Psychiatrist in the Death Penalty," East Tennessee State University, Department of Psychiatry and Behavioral Sciences, Grand Rounds, Cat I CME, March 30, 2018.
- "A Life of Translational Health Research: From Basements, Prison Cells, and Big Data to

the Courtroom “ (invited presentation), WPATH 25TH Scientific Symposium, Buenos Aires, Argentina, Cat I CME, November 5, 2018.

“Nationwide Transgender Veteran E-Consultation,” WPATH 25th Scientific Symposium, Buenos Aires, Argentina, Cat I CME, November 5, 2018.

“Overview of the Mountain Home/VHA Transgender Veteran Cohort” (invited Plenary Presentation), WPATH 25th Scientific Symposium, Buenos Aires, Argentina, Cat I CME, November 5, 2018.

“Grand Rounds: Diagnosis and Management of Gender Dysphoria,” Ballad Health/Bristol Regional Medical Center (invited presentation), Bristol, TN, Cat I CME, February 5, 2019.

“Medico-Psychiatric-Legal Issues with Transgender Inmates in the Corrections Environment,” invited four hour CME workshop, Idaho Department of Corrections, Boise, Idaho, April 10, 2019.

“Veterans and Gender Dysphoria,” invited presentation, Rotary Club of Johnson City, Johnson City, TN, August 12, 2019.

“Gender Dysphoria: Forensic Psychiatry Issues,” invited Grand Rounds presentation, New York Medical College, Westchester, NY, Cat I CME, March 24, 2020.

“Role of the Psychiatrist In The Death Penalty,” Psychiatry Grand Rounds, East Tennessee State University, Johnson City, TN, Cat 1 CME, Aug 14, 2020

SYMPOSIA ORGANIZED AND/OR MODERATED:

1. Psychosocial Aspects of HIV Disease in the Military, organizer/moderator/ presenter, Wichita Falls, Texas, 25 April, 1990.
2. Full Day Roundtable Symposium on Atypical Antipsychotics, organizer/moderator, Excerpta Medica, Asheville, North Carolina, 22 April, 1995.
3. Mountain Update on Anxiety Disorders, Course Director, East Tennessee State University, Blowing Rock, North Carolina, 28-29 April, 1995.
4. Medicine and Sexuality Course, Course Director, East Tennessee State University and James H. Quillen VAMC, Johnson City, TN, 13 June, 1997.
5. Half Day audiotaped symposium moderator/organizer on Innovative Uses of Atypical Antipsychotics, Excerpta Medica, Blackberry Inn, Townsend, TN, 16 November, 1997.
6. Novel Uses of Atypical Antipsychotics, Symposium Moderator, Marriot Griffin Resort, Janssen Research Foundation, Lexington, KY, 4 December, 1998.
7. Novel Uses of Atypical Antipsychotics, Symposium Moderator, Blackberry Inn, Townsend, TN, 10 April, 1999.
8. Psychiatry and Neurology Poster Session Moderator for Southern Medical Association’s 97th Annual Scientific Assembly, Atlanta, Georgia, November 6, 2003.
9. Moderator for East Tennessee State University Department of Psychiatry monthly Journal Club/Critical Evaluation of the Literature series, 2002-2011.
10. Chairman’s Rounds Program, Mountain Home VA/ETSU Department of Psychiatry, monthly live patient interview series, 2014-present.

TELEVISED and TAPED MEDIA EVENTS:

WKPT local television interview on sleep disorders, Johnson City, 1995.

TNN (The Nashville Network), filmed winning an international revolver competition and then interviewed on silhouette handgun shooting, Oakridge, TN, 1998.

CME, Inc. audiotaped faculty presentations as advertised in "Psychiatric Times," various cities and topics.

Channel 5, London, England; documentary on psychiatric aspects of firearms, 2004.

"Cruel and Unusual", documentary on transgender health care issues in the prison setting, 2005 release, available from jbaus@aol.com; aired on Women's Entertainment channel on July 2, 2007

ABC 20/20, "Becoming Diane" segment on gender identity disorders, October 12, 2005.

The Carter Jenkins Center, www.thecjc.org, taped CME cat I lecture available on the internet, "Evaluation and Management of Gender Identity Disorder," January 6, 2006.

CNN, Kosilek Trial testimony/interview, June 1, 2006.

CNBC, "The Big Idea with Donny Deutsch," interview, June 6, 2006.

PBS News Hour, Transgender Soldiers Gain Ground as US Military Transitions, May 9, 2016, <http://www.pbs.org/newshour/bb/transgender-soldiers-gain-ground-as-u-s-military-transitions/>

Multiple Psychiatry Grand Rounds completed at ETSU, 2010-present, available on line at the ETSU CME Office website, www.etsu.edu/CME and on Youtube.

RESEARCH PROJECTS AND GRANT SUPPORT:

Principal Investigator, "Phase III Comparison of Two Doses of Risperidone For Acute Exacerbations of Chronic Schizophrenia." Inpatient setting, grant support from Janssen Pharmaceutica, approximately \$50,000. Completed 1996.

Principal Investigator, Sexual Functioning and Personality Characteristics of Transgendered Men in a Nonclinical Setting. Collaboration with Tom Wise, M.D. (Chair, Dept. of Psychiatry, Fairfax Hospital, Falls Church, VA), Peter Fagan, Ph.D. (Johns Hopkins Sexual Behaviors Consultation Unit), and Paul Costa, Ph.D. (NIMH). Completed 1990-1995.

DSM-IV Reliability Field Trials, Site Coordinator, 10 investigators, completed in 1995.

Principal Investigator, Psychosocial Adjustment of Spouses of Transgendered Men; study involving long-term support group work and nationwide questionnaire data collection from 1986 to 1997. Completed. Private non-profit organization grant support received.

Coinvestigator, International Study of 800 Transgender Men: The Boulton and Park Experience. 1988-1992. This was the largest community based survey study of transgender people in the U.S. conducted to date. Completed.

Principal Investigator, "A Double-Blind, Placebo-Controlled, Dose-Response Comparison of the Safety and Efficacy of Three Doses of Sertindole and Three Doses of Haloperidol in Schizophrenic Patients." Phase III trial, inpatient setting. Grant support by Abbott Laboratories, approximately \$60,000 over one year. Completed 1994-1995. Contributed to FDA consideration

of Serlect for U.S. marketing, 1996-1997.

Principal Investigator, "An Open Label, Long Term, Safety Study of Sertindole in Schizophrenic Patients." Phase II trial, outpatient setting. Grant support from Abbott Laboratories, approximately \$50,000 over two years. Completed 1996.

Principal Investigator, "Biopsychosocial Natural History Study of HIV Infection in the USAF." RO-1 equivalent grant from Henry M. Jackson Foundation for the Advancement of Military Medicine, approximately \$2,000,000. Completed 1987-1993, including pilot data collection.

Unrestricted Educational Grants, \$19,000, for Mountain Update on Anxiety Disorders CME conference (SKB, Lilly, Mead-Johnson), 1995.

Unrestricted Educational Grants totaling approximately \$30,000 annually in support of the VAMC/ETSU Psychiatry Grand Rounds and Visiting Professor Program, 1994-2000; 2002-2006. Grant funding following CME guidelines and administered through the ETSU Office of Continuing Education.

Principal Investigator, "Double-Blind Crossover Study of Zolpidem and Temazepam in Elderly, Hospitalized Patients." Funded through Psychiatry Research Fund, Mountain Home VAMC, and Chair of Excellence in Geriatrics, ETSU. Approved study, ultimately closed due to lack of appropriate subjects available for recruitment.

Principal Investigator, "A Randomized, Double-Blind Placebo Controlled Study of Risperidone for Treatment of Behavioral Disturbances in Subjects with Dementia." Collaboration with R. Hamdy, Cecile Quillen Chair of Excellence in Geriatrics, approximately \$100,000 at full recruitment, 1995-1997; completed.

Associate Investigator, "Use of Nefazodone in Depressed Women with Premenstrual Amplification of Symptoms: a Pilot Study." Principal Investigator: Merry Miller, M.D. \$5,000 pilot study grant, 1996-1999; completed.

Associate Investigator, "Voice Characteristics Associated with Gender Misidentification: A Pilot Study." Principal Investigator: Robert King, M.A. Unfunded study in data analysis phase, 2001-2005; completed in 2007.

Principal Investigator, Johnson City site, VA Cooperative Study #430, "Reducing the Efficacy-Effectiveness Gap in Bipolar Disorder." Health services research conducted at 12 sites nationwide. Grant for this site's operations total \$435,000 over five years of study, 1997-2003; completed.

Coinvestigator, "Treatment for Erectile Disorder with Viagra in a VA Population: Efficacy and Patient and Partner Satisfaction." Principal Investigator: William Finger, Ph.D. Approximately \$30,000 total grant over two year period, 2000-2001; study concluded.

Principal Investigator, Johnson City site, "A Multicenter, Randomized, Double-Blind, Placebo Controlled Study of Three Fixed Doses of Aripiprazole in the Treatment of Institutionalized Patients with Psychosis Associated with Dementia of the Alzheimer's Type." Phase III clinical trial, sponsored by Bristol-Meyers Squibb, 2000-2001, \$174,000 at full recruitment. Extension phase, 42 weeks, separate grant at maximum of \$232,800. Approved April, 2000; completed.

Coinvestigator, "Effects of zaleplon on postural stability in the elderly." Principal Investigator: Faith Akin, Ph.D. \$1000 grant for subject recruitment expenses, 2000-2001.

Principal Investigator, James H. Quillen VA site, "ZODIAK study; An International, Multicenter Large Simple Trial (LST) To Compare the Cardiovascular Safety of Ziprasidone and Olanzapine."

Pfizer Pharmaceuticals, approximately \$20,000 at full recruitment. Approved April, 2002, recruitment completed and closed in 2004. Results published: Strom B, Eng S, Faich G, et al: comparative mortality associated with ziprasidone and olanzapine in real-world use among 18,154 patients with schizophrenia: The ziprasidone Observational Study of Cardiac Outcomes (ZODIAC). Amer J Psychiatry 168(2):193-201, 2011.

Coinvestigator, "Survey of Family and Systems Aggression Against Therapists." Unfunded study, completed between 2002 and 2003; Randi Ettner, Ph.D., Principle Investigator; completed.

Coinvestigator, "Effect of Olanzapine on the Auditory Gating Deficit in Patients with Schizophrenia." Principal Investigator: Barney Miller, Ph.D. Investigator-initiated study funded by Lilly, approximately \$85,000. 2002. Study did not recruit subjects at ETSU and was closed 2003.

Principal Investigator, multicenter study, "The SOURCE Study: Schizophrenia Outcomes, Utilization, Relapse, and Clinical Evaluation." Janssen Research, \$100,000 grant at full recruitment (two year open label follow-up study of risperidone Consta), 2005-2007; second highest recruitment of 43 centers in multicenter study. Completed. See publications from this study under the Publications section, numbers 128 and 129.

Coauthor on grants to VA Central Office for program enhancements to mental health programs at Mountain Home VAMC; approximately \$2,000,000 received for additional staff and support for residential treatment programs and PTSD clinic expansion, 2006-2007.

Principal Investigator in conjunction with Herbert Meltzer, MD, Vanderbilt University, " High Dose Risperidone Consta for Patients with Schizophrenia with Unsatisfactory Response to Standard Dose Risperidone or Long-Acting Injectable." Phase IV study of outpatients with schizophrenia who are partially responsive to risperidone oral and/or long-acting injectable, using a double-blind methodology to study doses between 50 and 100 mg every two weeks. Site funding of approximately \$100,000. 2008-2010. Approved by ETSU IRB but negotiations between sponsor and Department of Veterans Affairs were not completed on intellectual property rights. Study not initiated at Mountain Home VAMC.

Principal Investigator (Everett McDuffie, MD, coinvestigator), "Descriptive study of veterans with gender identity disturbances: Characteristics and comorbidities, 1987-2007." Unfunded study that is first to characterize a population of 75 U.S. veterans with gender identity disturbances over a 20 year time frame. Completed 2009.

Principal Investigator: "Analysis of State and Federal Prison Directives Related to Transgender Inmate Medical Care and Placement." Unfunded review of existing prison policies through the end of 2007. Completed 2008.

Principal Investigator: "Qualitative Analysis of Concerns of Transgender Inmates in the United States. Unfunded analysis of 129 letters from self-identified transgender inmates across the US." Completed 2012.

Coinvestigator, "Prevalence and Suicidality in Transgender Veterans"; coinvestigator with collaborators at the VA Center of Excellence for Suicide Prevention. 2011-2013. Completed; publication of results in October, 2013.

Principal Investigator, "Assessing Health Outcomes, Health Care Utilization, and Health Disparities in Transgender Veterans Receiving Care in the Veterans Health Administration." Approved by ETSU IRB 7/1/13; protocol remains open. Six manuscripts published; one in preparation.

Consultant, Patient-Centered Outcomes Research Institute grant on transgender healthcare

outcomes (STRONG), Michael Goodman, MD, Principal Investigator, Emory University, 2014-present.

Advisory Board Member, Health Outcomes and Health Care Use Among Transgender Veterans (CDA 14-408), John Blosnich, Principal Investigator, VHA HSR&D Career Development Award, 2016 – 2021, total award: \$863,394

References available upon request.

Exhibit 23(f)

BIBLIOGRAPHY

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2. Paul Albert, *Why Is Depression More Prevalent In Women?*, 40 *Journal of Psychiatry & Neuroscience* 219-221 (2015).
3. Anthony N. Almazan & Alex S. Keuroghlian, *Association Between Gender-Affirming Surgeries and Mental Health Outcomes*, *JAMA Surgery* (2021). doi: 10.1001/jamasurg.2021.0952.
4. American Medical Association, *Resolution 122 (A-08)* (2008), <http://www.imatyfa.org/assets/ama122.pdf>.
5. American Psychiatric Association, *Gender Dysphoria* (2013), https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf.
6. American Psychiatric Association, *Position Statement on Access to Care for Transgender and Gender Variant Individuals* (2012).
7. American Psychiatric Association, *Position Statement on Discrimination Against Transgender & Gender Variant Individuals* (2012).
8. American Psychological Association, *Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination* (2009).
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10. APA Dictionary of Psychology, 2nd ed. Apa.org (2015), <https://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf>.
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13. Aetna, *Gender Affirming Surgery*, http://www.aetna.com/cpb/medical/data/600_699/0615.html.
14. Greta R. Bauer et al., *Intervenable Factors Associated With Suicide Risk in Transgender Persons: A Respondent Driven Sampling Study in Ontario, Canada*, 15 *BMC Public Health* 215 (2015).
15. Reginald F. Baugh et al., *Clinical Practice Guideline: Tonsillectomy in Children*, S1 *Otolaryngology–Head and Neck Surgery* (2011).
16. Hans Berglund et al., *Male-to-Female Transsexuals Show Sex-Atypical Hypothalamus Activation When Smelling Odorous Steroids*, 18 *Cerebral Cortex* 1900-1908 (2008).
17. John R. Blosnich et al., *Mortality Among Veterans with Transgender-Related Diagnoses in the Veterans Health Administration, FY2000–2009*, 1 *LGBT Health* 269-276 (2014).
18. Blue Cross Blue Shield of North Carolina, Corporate Medical Policy, *Gender Affirmation Surgery and Hormone Therapy* (2021).
19. Iris Wagman Borowsky et al., *Suicide Attempts Among American Indian and Alaska Native Youth*, 153 *Archives of Pediatrics & Adolescent Medicine* 573-580 (1999).
20. Richard Bränström & John E. Pachankis, *Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study*, 177 *American Journal of Psychiatry* 727-734 (2020). doi: 10.1176/appi.ajp.2019.19010080.
21. Correction to Bränström and Pachankis, 177 *American Journal of Psychiatry* 734-734 (2020). doi: 10.1176/appi.ajp.2020.1778correction.
22. George R. Brown, *A Review of Clinical Approaches to Gender Dysphoria*, 51 *The Journal of Clinical Psychiatry* 57-64 (1990).
23. George R. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder*, 12 *International Journal of Transgenderism* 31-39 (2010).
24. George R. Brown, *Breast cancer in transgender veterans: A ten case series*, 2(1) *LGBT Health*, 77-80 (2015).

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139. Medical records for the transgender plaintiffs in this matter.

Exhibit 24

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

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MAXWELL KADEL, et al., :
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Plaintiffs, : No. 1:19-CV-272
: LCB-LPA
vs. :
:
DALE FOLWELL, et al., :
:
Defendants. :

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DEPOSITION OF LOREN SCHECHTER, M.D.
(Taken by the Defendants)
Morton Grove, Illinois
August 24, 2021

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Reported by: Jackie J. Johnson
Court Reporter
Notary Public

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- - -

Deposition of LOREN SCHECHTER, M.D., taken by the
Defendants in Chicago, Illinois, on the 24th day of
August, 2021 at 10:27 a.m., before Jackie J. Johnson,
Court Reporter and Notary Public.

C O N T E N T S

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The Witness: LOREN SCHECHTER, M.D.

By Mr. Knepper.....6

By Mr. McInnes.....132

By Mr. Knepper.....142

I N D E X O F T H E E X H I B I T S

For the Defendants

Exhibit 1 Curriculum Vitae.....15

Exhibit 2 Curriculum Vitae and attached Rebuttal
Report.....15

Exhibit 3 DSM-5 on Gender Dysphoria.....25

Exhibit 4 Expert Disclosure Report of Loren
S. Schechter, M.D. 3/1/20.....40

Exhibit 5 Article titled Guiding the Conversation
Types of Regret After Gender-Affirming
Surgery and Their Associated
Etiologies.....61

Exhibit 6 Article titled Reduction in Mental
Health Utilization Among Transgender
Individuals After Gender-Affirming
Surgeries: A Total Population

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2
3
4
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6
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8
9
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Study.....78

Exhibit 7 Expert Rebuttal Report of Loren S.
Schechter, M.D. 6/1/21.....84

Exhibit 8 Letters to the Editor.....87

Exhibit 9 Long-Term Follow-Up of Transsexual
Persons Undergoing Sex Reassignment
Surgery: Cohort Study in Sweden....93

1 A. It has. It's been signed and executed, yes.

2 Q. By you and Rush University; is that correct?

3 A. That is correct.

4 Q. Do you have possibly a copy of that contract,
5 Doctor Schechter?

6 A. I'll have to look. That may be under a
7 Confidentiality Agreement with the University.

8 Q. Thank you.

9 So I want to start with a couple of sort of
10 broader questions related to the medical treatment for
11 the Plaintiffs in this case.

12 Doctor Schechter, what is gender dysphoria?

13 A. Gender dysphoria relates to the distress
14 experienced by individuals, transgender individuals,
15 related to the incongruence between one's body, meaning
16 their physical anatomy, and their gender identity.

17 Q. Is gender dysphoria a psychiatric diagnosis?

18 A. It is a medical condition.

19 Q. It's a medical condition.

20 So are you testifying that it is not a
21 psychiatric illness?

22 A. I'm testifying that it's a medical condition.

23 Q. And what is a medical condition --

24 A. A medical condition --

25 Q. -- as the term's described by you?

Exhibit 24(a)

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, *et al.*,

Defendants.

No. 1:19-cv-00272-LCB-LPA

**EXPERT DISCLOSURE REPORT OF
LOREN S. SCHECHTER, M.D.**

I. PRELIMINARY STATEMENT

1. I am a board-certified plastic surgeon. I specialize in performing gender confirming surgeries (including chest reconstruction surgeries, genital reconstruction surgeries, and other procedures to feminize or masculinize the face and body, as described in more detail below), and I am a recognized expert in this field.

2. I have been retained by counsel for Plaintiffs in the above-captioned lawsuit to provide an expert opinion on: 1) the standards of care for treating individuals diagnosed with gender dysphoria; 2) the safety, efficacy, and cost of gender confirming surgeries as treatment for gender dysphoria; 3) the similarities between surgical techniques to treat gender dysphoria with those utilized for surgical treatment of other diagnoses; and 4) whether the categorical exclusion of transition-related surgical care in the North Carolina State Health Plan for Teachers and State Employees is consistent with the standards of

care for treating transgender individuals diagnosed with gender dysphoria.

3. I refer to the family of procedures discussed in this report as “gender confirmation,” “gender confirming surgeries,” or “gender affirming surgeries” because they are one of the therapeutic tools used to enable people to be comfortable living in accordance with their gender identities. Out of the myriad of labels I’ve heard for these procedures—“sex reassignment surgery,” “gender reassignment surgery,” and “sex change operation,” to name but a few—none is as accurate when it comes to describing what is actually taking place as “gender confirmation” or “gender affirmation surgery.” Most, if not all, of the other names used for these procedures suggest that a person is making a choice to switch genders, or that there is a single “surgery” involved. From the hundreds of discussions I have had with patients over the years, nothing could be further from the truth. This is not about choice; it is about using one or more surgical procedures as therapeutic tools to enable people to live authentically.

II. BACKGROUND AND QUALIFICATIONS

A. Qualifications

4. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae (“CV”). A true and correct copy of my most up-to-date CV is attached as Exhibit A.

5. I received my medical degree from the University of Chicago, Pritzker School of Medicine. I completed my residency and chief residency in plastic and reconstructive surgery and a fellowship in reconstructive microsurgery at the University

of Chicago Hospitals.

6. I am currently a Clinical Professor of Surgery at the University of Illinois at Chicago and an attending surgeon at Rush University Medical Center, where I hold the title of adjunct assistant professor surgery. I also maintain a clinical practice in plastic surgery in Illinois where I treat patients from around the country, as well as from around the world.

7. I have been performing gender confirming surgeries for nearly 25 years. For at least the past five years, I have been performing approximately 150 gender confirmation procedures every year. I have performed over 1,000 gender confirmation surgeries during my medical career. Currently, approximately 90 percent of the patients in my clinical practice are transgender individuals seeking gender confirmation surgeries.

8. I was a contributing author to the Seventh Version (current) of the World Professional Association for Transgender Health's ("WPATH") Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People ("Standards of Care"). In particular, I wrote the section focused on the relationship of the surgeon with the treating mental health professional and the physician prescribing hormone therapy. WPATH is in the midst of drafting the eighth version of the Standards of Care, and I am the co-lead author of the surgical and postoperative care chapter.

9. The Standards of Care provide clinical guidance for health professionals based on the best available science and expert professional consensus. The purpose of the Standards of Care is to assist health providers in delivering medical care to transgender

people in order to provide them with safe and effective pathways to achieving lasting personal comfort with their gendered selves and to maximize their overall health, psychological well-being, and self-fulfillment.

10. In addition, I have written a number of peer-reviewed journal articles and chapters in professional textbooks about gender confirmation surgeries. In 2016, I published *Surgical Management of the Transgender Patient*, the first surgical atlas (a reference guide for surgeons on how to perform surgical procedures using safe, well-established techniques) dedicated to gender confirming surgeries. In 2020, I published a guide for surgeons entitled *Gender Confirmation Surgery: Principles and Techniques for an Emerging Field*. A full and complete list of my publications is included in my CV.

11. I am a guest reviewer for several peer-reviewed medical journals, including the *Journal of Plastic and Reconstructive Surgery*, the *Journal of Reconstructive Microsurgery*, the *Journal of the American College of Plastic Surgeons*, the *Journal of Plastic and Reconstructive Surgery*, *The Journal of Plastic and Aesthetic Research*, and the *Journal of Sexual Medicine*. I also serve on the editorial board of both *Transgender Health* and the *International Journal of Transgender Health*. Each of these publications is a peer-reviewed medical journal. A full and complete list of my reviewerships and editorial roles is included in my CV.

12. I am actively involved in training other surgeons to perform gender confirmation surgeries. In 2017, I started the surgical fellowship in gender surgery, now placed at Rush University Medical Center in Chicago. I am also the Medical Director of

the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. I am a co-investigator on a study regarding uterine transplantation for transgender women.

13. I have given dozens of public addresses, seminars, and lectures on gender confirming surgery, including many through the American Society of Plastic Surgeons. I have also taught a number of courses through WPATH's Global Education Initiative, which provides training courses toward a member certification program in transgender health for practitioners around the world. In addition, in 2018, I co-directed the first live surgery course in gender confirming procedures at Mount Sinai Hospital in New York City. In 2019, I directed the inaugural Gender Affirming Breast, Chest, and Body Master Class for the American Society of Plastic Surgeons.

14. I am also a founding member and president of the American Society of Gender Surgeons; a current member of the Executive Committee of the Board of Directors of the World Professional Association for Transgender Health, where I serve as treasurer; and a former member of the Board of Governors of the American College of Surgeons. I have been an invited discussant at the Pentagon regarding transgender servicemembers.

B. Compensation

14. I am being compensated at an hourly rate of \$400/hour plus expenses for my time spent preparing written testimony and reports, and providing local testimony (including deposition or providing hearing testimony by telephone or video-teleconference). I will be compensated a flat daily rate of \$7,500 for any out-of-town

deposition or hearing testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

C. Previous Testimony

15. Over the past four years, I have given expert testimony at trial or by deposition in the following cases:

- *Willis v. Flagg*, Cook County, IL (trial)
- *Bruce v. South Dakota*, D. S.D. (deposition)
- *Boyden v. State of Wisconsin*, W.D. Wis. (deposition)

To the best of my recollection, I have not given expert testimony at a trial or at a deposition in any other case during this period.

III. BASIS FOR OPINIONS

16. My opinions contained in this report are based on all of the following: (1) my clinical experience of nearly 25 years of caring for transgender individuals; (2) my review and familiarity with relevant peer-reviewed literature;¹ and (3) discussions with colleagues and other experts in the field, including attendance and participation in various

¹ I regularly and routinely perform literature searches as an educator, including in my roles as clinical professor of surgery at the University of Illinois and attending surgeon at Rush University, where I participate in fellow, resident, and student education; Director of the Center for Gender Confirmation Surgery at Weiss Memorial Hospital; lecturer for the Global Education Initiative for WPATH; invited lecturer at national and international conferences; co-lead author of the surgery and post-operative care chapter of the upcoming WPATH Standards of Care Version 8; an editor and reviewer for peer-reviewed publications; and a course director for various educational opportunities for WPATH, American Society of Plastic Surgeons, and other organizations.

educational conferences both nationally and internationally. The research I relied on in preparing this report is cited in the footnotes and detailed in the reference list attached as Exhibit B to this report.

IV. DISCUSSION

A. Background on Gender Identity and Gender Dysphoria

17. The term “transgender” is used to describe a diverse group of individuals whose gender identity, or internal sense of gender, differs from the sex they were assigned at birth.

18. Many transgender individuals experience gender dysphoria at some point in their lives. Gender dysphoria is a serious medical condition, defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) published by the American Psychiatric Association as “a difference between one’s experienced/expressed gender and assigned gender, and significant distress or problems functioning.” Gender dysphoria is also recognized by the International Classification of Diseases-11 (ICD-11), under the label of gender incongruence, and the International Classification of Diseases-10 (ICD-10). Individuals diagnosed with gender dysphoria have an intense and persistent discomfort with the primary and/or secondary sex characteristics of the sex they were assigned at birth. Gender dysphoria can lead to debilitating anxiety and depression, as well as serious incidents of self-harm, including self-mutilation, suicide attempts, and suicide.

19. Appropriate medical care, including mental health services, hormone

therapy, and gender confirmation surgeries can help alleviate gender dysphoria. Gender confirmation surgeries, which bring a person's body into better alignment with their gender identity, have been shown to be an effective treatment for gender dysphoria.

B. Gender Confirming Surgeries are Standard, Medically Accepted, and Medically Necessary Treatments for Gender Dysphoria for Many Transgender People

20. It is my professional opinion, supported by the prevailing consensus of the medical community, that procedures used to treat gender dysphoria are medically necessary treatments for many transgender individuals; these procedures are properly considered as medically necessary, and are not cosmetic in nature; and these procedures are safe and effective treatments for gender dysphoria.

1. *Applicable Standards of Care for Treating Gender Dysphoria*

21. WPATH is a non-profit professional and educational organization devoted to transgender health. WPATH's mission is "to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health."² WPATH publishes the Standards of Care. The Standards of Care are based on the best available scientific evidence and expert professional consensus. WPATH published the first version of the Standards of Care in 1979. Since that time, the guidelines have been updated through seven versions, reflecting the significant advances made in the understanding, management, and care of transgender individuals. The Standards of Care are widely

² WPATH, Mission and Vision, <https://www.wpath.org/about/mission-and-vision>.

recognized guidelines for the clinical management of transgender individuals with gender dysphoria. Most surgeons who regularly treat individuals experiencing gender dysphoria, including myself, practice in accordance with the Standards of Care.

22. As indicated in the Standards of Care, effective treatment options for gender dysphoria include mental health care, hormone therapy, and various surgical procedures to align a person’s primary and/or secondary sex characteristics with the person’s gender identity. (Standards of Care at 9-10). Surgery is often the last and most considered of the treatment options for gender dysphoria in transgender individuals. Not every transgender person wants, requires, or qualifies for every available surgical procedure. In fact, the Standards of Care note that “[t]he number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.” (Standards of Care at 58). Evidence shows that while some transgender individuals do not require surgery, “for many others surgery is essential and medically necessary to alleviate their gender dysphoria. For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.” (Standards of Care at 54-55).

23. The Standards of Care set forth criteria for initiation of surgical treatment. The Endocrine Society—the leading professional organization devoted to research on hormones and the clinical practice of endocrinology—has also issued clinical guidelines

for the treatment of transgender individuals.³ The guidelines indicate, that for many transgender individuals, gender confirming surgeries are necessary and effective treatments.⁴

24. The broader medical community, including the American Medical Association, American Psychological Association, American Psychiatric Association, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, and World Health Organization, recognizes that gender confirming surgeries are standard, appropriate, and necessary treatments for many people with gender dysphoria.

2. *Surgical Treatments for Gender Dysphoria*

25. For transgender women, surgical treatment options that are generally accepted in the medical community and are consistent with the Standards of Care include, but are not limited to:

- Chest reconstruction surgery: augmentation mammoplasty (breast implants);
- Genital reconstruction surgeries: penectomy (removal of the penis), orchiectomy (removal of the testes), vaginoplasty, clitoroplasty, and/or vulvoplasty (creation of female genitalia including the labia minora and majora);
- Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), and hair reconstruction, among others.

³ Wylie C Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clin. Endocrinology & Metabolism 3869 (2017).

⁴ *Id.*

26. For transgender men, surgical treatment options that are generally accepted in the medical community and are consistent with the Standards of Care include, but are not limited to:

- Chest reconstruction surgery: subcutaneous mastectomy, creation of a male chest;
- Genital surgery: hysterectomy/oophorectomy, reconstruction of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;
- Non-genital, non-breast surgical interventions: liposuction, lipofilling, pectoral implants, various aesthetic procedures, and sometimes voice surgery (rare).

3. *Gender Confirmation Surgeries are Medically Necessary, Not Cosmetic*

26. The medical community and insurance providers recognize a distinction between surgery which is medically necessary, and cosmetic surgery, which generally is not. No particular procedure is inherently cosmetic or inherently medically necessary; rather, the underlying diagnosis determines whether the procedure is considered cosmetic or medically necessary.

27. With respect to surgical treatments for gender dysphoria, the medical community generally consider those surgeries to be medically necessary. This is true even though the same surgical procedures might be considered cosmetic when performed on someone without a diagnosis of gender dysphoria. Gender confirming surgeries are not cosmetic because, when performed in accordance with the Standards of Care, they are clinically indicated to treat the underlying medical condition of gender dysphoria. Indeed, as explained further below, the surgical procedures listed above to treat gender dysphoria

are similar to surgical procedures performed for other diagnoses (e.g., breast cancer). Because these medically necessary procedures help transgender individuals live and present in a manner more consistent with their gender identity and therefore reduce and/or treat their gender dysphoria, the professional medical consensus is that these are appropriately categorized as medically necessary.

28. Certain surgical procedures are medically necessary when used to treat gender dysphoria or another medical condition, but are cosmetic when they are used only to alter one's appearance without an underlying medical diagnosis (e.g., a non-transgender woman obtaining a breast augmentation for aesthetic reasons). While the procedures themselves are technically similar, the reasons for performing the procedures are not.

C. Gender Confirming Surgeries are Safe, Effective, and Cost Efficient

29. The prevailing peer-reviewed clinical research, as well as my own clinical expertise as a plastic surgeon specializing in gender confirmation surgeries, shows that surgical procedures for gender dysphoria are safe, effective, and cost efficient; and that many of these procedures are analogous to surgical procedures used to treat other medical conditions.

1. Gender Confirming Surgeries are Safe

30. It is my professional opinion, based on my clinical experience and review of available peer-reviewed research, that gender confirmation surgeries are safe. Notably, when performing gender confirmation surgeries, surgeons use many of the same

procedures that they use to treat other medical conditions. The fact that the medical community deems these analogous procedures sufficiently safe to treat conditions other than gender dysphoria is by itself more than sufficient to support the safety of those surgeries to treat gender dysphoria. There is no medical basis to conclude that the same surgical procedures are more or less safe simply because they are used to treat gender dysphoria, versus other underlying medical conditions.

31. For example, surgeons regularly perform mastectomies and chest/breast reconstruction, hysterectomies/salpingo-oophorectomies (which includes removal of the fallopian tubes and ovaries), and orchiectomies to treat individuals with cancer, or a genetic predisposition to cancer (BRCA 1, 2 genes in the case of prophylactic mastectomy or oophorectomy). Similarly, surgeons perform procedures to reconstruct external genitalia for individuals who have certain medical conditions (e.g., cancer) or who have suffered traumatic injuries or disabling infections to their genitalia. This would include procedures to correct conditions such as hypospadias (a disorder in which the urinary opening is not in the typical location on the glans penis), epispadias (a condition where the urethra is not properly developed), exstrophy (where the bladder develops outside the fetus), fournier's gangrene (where tissue dies because of an infection), penile webbing, or buried penis (which can occur as a result of obesity, diabetes, or recurrent infections). This would also include procedures to correct conditions such as congenital absence of the vagina or reconstruction of the vagina/vulva following oncologic resection, traumatic injury, or infection.

2. *Gender Confirmation Surgeries Effectively Treat Gender Dysphoria*

32. It is my professional opinion, based on decades of clinical experience, as well as a substantial body of peer-reviewed research, that standard medical surgical treatments for gender dysphoria are effective when performed in accordance with the Standards of Care.

33. Peer-reviewed studies find that transgender women who undergo one or more gender confirmation surgeries report positive health outcomes. For example, a peer-reviewed study of transgender women found that those who underwent breast reconstruction surgeries experienced statistically significant improvements in their psychosocial well-being.⁵ Another peer-reviewed study of transgender women who had vaginoplasty found that study participants' mean improvement in quality of life after surgery was 7.9 on a scale from one to ten.⁶ Another study of transgender women found that surgical interventions were highly correlated with alleviating gender dysphoria.⁷ A recent literature review concluded that in appropriately selected individuals, gender

⁵ Weigert, R., Frison, E., Sessiecq, Q., Mutairi, K. A., & Casoli, V. (2013). Patient Satisfaction with Breasts and Psychosocial, Sexual, and Physical Well-Being after Breast Augmentation in Male-to-Female Transsexuals. *Plastic and Reconstructive Surgery*, 132(6), 1421-1429. doi:10.1097/01.prs.0000434415.70711.49.

⁶ Horbach, S. E. R., Bouman, M., Smit, J. M., Ozer, M., Buncamper, M. & Mullender, M. G. (2015). Outcome of Vaginoplasty in Male-to-Female Transgenders: A Systematic Review of Surgical Techniques.

⁷ Hess, J., Neto, R., Panic, L., Rubben, H. & Senf, W. (2014). Satisfaction with Male-to-Female Gender Reassignment Surgery. (Among survey respondents, the majority (90.2%) said that that their expectations for life as a woman were fulfilled after surgery. A similarly high percentage (85.4%) saw themselves as women.)

confirmation surgery is effective at improving quality of life, overall happiness, and sexual functioning in transgender women who are diagnosed with gender dysphoria.⁸ Another recent post-operative and six-month follow-up survey of transgender female patients found improvements in quality of life in a significant majority of patients.⁹

34. The available peer-reviewed literature likewise concludes that when performed in accordance with the prevailing standards of care, male chest reconstruction surgery is safe and effective in alleviating gender dysphoria. For example, one study found that transgender men who received chest reconstruction experienced few clinical complications and were overwhelmingly satisfied with their surgical outcomes.¹⁰ Another peer-reviewed study of transgender men who received chest reconstruction found that the procedure improved psychosocial well-being and physical well-being among

⁸ Hadj-Moussa, M., et al. Feminizing Genital Gender-Confirmation Surgery, 2018, 1-14. 2018 Jul;6(3):457-468.e2. doi: 10.1016.

⁹ Papadopulos, N.A., et al. Male-to-Female Sex Reassignment Surgery Using the Combined Technique Leads to Increase Quality of Life in a Prospective Study. *Plast Reconstr Surg.* 2017 Aug;140(2):286-294. doi: 10.1097.

¹⁰ Frederick, M. et al., (2017), Chest Surgery in Female to Male Transgender Individuals, *Annals of Plastic Surgery*, 78(3), 249-253.

participants.¹¹ Numerous other studies have reached similar conclusions.¹² These findings extend to adolescents; for example, a recent study in JAMA Pediatrics concluded that: “Chest dysphoria was high among presurgical transmasculine youth, and surgical intervention positively affected both minors and young adults.”¹³

35. The overwhelming majority of patients who obtain gender confirmation surgery in a manner consistent with the Standards of Care are both satisfied and experience a reduction of gender dysphoria. For the vast majority of transgender people who seek such surgery, the surgery is successful at treating gender dysphoria and alleviating a lifelong struggle to find peace of mind and comfort with their bodies.

3. Gender Confirmation Surgeries are Cost Efficient

36. When billing insurers for reimbursement, health care providers use Current Procedural Terminology (CPT) codes, which are developed and maintained by the American Medical Association. The same code or codes may apply to a particular

¹¹ Agarwal, C. et al., (2018). Quality of life improvement after chest wall masculinization in female-to-male transgender patients: A prospective study using the BREAST-Q and Body Uneasiness Test, 71, 651-657.

¹² E.g., Olson-Kennedy, J. et al., (2018), Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults, JAMA Pediatrics, 172(5), 431-436; Van de Grift, T., et al., (2017), Surgical Indications and Outcomes of Mastectomy in Transmen: A Prospective Study of Technical and Self-Reported Measures. Plastic and Reconstructive Surgery, 140(3), 415e-424e. doi:10.1097/PRS.0000000000003607; Berry, M.G. et al., (2012), Female-to-male transgender chest reconstruction: A large consecutive, single-surgeon experience. Journal of Plastic, Reconstructive & Aesthetic Surgery 65, 711-719.

¹³ Olson-Kennedy, J. *supra* at n. 12. Additionally, Frederick et al., *supra* at n. 10, included adolescents aged 15-17, as well as adults.

procedure regardless of whether the procedure is performed on a transgender patient or a non-transgender patient. For example, vaginoplasty may be performed for a non-transgender woman as treatment for congenital absence of the vagina or for a transgender woman with gender dysphoria. The same CPT code(s) may be used for both procedures. The same is true for a subcutaneous mastectomy, which may be performed for a non-transgender woman to reduce her risk of breast cancer or for a transgender man with gender dysphoria.

37. Researchers affiliated with the Johns Hopkins Bloomberg School of Public Health, the Commonwealth of Massachusetts Group Insurance Commission, and the University of Colorado, found access to gender confirmation surgeries through insurance to be a likely cost-effective treatment long-term.¹⁴ Gender confirmation surgery typically results in, at a minimum, a significant reduction of gender dysphoria. Transgender people with gender dysphoria who, for lack of insurance access, are unable to obtain gender confirmation surgeries tend to have higher rates of negative health outcomes such as depression, HIV, drug abuse, and suicidality. These researchers found that the one-time costs of gender confirmation surgeries coupled with standard post-operative care, primary and maintenance care, were overall less expensive at 5- and 10-year marks, as compared to the long-term treatment of the negative health outcomes associated with lack of

¹⁴ William V Padula, Shiona Heru & Jonathan D Campbell, Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis, *J Gen Intern Med*, 31(4), 394–401 (2015). doi: 10.1007/s11606-015-3529-6.

insurance and resulting healthcare access.¹⁵ Similarly, a RAND Corporation study reported findings that due to discrimination, lack of insurance, and problematic interactions with providers, transgender people often avoid seeking treatment for gender dysphoria and other more common health issues. This avoidance resulted in negative healthcare outcomes and greater potential costs related to treating to those outcomes in the long-term.¹⁶ Additionally, this research confirms that coverage for gender confirmation surgeries is affordable and a nominal percentage of the care offered through group health plans.

V. SUMMARY OF OPINIONS AND CONCLUSIONS

38. Based on nearly 25 years of clinical experience performing gender confirmation procedures and caring for transgender individuals, my knowledge of the standards of care and relevant peer-reviewed literature, and my discussions and interactions with experts throughout the world, it is my professional opinion that gender confirmation surgeries are a safe, effective, and medically necessary treatments for gender dysphoria in many transgender individuals. In my experience, the overwhelming number of individuals who undergo gender confirmation procedures describe relief and/or reduction of their gender dysphoria and improvement in their quality of life and overall

¹⁵ *Id.* at 398.

¹⁶ Schaefer, Agnes Gereben, Radha Iyengar Plumb, Srikanth Kadiyala, Jennifer Kavanagh, Charles C. Engel, Kayla M. Williams, and Amii M. Kress, *The Implications of Allowing Transgender Personnel to Serve Openly in the U.S. Military*. Santa Monica, CA: RAND Corporation, 2016. https://www.rand.org/pubs/research_briefs/RB9909.html.

functioning.

39. Furthermore, based on my clinical and professional experience and my ongoing review of the literature, it is my professional opinion that the denial of necessary medical care is likely to perpetuate gender dysphoria and create or exacerbate other medical issues, such as depression and anxiety, leading to an increased possibility of self-harm, negative health outcomes, and even suicide.

40. In conclusion, it is my professional opinion that the categorical exclusion of transition-related surgical care in the North Carolina State Health Plan for Teachers and State Employees is 1) inconsistent with the Standards of Care for treating transgender individuals diagnosed with gender dysphoria, 2) inconsistent with the peer-reviewed scientific and medical research demonstrating that gender confirmation surgeries are safe, effective, and more cost efficient treatments for gender dysphoria over the long-term, 3) and inconsistent with expert medical and surgical consensus. To the extent the exclusion is premised on the assumption that gender confirmation surgical care is not medically necessary, that assumption is wrong. The Standards of Care confirm, based on clinical evidence, that gender confirmation surgeries are medically necessary to help people alleviate the often serious and life-threatening symptoms of gender dysphoria.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed this 28th day of February, 2021.

loren s schechter

Loren S. Schechter, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on March 1, 2021, I caused a copy of the foregoing document and all attachments to be served upon the following parties via email:

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Exhibit B

References

1. Agarwal, A. et al., (2018). Quality of life improvement after chest wall masculinization in female-to-male transgender patients: A prospective study using the BREAST-Q and Body Uneasiness Test, 71, 651-657.
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9. Science AMA Series: I'm Cecilia Dhejne a fellow of the European Committee of Sexual Medicine, from the Karolinska University Hospital in Sweden. I'm here to talk about transgender health, suicide rates, and my often misinterpreted study. Ask me anything!, *Reddit.com*, July 27, 2017 05:14, 30Thttps://www.reddit.com/r/science/comments/6q3e8v/science_ama_series_im_cecilia_dhejne_a_fellow_of30T.
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Exhibit 24(b)

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, *et al.*,

Defendants.

No. 1:19-cv-00272-LCB-LPA

**EXPERT REBUTTAL REPORT OF
LOREN S. SCHECHTER, M.D.**

I, Loren S. Schechter, M.D., declare as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
2. I previously submitted an expert witness report in this case (“Schechter Report”). I submit this report to respond to points raised in the declarations of Patrick W. Lappert, M.D. (“Lappert Decl.”), Stephen B. Levine, M.D. (“Levine Decl.”), Paul W. Hruz M.D. (“Hruz Decl.”), and Paul R. McHugh, M.D. (“McHugh Decl.”) which defendants provided.
3. My background, qualifications, and compensation for my services in this case, and the bases for my opinions in this case are described in my original report. In preparing this report, I was provided with and reviewed the declarations from defendants described above and the accompanying exhibits.

4. My opinions contained in this report are based on my professional background as described in my updated curriculum vitae (attached as Exhibit A); my clinical experience of nearly 25 years of caring for transgender individuals; my review and familiarity with relevant peer-reviewed literature, including my own research;¹ and discussions with colleagues and other experts in the field, including attendance and participation in various educational conferences both nationally and internationally. The research I relied on in preparing this report is cited in my curriculum vitae, my original expert report, and the sources cited herein and my bibliography.²

5. Since the disclosure of my original declaration on February 28, 2021, there have been several relevant peer reviewed articles published, including some which I have co-authored. An updated bibliography including these new references and others that are relevant to the opinions below is attached as Exhibit B to this report.

¹ As mentioned in my original report, I regularly and routinely perform literature searches in my academic roles at the University of Illinois, Chicago and Rush University; and as Director of the Center for Gender Confirmation Surgery at Weiss Memorial Hospital; lecturer for the Global Education Initiative for WPATH; invited lecturer at national and international conferences; co-lead author of the surgery and post-operative care chapter of the upcoming WPATH Standards of Care Version 8; an editor and reviewer for peer-reviewed publications; and a course director for various educational opportunities for WPATH, American Society of Plastic Surgeons, and other organizations.

² Dr. Lappert's suggestion that the sources cited in my original report deal only with technical issues, and not the medical necessity of gender-affirming care, is incorrect. Lappert Decl. at 9, 39. Based on the substantial body of literature in this area, including the literature cited in my reports in this case, professional organizations such as The American Society of Plastic Surgeons recognize gender-confirming care as reconstructive, meaning that it is medically necessary.

6. I have personal knowledge of the matters stated in this report. I may further supplement these opinions in response to information produced by Defendants in discovery and in response to additional information from Defendants' experts.

I. QUALIFICATIONS OF DEFENDANTS' WITNESSES

7. Based on the disclosures in Dr. Lappert's report, he appears to lack the requisite qualifications to offer his opinions. Dr. Lappert's board certification with the American Board of Plastic Surgery is expired. Dr. Lappert is neither board-certified in plastic surgery, nor does he appear to hold any board-certification from a member board of The American Board of Medical Specialties.

8. Dr. Lappert is not a member of The American Society of Plastic Surgeons (ASPS), despite its role as the largest plastic surgery specialty organization in the world. ASPS represents 93% of all board-certified plastic surgeons in the United States, and more than 8,000 plastic surgeons worldwide. *See* plasticsurgery.org (website of ASPS). Dr. Lappert does not appear to be a member of any other major or relevant surgical organization, such as The American College of Surgeons.

9. Dr. Lappert lists no current hospital affiliations, nor does he appear to perform surgical procedures any longer. Dr. Lappert has no recent or relevant scientific publications pertaining to the field of gender-affirming surgery.³ Dr. Lappert references

³ As explained further in my original report, I typically use the terms "gender confirmation" and "gender affirmation" as the terms that most accurately describe the therapeutic tools used to treat gender dysphoria, and I use those terms interchangeably herein. Schechter Report ¶ 3.

having performed an unspecified number of surgeries for patients who previously identified as transgender, however, he does not disclose any experience in treating individuals in a manner consistent with World Professional Association for Transgender Health's ("WPATH") Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People ("Standards of Care").⁴

10. Drs. Levine, Hruz, and McHugh opine on surgical interventions pertaining to gender dysphoria. None of these individuals provide evidence as to training or experience in a surgical discipline. Additionally, none of Drs. Lappert, Levine, Hruz, or McHugh appear to be members of WPATH, which is recognized by the mainstream medical consensus as the authoritative entity that has established comprehensive Standards of Care in this field.

II. THE OPINIONS OF DR. LAPPERT AND THE OTHERS ARE INCONSISTENT WITH THE MAINSTREAM MEDICAL CONSENSUS

A. Gender-Confirming Surgery is Safe and Effective

11. As discussed in my original report, the research, as well as my own clinical

⁴ There are other indications of Dr. Lappert's lack of expertise in this field. Dr. Lappert incorrectly claims that "much" of the support for gender-affirming care comes from anecdotal data, and analogizes this treatment to "bleeding and leeching." Lappert Decl. pp. 13-14. This not only ignores the large body of peer-reviewed literature supporting gender-affirming care, but to the extent Dr. Lappert attempts to disparage it with comparisons to use of leeches, reveals gaps in his knowledge. Despite claiming to be an expert in microvascular surgery, Dr. Lappert fails to note the substantial volume of scientific literature regarding the beneficial use of medicinal leeches in microsurgery. *See, e.g.,* Iris Seitz et al., *Successful Tongue Replantation Following Segmental Autoamputation Using Supermicrosurgical Technique*, 02 Journal of Reconstructive Microsurgery Open e132-e135 (2017).

expertise, show that surgical procedures for gender dysphoria are safe and effective, and that many of these procedures are analogous to surgical procedures used to treat other medical conditions. The fact that the medical community deems these analogous procedures sufficiently safe to treat conditions other than gender dysphoria is by itself more than sufficient to support the safety of those surgeries to treat gender dysphoria, since nothing about the safety of these procedures varies when they are used to treat gender dysphoria. Notably, Dr. Lappert concedes that chest reconstructive surgery in the form of a mastectomy is “very safe, and typically performed in the outpatient setting.” Lappert Decl. at 37-38. Dr. Lappert also concedes that “[s]urgical enhancement procedures are exactly the same in both men and women.” *Id.* at 38.

12. Dr. Lappert suggests that gender-confirming surgeries have a high rate of complications, Lappert Decl. ¶ 18, but when compared with analogous procedures for other conditions, gender-confirming surgeries do not have a particularly high rate of complications. For example, a recent study of 7,905 persons with gender dysphoria, of whom 1,047 underwent surgery between 2009-2015, revealed an overall complication rates for all surgical procedures on persons with gender dysphoria of only 5.8%.⁵

13. Looking specifically at the complication rates for chest surgeries (subcutaneous mastectomy and chest wall contouring), two recent studies reveal a

⁵ Megan Lane et al., *Trends in Gender-affirming Surgery in Insured Patients in the United States*, 6 *Plastic and Reconstructive Surgery - Global Open* e1738 (2018).

complication rate among transgender men of between 11% -12%,⁶ in comparison to the complication rate of 43% for cisgender women undergoing breast reduction shown in a 2005 study.⁷ Likewise, in a systematic review of cisgender women undergoing nipple-sparing mastectomy and immediate breast reconstruction using breast implants and acellular dermal matrix the complication rates include: 11% skin necrosis, 5% nipple necrosis, 12% infection, 1% hematoma, 5% seroma, 4% explantation, and 9% unplanned return to the operating room.⁸ Similarly, in a study which queried the American College of Surgeons National Surgical Quality Improvement database from 2006-2017 regarding augmentation mammoplasty in 1,360 cisgender and transgender individuals, “the rates of all-cause complications were low in both cohorts, and differences were not significant” (1.6% for transgender women versus 1.8% for cosmetic breast augmentation).⁹

⁶ M.G. Berry et al., *Female-To-Male Transgender Chest Reconstruction: A Large Consecutive, Single-Surgeon Experience*, 65 *Journal of Plastic, Reconstructive & Aesthetic Surgery* 711-719 (2012).; Cori A. Agarwal et al., *Quality of Life Improvement After Chest Wall Masculinization in Female-To-Male Transgender Patients: A Prospective Study Using the BREAST-Q and Body Uneasiness Test*, 71 *Journal of Plastic, Reconstructive & Aesthetic Surgery* 651-657 (2018).

⁷ Bruce L. Cunningham et al., *Analysis of Breast Reduction Complications Derived from the BRAVO Study*, 115 *Plastic and Reconstructive Surgery* 1597-1604 (2005).

⁸ Lene Nyhøj Heidemann et al., *Complications following Nipple-Sparing Mastectomy and Immediate Acellular Dermal Matrix Implant-based Breast Reconstruction—A Systematic Review and Meta-analysis*, 6 *Plastic and Reconstructive Surgery - Global Open* e1625 (2018).

⁹ Nicholas G. Cuccolo et al., *Epidemiologic Characteristics and Postoperative Complications following Augmentation Mammoplasty: Comparison of Transgender and Cisgender Females*, 7 *Plastic and Reconstructive Surgery - Global Open* e2461 (2019).

14. Additionally, complication rates for vaginoplasties in transgender women are commensurate to rates of complications for cisgender women undergoing vaginal or vulvar reconstruction for medical conditions (*e.g.*, cancer).¹⁰

15. Dr. Lappert asserts that distinguishing “cosmetic breast surgery from ‘medically indicated’ surgery is based upon the diagnosis of the underlying pathology.”

Lappert. Decl. at 38. Dr. Lappert fails to acknowledge that breast augmentation or

¹⁰ For example, a 2018 study looking at complications and patient reported outcomes in 3716 cases of male-to-female vaginoplasty found complication rates of 2% fistula, 14% stenosis and strictures, 1% tissue necrosis, and 4% prolapse with patient-reported satisfaction of 93% (overall results). See Oscar J. Manrique et al., *Complications and Patient-Reported Outcomes in Male-to-Female Vaginoplasty—Where We Are Today*, 80 *Annals of Plastic Surgery* 684-691 (2018). An additional 2018 study published in the *Journal of Urology* evaluated 330 patients presenting for primary vaginoplasty. The overall complication rate in this study was 28.7%. Thomas W. Gaither et al., *Postoperative Complications following Primary Penile Inversion Vaginoplasty Among 330 Male-to-Female Transgender Patients*, 199 *Journal of Urology* 760-765 (2018). In comparison, studies examining complication rates in cisgender women undergoing vaginal and vulvar reconstruction demonstrate complication rates ranging as high as 61%. Melissa A. Crosby et al., *Outcomes of Partial Vaginal Reconstruction with Pedicled Flaps following Oncologic Resection*, 127 *Plastic and Reconstructive Surgery* 663-669 (2011). And additional studies demonstrate complication rates for cisgender women of 22.3%-26.7% for flap-related complications and between 7%-22% for donor site and flap-related complications. See Violante Di Donato et al., *Vulvovaginal Reconstruction After Radical Excision From Treatment of Vulvar Cancer: Evaluation of Feasibility and Morbidity of Different Surgical Techniques*, 26 *Surgical Oncology* 511-521 (2017). (flap-related complications); Adrian McArdle et al., *Vaginal Reconstruction Following Radical Surgery for Colorectal Malignancies: A Systematic Review of the Literature*, 19 *Annals of Surgical Oncology* 3933-3942 (2012). (donor site and flap-related complications). Additional studies reviewing reconstruction of congenital deformities found complication rates as high as 57%. H. P. Versteegh et al., *Postoperative Complications After Reconstructive Surgery for Cloacal Malformations: A Systematic Review*, 19 *Techniques in Coloproctology* 201-207 (2015).

mastectomy may be medically indicated for the treatment of gender dysphoria.¹¹ The medical community and insurance providers recognize a distinction between plastic surgery that is cosmetic and reconstructive plastic surgery that is medically necessary. No particular surgery is inherently cosmetic or inherently reconstructive; rather, the underlying diagnosis determines whether the procedure is considered cosmetic or reconstructive. Gender-confirming surgeries are not cosmetic surgeries because, when performed in accordance with the Standards of Care, they are clinically indicated to treat the medical condition of gender dysphoria. The professional medical consensus recognizes that these are appropriately categorized as reconstructive procedures. In a study published in 2019 by Miller, et al., 100% of transgender women who underwent breast augmentation reported improvement in their gender dysphoria and “would undergo the operation again.”¹²

16. Dr. Lappert appears to argue that gender-confirming surgery cannot be considered medically necessary because it operates on physiologically healthy tissue and because it promotes a patient’s psychological wellbeing. Lappert Decl. at 35. But neither of those things is unique to gender-confirming surgery. Surgeons can operate on physiologically healthy tissue in order to prevent disease. The most obvious example is prophylactic mastectomy for cisgender women who are carriers of one of the BRCA

¹¹ Dr. Lappert incorrectly refers to breast growth in transgender women as “gynecomastia.” Gynecomastia refers to enlargement of the male breast, not to breast growth in transgender women.

¹² Travis J. Miller et al., *Breast Augmentation in Male-to-Female Transgender Patients: Technical Considerations and Outcomes*, 21 JPRAS Open 63-74 (2019).

genes. Women may choose to undergo elective removal of their breasts (presumably normal and non-cancerous) so as to reduce their risk of developing cancer. For the same reason, women with a genetic or hereditary disposition to ovarian cancer may similarly choose to undergo prophylactic oophorectomy, which is sterilizing.

17. Dr. Lappert misunderstands that gender dysphoria is a medical condition for which there are medical and surgical treatments. While plastic surgeons may encounter individuals with mental health conditions, such as body dysmorphic disorder, surgery for this condition is highly ineffective. This is in contrast to surgery as treatment for gender dysphoria; where medically indicated, surgical procedures for gender dysphoria are both safe and medically effective.

18. Additionally, reconstructive surgery often has the additional benefit of promoting and improving a patient's quality of life and well-being; which is often a component of medically necessary care. Indeed, aside from the primary purpose of alleviating or reducing a patient's gender dysphoria, gender confirmation surgery also has been demonstrated to have other salutary effects, such as improving quality of life and reducing negative health outcomes. In a prospective study utilizing a validated quality of life assessment tool, Alcon, et al. demonstrated significant improvements in quality of life up to 1 year following chest surgery.¹³ The authors indicated that "the effect sizes

¹³ Loren S. Schechter, *Discussion: Quantifying the Psychosocial Benefits of Masculinizing Mastectomy in Trans Male Patients with Patient-Reported Outcomes: The University of California, San Francisco, Gender Quality of Life Survey*, 147 *Plastic & Reconstructive Surgery* 741e-742e (2021).

were large and...exhibited excellent internal validity.” The authors report that “every patient surveyed at 1 year reported that gender-affirming surgery changed their life for the better” and that, “every patient surveyed after surgery said they would choose it (surgery) again knowing what they know.” In addition, in a 2006 study published in *Quality of Life Research*, Newfield, et al. found that, “Chest reconstruction not only enhances the FTM transgender identity, increases self-esteem, and improves body image, but provides some security and safety for those who remove their shirts in public areas, such as gyms or beaches. Those who had received top surgery reported higher QOL (quality of life) scores than those who had not received surgery, statistically significant findings ($p < 0.01$) for the General Health, Social Functioning, and all three mental health concepts.”¹⁴

19. The overwhelming majority of patients who obtain gender confirmation surgery in a manner consistent with the Standards of Care are both satisfied and experience a reduction of gender dysphoria. For the vast majority of transgender people who seek such surgery, the surgery is successful at alleviating and/or reducing gender dysphoria and alleviating a lifelong struggle to find peace of mind and comfort with their bodies.

B. Medically Necessary Care to Treat Gender Dysphoria is Not Experimental

20. It is my professional medical opinion that the contention of Drs. Lappert,

¹⁴ Emily Newfield et al., *Female-to-Male Transgender Quality of Life*, 15 *Quality of Life Research* 1447-1457 (2006).

Levine, Hruz, and McHugh that gender-confirming surgeries are experimental is unsupported by the professional medical consensus and prevailing standards of care for treating gender dysphoria, and is inconsistent with mainstream medical standards. To the contrary, the prevailing consensus of the medical community recognizes that procedures used to treat gender dysphoria are reconstructive, not experimental, and are medically necessary.

21. Surgical care is not considered experimental when it uses accepted techniques and has demonstrative benefits. The techniques used in gender-affirming care are employed in other surgeries and are well-established. For example, urethroplasties, orchiectomies, skin grafts, and mastectomies are all accepted techniques for congenital, oncological, and traumatic conditions. They are not experimental simply because they are applied to the well-established diagnosis of gender dysphoria.

22. Gender-affirming surgery has been performed for decades, utilizes accepted surgical techniques, and yields demonstrated benefits for patients. In addition, gender-affirming surgeries are: 1) part of the core curriculum in plastic surgery resident education; and 2) a component of both the written and oral board exams in plastic surgery. I have given presentations at multiple professional societies, and none of them consider gender-affirming surgery experimental. In the disclosures required to give presentations of this kind there is no requirement that they be called experimental. It is

widely accepted by professional surgical societies that gender-affirming surgeries are not experimental.¹⁵

23. Finally, Dr. Lappert also discusses that the use of hormone therapy to treat transgender patients has not yet been approved by the FDA. Lappert Decl. at 20. But this also says nothing about surgical care, since the FDA does not regulate surgery.

C. Quality of Evidence

24. The quality of the evidence supporting gender-affirming surgeries is comparable to that supporting many surgeries and clinical procedures. While prospective, randomized, double-blind, placebo-controlled studies are the gold standard, they cannot be used to evaluate many clinical procedures. There are simply inherent limitations to our ability to conduct such studies in clinical medicine. First, it is unethical to withhold medically necessary care. As such, in many situations, clinicians cannot conduct a study that uses a control group who is deprived of the treatment being studied. Practice guidelines published in 2013 by the Royal College of Psychiatrists indicated that a randomized controlled study to evaluate feminizing vaginoplasty would be “impossible to carry out.”¹⁶ For these reasons, and the fact that we do not perform gender-affirming surgery on children, it is particularly unsurprising that “[n]o studies show that affirmation of children (or anyone else) reduces suicide, prevents suicidal ideation, or improves long-

¹⁵ Also, in his assertion that “affirmation treatments are currently experimental,” Dr. Lappert erroneously refers to HIV infection as a “psychosocial” condition rather than a medical condition.

¹⁶ Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria, Royal College of Psychiatrists 1-59 (2013).

term outcomes, as compared to either a ‘watchful waiting’ or a psychotherapeutic model of response.” Levine Decl. ¶ 75; *see also* Lappert Decl. ¶ 14. The withholding of medically necessary care that would be required for such a comparison would be considered unethical.

25. It is not possible to perform a double-blind study of surgeries that modify body parts, nor is there a placebo that can mimic such a surgery – unlike studies that use placebo drug regimens, for example, people will know if they have had an operation or not. For relatively uncommon conditions like gender dysphoria, sample sizes of individuals with the condition who are available to participate in a clinical study tend to be small. This is especially true where treatment for a condition has not been covered by insurance programs and plans, and where additional barriers (such as ongoing stigmatization) prevent patients from accessing care. That very lack of access to the procedure results in there being fewer people who have received treatment and who can participate in a prospective study of that treatment’s effect.

26. Put simply, the scientific literature pertaining to gender-affirming surgical interventions is similar to that of other accepted plastic surgery procedures. The recommendation for ongoing research is a standard recommendation in many, if not most or all clinical scenarios. This recommendation for ongoing study in a particular clinical area does not mean that surgical care is withheld.

D. Misrepresentation of the Literature on Medical Necessity, Safety, and Effectiveness

27. The overwhelming weight of the scientific and medical literature supports the benefits of gender-affirming surgical interventions. Gender-affirming interventions have been performed for decades, and the safety and efficacy of these procedures have been reported by multiple surgeons practicing at different institutions in different countries and continents. Dr. Lappert fails to acknowledge this literature, referencing instead several non-scientific sources to support his opinions. As a few representative examples, he relies on an article published in *The New Atlantis* (Lappert Decl. at 12-13), a journal whose own website specifically says that it is “not an academic journal”; and a Canadian website (<https://genderreport.ca>) which does not represent a professional medical or scientific organization.

28. Drs. Lappert, Levine, and Hruz all cite a study by Dhejne, et al. to imply that because individuals who received gender confirming surgeries had higher morbidity and mortality rates compared to the general population, the surgeries are not effective. Lappert Decl. ¶ 20; Levine Decl. ¶ 74; Hruz Decl. ¶ 58. They appear to misunderstand that study. First, the study itself clearly states that it is not intended to evaluate whether gender-affirming surgeries are “an effective treatment or not.” Second, those who receive medically necessary surgery generally have reduced morbidity and mortality compared to those with the same condition who do not, even if morbidity and mortality for both groups is higher than average. Third, the study includes patients who had

surgery prior to the development of the current standards of care. Finally, the fact that gender confirming surgeries do not entirely resolve all possible causes of morbidity and mortality among transgender individuals is completely unsurprising. While surgery can treat gender dysphoria by aligning transgender people's bodies with their gender identity, surgery alone cannot fully eliminate the stigma and discrimination that transgender people face. Moreover, it is rare for any surgery to eliminate morbidity and mortality. For example, people who have surgery to remove a cancerous tumor may still experience higher rates of morbidity and mortality than the general population, but that does not mean that they should not undergo the surgery. In addition, individuals suffering from other medical conditions (including chronic conditions and traumatic injuries such as burns) are also at elevated risk of suicide. The increased risk of suicide does not preclude treatment of burn patients.¹⁷

29. For instance, one study cited by Dr. Levine concluded that gender-affirming surgeries “may reduce psychological morbidity for some individuals while increasing it for others.”¹⁸ The fact that surgery does not always reduce morbidity for everyone who receives it does not mean that the surgery is not safe or effective, particularly given the number of potential confounding factors that can impact morbidity. Similarly, the continued existence of elevated morbidity and mortality rates, compared to

¹⁷ Sheera F Lerman et al., *Suicidality After Burn Injuries: A Systematic Review*, 42 *Journal of Burn Care & Research* 357-364 (2021).

¹⁸ Rikke Kildevæld Simonsen et al., *Long-Term Follow-up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity and Mortality*, 70 *Nordic Journal of Psychiatry* 241-247 (2016).

the population at large, say nothing about whether a treatment is a safe and effective way to treat a particular condition. Similarly, in a study regarding “quality of life and patient satisfaction in adults treated for a cleft lip and palate,” Kappen, et al. found that although some study participants “had accepted their diagnosis they were not entirely satisfied with their treatment outcome. These participants were still thinking about a possible correction in the future, occasionally inquired about new treatment options, and/or had to weigh the risk of complications or adverse outcomes against the (minor) benefits of surgery.” The authors also state that, “Two patients ... still had difficulties coping ... Both were psychologically affected at the time of interview: one was coping with depression, while the other was experiencing a mild form of generalized anxiety.” Additionally, four patients sought “professional psychological help ...”¹⁹ But that does not suggest that withholding medically necessary care is appropriate for those patients, any more than it is for transgender people.

30. Dr. Lappert conflates various treatments options (i.e., pubertal suppression in adolescents, hormone therapy, gender-affirming surgeries) in a wide range of clinical scenarios (i.e., treatment of children, treatment of adolescents, treatment of adults, etc.). As with many areas of medicine, treatment options may differ depending upon the unique circumstances of the individual seeking care. The Center for Study of Inequality at Cornell University conducted a systematic review of all peer-reviewed articles published

¹⁹ Isabelle F. P. M. Kappen et al., *Quality of Life and Patient Satisfaction in Adults Treated for a Cleft Lip and Palate: A Qualitative Analysis*, 56 *The Cleft Palate-Craniofacial Journal* 1171-1180 (2019).

in English between 1991 and June 2017.²⁰ 93% of the studies “found that gender transition improves the overall well-being of transgender people...” Only 7% of the studies reported “mixed or null findings.” In addition, no studies concluded that gender transition causes overall harm.

E. Informed Consent

31. Dr. Lappert asserts that “informed consent is not yet possible” for surgical treatments to treat gender dysphoria because of the purported insufficiency of the evidence supporting this care. Lappert Decl. at 18. Gender-affirming surgical procedures, however, have been shown beneficial by multiple surgeons, in multiple countries, over decades. The risks of gender-affirming surgical procedures are well-known and well-described in the literature.²¹ Additionally, because analogous surgical techniques have long been used to treat other underlying diagnoses, the risks of these techniques are well-understood.

32. The Standards of Care specifically discuss the obligation of the surgeon to obtain informed consent and recommend mental health assessments prior to these gender-affirming surgical interventions. The options, including the potential complications, and

²⁰ What does the scholarly research say about the effect of gender transition on transgender well-being? What We Know (2021), <https://whatwewknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/>.

²¹ See, e.g., Loren S. Schechter, *The Surgeon's Relationship with the Physician Prescribing Hormones and the Mental Health Professional: Review for Version 7 of the World Professional Association for Transgender Health's Standards of Care*, 11 *International Journal of Transgenderism* 222-225 (2009).

risks and benefits of each, are discussed with patients. For adolescents, these discussions include the caregiver or parents who must consent as well.

33. The process of securing informed consent is done in a multidisciplinary way. One component of the preoperative mental health evaluation is an assessment of the individual's ability to provide informed consent. This represents a clinical standard which exceeds the threshold to perform many other types of surgical interventions, including those that are sterilizing.

34. Dr. Lappert also suggests that informed consent is ineffective because it does not involve discussion of effects of the surgery on, for example, relationships with others. Lappert Decl. at 28. Setting aside Dr. Lappert's disparaging suggestion that transgender people who have received care will experience an "inability to form healthy romantic relationships and attract a desirable mate" (*id.*), the fact that surgery can affect multiple domains of a person's life is not unique to gender-affirming surgery. For example, an oophorectomy may cause hot flashes and mood swings and affect one's romantic life, but there is no requirement that cisgender women see a mental health professional before obtaining that care. In contrast, transgender people are subject to a higher standard because they are required to seek mental health care before accessing the same kinds of surgical procedures.

1. Fertility Counseling

35. As discussed in the Standards of Care, individuals are counseled as to fertility-preserving options prior to undergoing sterilizing procedures. Individuals make

decisions regarding interventions that affect fertility in a variety of clinical circumstances. These include procedures such as vasectomy, tubal ligation, and oophorectomy (whether for cancer or as a risk-reduction strategy). In the case of gender-affirming surgery, not only does the surgeon discuss the issue of fertility prior to surgery, individuals typically address this with their medical and/or mental health professionals as well. Once again, individuals seeking gender-affirming surgical interventions must meet a higher standard as compared to individuals undergoing sterilizing procedures for diagnoses or reasons other than gender dysphoria.

2. Co-Occurring Diagnoses

36. Dr. Lappert suggests that patients with co-occurring mental illness “cannot be considered competent to consent for any form of surgery.” Lappert Decl. at 51. That position is not supported by any evidence. Co-occurring mental health conditions are not uncommon in patients who need surgery, including patients with gender dysphoria, which the Standards of Care recognize. The Standards of Care specifically indicate the importance of mental health assessments prior to surgery, as well as the importance of a multi-disciplinary and collaborative approach between surgeons, mental health professionals, and primary care providers. *See* Standards of Care at 56-57. Working in this interdisciplinary way, surgeons determine if a patient has any medical or mental health conditions that could affect their suitability for surgery or complicate their recovery after surgery. *See* Standards of Care at 59.

37. Patients with co-occurring mental health conditions, such as depression, anxiety, substance use disorder, and post-traumatic stress disorder, regularly and appropriately assent to surgical care. Generally, these conditions do not prevent patients from understanding the procedure, the risks and complications of the procedure, and the benefits that they can reasonably expect to achieve from surgery.

38. With regard to gender-affirming surgical interventions, not only does the surgeon assess the ability of the individual to provide informed consent, but the individual also undergoes a preoperative assessment by a mental health professional. As mentioned above, this actually requires those seeking gender-affirming surgical interventions to meet a higher standard as compared to individuals seeking surgical interventions for diagnoses other than gender dysphoria.

39. Dr. Lappert also ignores the health risks and complications that can arise from withholding surgical care, including worsening gender dysphoria; anxiety; depression; and self-harm, suicide attempts, and suicide.

F. “Error Rates”

40. The term “error rate” used by Drs. Lappert, Levine, Hruz, and McHugh is not a term typically used in medical science. Lappert Decl. at 22; Levine Decl. ¶ 65; Hruz ¶ 82; McHugh at 14. To the extent Dr. Lappert intends to refer to rates of complications or regret, rates of complications are regularly discussed in medical

literature on treatments for gender dysphoria. Rates of regret for procedures among individuals with gender dysphoria remain extremely low.²²

41. Dr. Lappert expresses concerns that transgender patients may suffer “desistance or regret.” Lappert Decl. at 21. To demonstrate that transgender patients experience regret from gender confirming surgery, Dr. Lappert cites the work of Dr. Miroslav Djordjevic regarding his experience with patients seeking “reversal of their sex reassignment surgeries.” But those patients all received surgery without following the Standards of Care. Dr. Lappert’s cites other sources, such as an unspecified “online community of young women who have desisted” and a YouTube source (Lappert Decl. at 22), but those are not medical or scientific sources. In fact, all available scientific research indicates that reports of regret are extremely low when gender confirming surgery is provided in accordance with the Standards of Care.²³

42. Drs. Lappert, Levine, and Hruz suggest that gender confirming surgery is not safe and effective because some patients could later regret their transition and the procedure. *See, e.g.*, Lappert Decl. at 21-22; Levine Decl. at 76-77; Hruz Decl. at 86. Dr. Lappert offers only anecdotal support for his opinion and cites the anonymous social media site, Reddit. *See* Lappert Decl. at 21-22. Dr. Levine points to his own experience

²² Sasha Karan Narayan et al., *Guiding the Conversation—Types of Regret After Gender-Affirming Surgery and Their Associated Etiologies*, 9 *Annals of Translational Medicine* 605-616 (2021).

²³ Chantal M. Wiepjes et al., *The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets*, 15 *The Journal of Sexual Medicine* 582-590 (2018).

working with “multiple individuals who have abandoned trans female identity after living in that identity for years,” Levine Decl. ¶ 95, and vague references to stories on the internet. That Dr. Levine states that he has seen this happen several times in almost 40 years does not mean that it is a common occurrence among transgender individuals generally or among those who have received gender confirming surgery. All available research—as well as my own clinical experience—indicates that very few patients experience regret when gender confirming surgery is provided in accordance with the WPATH SOC and by a qualified surgeon. Regret of any kind is rare (0.6% in transgender women and 0.3% in transgender men),²⁴ but “true regrets,” as opposed to regrets due to lack of social or familial acceptance, comprise an even smaller percentage (approximately half this group, roughly 0.3% in transgender women and 0.15% in transgender men).²⁵ Having performed gender confirming surgeries for over 20 years, I have never had a patient request a reversal of male chest reconstruction.

43. In a recent study I co-authored regarding regret following gender-affirming surgery, Narayan, et al. queried 154 surgeons surgically treating between 18,125 to

²⁴ *Id.*

²⁵ *Id.* at 585, 587 (researchers classified “social regrets” as those experienced by individuals who still identified as transgender women, but reported feeling “ignored by surroundings” or regretted loss of relatives,” and classified “true regrets” as those experienced by individuals who “thought gender affirming treatment would be a ‘solution’ for, for example, homosexuality or [lack of] personal acceptance, but, in retrospect, regretted the diagnosis and treatment”).

27,325 individuals.²⁶ The rate of regret was found to be between 0.2-0.3%, consistent with previous literature.

44. Moreover, issues pertaining to regret following surgical procedures are not limited to gender-affirming surgical interventions.²⁷ Some cisgender women experience regret following breast reconstruction (40%), some cisgender women (6%) expressed regret following prophylactic mastectomy and prophylactic oophorectomy (7%).

G. Patient Self-Reporting

45. Dr. Lappert claims that gender-confirming surgeries are based on “nothing more than unverified self-reports.” Lappert Decl. at 15. Dr. Lappert misrepresents the preoperative process and multidisciplinary assessment that occurs prior to gender-affirming surgical interventions.²⁸

46. Dr. Lappert’s statements demonstrate a lack of familiarity with both the process of diagnosis done by mental health professionals before the transgender patient is

²⁶ Sasha Karan Narayan et al., *Guiding the Conversation—Types of Regret After Gender-Affirming Surgery and Their Associated Etiologies*, 9 *Annals of Translational Medicine* 605-616 (2021).

²⁷ Toni Zhong et al., *Decision Regret Following Breast Reconstruction: The Role of Self-Efficacy and Satisfaction With Information in the Preoperative Period*, 132 *Plastic and Reconstructive Surgery* 724e-734e (2013).; Leslie L. Montgomery et al., *Issues of Regret in Women With Contralateral Prophylactic Mastectomies*, 6 *Annals of Surgical Oncology* 546-552 (1999).; Elizabeth M. Swisher et al., *Prophylactic Oophorectomy and Ovarian Cancer Surveillance*, 46 *The Journal of Reproductive Medicine* 87-94 (2001).

²⁸ See the Standards of Care; Loren S. Schechter, *The Surgeon's Relationship with the Physician Prescribing Hormones and the Mental Health Professional: Review for Version 7 of the World Professional Association for Transgender Health's Standards of Care*, 11 *International Journal of Transgenderism* 222-225 (2009).(now *International Journal of Transgender Health*).

eligible for surgery, and also the role and responsibility of the surgeon in providing this care.

47. The surgeon receives in writing one or more assessments of the patient's diagnosis and medical necessity of the care by one or more mental health professionals, as required for the relevant procedure under the Standards of Care. But that is only one step in the assessment for surgical interventions. Contrary to Dr. Lappert's suggestions, the surgeon remains ultimately responsible for deciding whether a particular surgical intervention is medically indicated. The surgeon evaluates the patient and makes the final decision about whether it is safe and medically indicated to proceed. This includes an evaluation of the patient's understanding of the condition, their self-awareness, and their goals and expectations for the intervention. The surgeon also evaluates other factors that would affect the patient's fitness for the surgery, such as obesity or smoking, and determines whether additional studies might be required, such as x-rays or laboratory work. The surgeon also typically obtains an assessment from their primary care physician about their overall health. In my own clinical practice, I have had occasion to decline to perform a requested intervention based on my exercise of professional judgment.

III. MEDICAL ASSOCIATIONS

A. WPATH is a Professional Medical Association

48. Drs. Lappert, Levine, and Hruz all attempt to discount the broad medical consensus that gender confirming surgeries are medically necessary by claiming that

WPATH is an “advocacy organization” and not a professional one. *See* Lappert Decl. at 41; Levine Decl. ¶ 47; Hruz Decl. at 100. First, most medical associations and societies engage in advocacy on behalf of health care professionals, their patients, and their medical specialty generally. For example, the Endocrine Society – of which Dr. Hruz is a member – describes itself as devoted to “advocating on behalf of the global endocrinology community,” including patients with endocrine conditions. Endocrine Soc’y, Who We Are, <https://www.endocrine.org/about-us>; *see also* Endocrine Soc’y, Advocacy, <https://www.endocrine.org/advocacy>, Endocrine Soc’y, Shaping Healthcare and Research Policy, <https://www.endocrine.org/our-community/shaping-healthcare-and-research-policy>. Similarly, the American Society of Plastic Surgeons uses advocacy “to support its members in the provision of excellent patient care.” Am. Soc’y of Plastic Surgeons, About ASPS, <https://www.plasticsurgery.org/about-asps>. Far from being unique, engaging in advocacy is the norm among professional medical associations. *See, e.g.*, Am. Medical Ass’n, Health Care Advocacy, <https://www.ama-assn.org/health-care-advocacy>; Am. Psychiatric Ass’n, Make a Difference Through APA Advocacy, <https://www.psychiatry.org/psychiatrists/advocacy>; Am, Acad. of Pediatrics, Advocacy, <https://services.aap.org/en/advocacy/>.

49. Drs. Lappert, Hruz, Levine, and McHugh also mischaracterize the role of voting in professionals societies. *See, e.g.*, Lappert Decl. at 10-11, Hruz Decl. at 26-27, Levine Decl. at 47, McHugh Decl. at 14. As described above, voting on a society’s position regarding a medical issue is typically done after a review of the medical

literature. Votes allow members to express their medical and scientific opinions – promoting robust debate, and ensuring that these societies’ positions are reflective of a broad range of scientific views, rather than a top-down decision by a single person.

50. WPATH has transgender members who are licensed professionals in the wide range of specialties associated with transgender health as well as transgender members who bring the voice of the community into the organization. This is analogous to other professional societies, such as The American Burn Association, in which firefighters may be members. See <https://ameriburn.org/> (The American Burn Association website).

51. The presence and participation of transgender people in WPATH in no way restricts “honest, methodologically competent scientific debate” among professionals. *Cf.* Levine Decl. ¶ 47. To the contrary, it enriches the discussion of important topics, just as the participation of patients and patient support groups does during discussions at conferences for other professional societies to which I belong. Having transgender members is vital to WPATH and the development of the Standards of Care, but notably, voting privileges are limited to members who are professionals. Thus, the implication that the participation of transgender members degrades WPATH’s scientific integrity or impartiality has no merit. Moreover, in conjunction with WPATH’s biennial conference, it hosts a meeting that is limited to surgeons and healthcare professionals directly involved in surgical care (a meeting that I started at the 2007 WPATH Biennial meeting in Chicago and continue to organize and participate in at each of the subsequent

meetings). During the meeting, surgeons openly discuss a wide range of issues, including surgical techniques and ethical questions.

B. Every Major Medical Organization Supports the Current Standards of Care

52. Drs. Lappert, Levine, Hruz, and McHugh ignore that every relevant medical and behavioral health association agrees that gender-confirming care is a medically necessary treatment for individuals with gender dysphoria. *See, e.g.*, Schechter Report ¶ 24 (noting that the American Medical Association, American Psychological Association, American Psychiatric Association, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, and World Health Organization recognize gender confirming surgeries as standard, appropriate, and necessary treatments for gender dysphoria); *see also* Am. Psychological Ass'n, Guidelines for Psychological Practice With Transgender and Gender Nonconforming People (2015), <https://www.apa.org/practice/guidelines/transgender.pdf>; Am. Psychiatric Ass'n, A Guide for Working With Transgender and Gender Nonconforming Patients (2017), <https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients>.

53. The complaints by Drs. Lappert, Levine, Hruz, and McHugh that WPATH's Standards of Care are developed through a consensus process among its members are curious, at best. WPATH members have dedicated a significant portion of, if not their entire professional careers, to advancing the health and wellbeing of

transgender people. That level of expertise is essential in creating a standard-setting document.

C. Clinical Guidelines are Typically Determined Through Literature Review and Expert Testimony

54. Based on my review of Dr. Lappert's declaration, it appears that he has fundamental and severe misunderstanding of how the standards of care are developed. I have served as chairman on prior committees that have drafted clinical guidance. In 2011, I helped to co-write the reduction mammoplasty clinical guidelines. The establishment of clinical guidelines process involves:

- Careful evaluation of the relevant medical and scientific peer-reviewed literature.
- Testimony from experts in the relevant field.
- Disclosure of conflicts of interest.

55. Contrary to Dr. Lappert's assertions, the Standards of Care are the result of careful and deliberate reviews of the relevant medical and scientific literature and expert testimony. Experts in the field often serve as author or co-author on practice guidelines – including, for example, practice guidelines in other areas of plastic surgery, such as for reduction mammoplasty – and that poses no inherent conflict of interest. To the contrary, it would make no sense to exclude the providers who actually perform the care for which the guidelines are developed. Professional societies and organizations have mechanisms to address and mitigate potential or perceived conflicts. It is unreasonable to assume that individuals without expertise in a field of study would be asked to author professional guidelines.

56. Review of guidelines is a constant revision process based on the latest available evidence.²⁹ There is no area of medicine where there is complete and absolute knowledge where no further research is needed.

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

Executed this 29th day of May, 2021.

Loren S. Schechter

Loren S. Schechter, M.D.

²⁹ Indeed, in keeping with that sentiment and years after Dr. McHugh forced the closure of the transgender clinic at John Hopkins University, John Hopkins has now established a new Center for Transgender Health that “offers comprehensive, evidence-based and affirming care for transgender youth and adults that is in line with the standards of care set by the World Professional Association for Transgender Health (WPATH).” The care offered is interdisciplinary and includes gender-affirming surgeries, hormone treatment, and mental health.

CERTIFICATE OF SERVICE

I hereby certify that on June 1, 2021, I caused a copy of the foregoing document and all attachments to be served upon the following parties via email:

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Exhibit B

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Exhibit 24(c)

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CHILDREN: Owen Slone Schechter

Miles Slone Schechter

CERTIFICATION: The American Board of Plastic Surgery 2001
Certificate Number 6271
Date Issued: September 2001
Maintenance of Certification: 2011

EDUCATION:
1986-1990 The University of Michigan BS, 1990
1990-1994 The University of Chicago MD, 1994
Pritzker School of Medicine

POSTGRADUATE TRAINING:

Residency: The University of Chicago Hospitals 1994-1999
Coordinated Training Program in
Plastic and Reconstructive Surgery
Chief Resident: The University of Chicago Hospitals 1998-1999
Section of Plastic and Reconstructive
Surgery
Fellowship: Reconstructive Microsurgery 1999-2000
The University of Chicago Hospitals
Section of Plastic and Reconstructive
Surgery

TEACHING APPOINTMENT:

Professor of Surgery, Chief Section of Gender-Affirmation Surgery, Rush University Medical Center-In Process

Clinical Professor of Surgery, The University of Illinois at Chicago-resigned to accept position at Rush University

Adjunct Assistant Professor, Dept. of Surgery, Rush University Medical Center

Associate Professor, Physician Assistant Program, College of Health Professionals, Rosalind Franklin University

LICENSURE:

Illinois
Illinois Controlled Substance
DEA

STAFF APPOINTMENTS:

University of Illinois at Chicago Hospital
Rush University Medical Center
Advocate Lutheran General Hospital
Louis A. Weiss Memorial Hospital
Illinois Sports Medicine and Orthopedic Surgery Center

HONORS AND AWARDS:

2020 The University of Minnesota Program in Human Sexuality, recipient of 50 Distinguished Sexual and Gender Health Revolutionaries
2017-2020 Castle Connolly Top Doctor (Chicago)
2017 Chicago Consumer Checkbook Top Doctor
2015 University of Minnesota Program in Human Sexuality Leadership Council
2014-2015 Rosalind Franklin University of Medicine and Science Chicago Medical School Honors and recognizes for dedication and commitment to teaching
2014 National Center for Lesbian Rights honored guest
2013 Illinois State Bar Association Award for Community Leadership
2010 Advocate Lutheran General 2009 Physicians Philanthropy Leadership Committee-Outstanding Leadership
2009 Advocate Lutheran General Hospital Value Leader (received for compassion)
1994 Doctor of Medicine with Honors
1994 University of Chicago Department of Surgery Award for Outstanding Performance in the Field of Surgery

1994 Catherine Dobson Prize for the Best Oral Presentation Given at the 48th Annual Senior Scientific Session in The Area of Clinical Investigation

1993 Alpha Omega Alpha

1991 University of Chicago National Institutes Of Health Summer Research Award

1990 Bachelor of Science with High Distinction And Honors in Economics

1990 James B. Angell Award for Academic Distinction

1989 Omicron Delta Epsilon-National Economic Honor Society

1988 College Honors Program Sophomore Honors Award For Academic Distinction

1988 Class Honors (Dean's List)

MEMBERSHIPS :

2018- The American Association of Plastic Surgeons

2016- The American Society for Gender Surgeons (founding member and president-elect)

2010- World Society for Reconstructive Microsurgery

2005- The University of Chicago Plastic Surgery Alumni Association

2005- The Chicago Surgical Society

2004- The American Society for Reconstructive Microsurgery

2003- The American College of Surgeons

2002- The American Society of Plastic Surgeons

2001- Illinois Society of Plastic Surgeons (formerly, Chicago Society of Plastic Surgeons)

2001- The American Society of Maxillofacial Surgeons

2001- American Burn Association

2001- Midwest Association of Plastic Surgeons

2001- WPATH

1994- The University of Chicago Surgical Society

1994- The University of Chicago Alumni Association

1992- American Medical Association

1992- Illinois State Medical Society

1992- Chicago Medical Society

1990- The University of Michigan Alumni Association

CURRENT HOSPITAL COMMITTEES :

Director, Center for Gender Confirmation Surgery, Louis A. Weiss Memorial Hospital

PROFESSIONAL SOCIETY COMMITTEES :

WPATH Executive Committee

Treasurer, The World Professional Association for Transgender Health

Chair, Finance and Investment Committee, The American Society of Plastic Surgeons

WPATH 2020 Biennial Meeting Steering Committee

American Society of Breast Surgeons Research Committee, ASPS representative

American Board of Plastic Surgery, Guest Oral Board Examiner

WPATH Ethics Committee

American College of Radiology Committee on Appropriateness Criteria Transgender Breast Imaging Topic, Expert Panel on Breast Imaging: Transgender Breast Cancer Screening Expert Panel on Breast Imaging

American Society of Plastic Surgeons, Finance and Investment Committee

Board of Directors, at-large, The World Professional Association for Transgender Health

PlastyPac, Board of Governors

Medicare Carrier Advisory Committee

OTHER:

Guest Reviewer, Pain Management

Guest Reviewer, Plastic and Aesthetic Research

Guest Reviewer, European Medical Journal

Guest Reviewer, Open Forum Infectious Diseases

Guest Reviewer, The Journal of The American College of Surgeons

Guest Book Reviewer, Plastic and Reconstructive Surgery

Editorial Board, Transgender Health

Editorial Board (Associate Editor), International Journal of Transgenderism

Fellow of the Maliniac Circle

Guest Reviewer, Journal of Reconstructive Microsurgery

Guest Reviewer, Journal of Plastic and Reconstructive Surgery

Guest Reviewer, Journal of Sexual Medicine

Guest Editor, Clinics in Plastic Surgery, Transgender Surgery (Elsevier Publishing)

Guest Reviewer, The Journal of Plastic and Reconstructive Surgery

PREVIOUS EDITORIAL ROLE:

Guest Reviewer, EPlasty, online Journal

Module Editor for Patient Safety, Plastic Surgery Hyperguide

Editorial Advisory Board, Plastic Surgery Practice

Guest Reviewer, International Journal of Transgenderism

Guest Reviewer, Pediatrics

PREVIOUS ACADEMIC APPOINTMENT:

Visiting Clinical Professor in Surgery, The University of Illinois at Chicago

Chief, Division of Plastic and Reconstructive Surgery, Chicago Medical School, Rosalind Franklin University of Medicine and Science

Associate Professor of Surgery, The College of Health Professionals, Rosalind Franklin University

Clinical Associate in Surgery, The University of Chicago

PREVIOUS HOSPITAL COMMITTEES:

Division Director, Plastic Surgery, Lutheran
General Hospital

Division Director, Plastic Surgery, St. Francis
Hospital

Medical Staff Executive Committee, Secretary,
Advocate Lutheran General Hospital

Credentials Committee, Lutheran General Hospital

Pharmacy and Therapeutics Committee Lutheran
General Hospital

Operating Room Committee, St. Francis Hospital

Cancer Committee, Lutheran General Hospital
-Director of Quality Control

Risk and Safety Assessment Committee, Lutheran
General Hospital

Nominating Committee, Rush North Shore Medical
Center

Surgical Advisory Committee, Rush North Shore
Medical Center

Section Director, Plastic Surgery, Rush North
Shore Medical Center

PREVIOUS SOCIETY COMMITTEES:

PlastyPac, Chair, Board of Governors

Chair of the Metro Chicago District #2 Committee
on Applicants, American College of Surgeons

American Society of Plastic Surgery, Health
Policy Committee

American Society of Plastic Surgery, Patient
Safety Committee

American Society of Plastic Surgeons, Coding and
Payment Policy Committee

American Society of Plastic Surgeons, Practice
Management Education Committee

Board of Governors, Governor-at-large, The American College of Surgeons

American College of Surgeons, International Relations Committee

Chair, Government Affairs Committee, American Society of Plastic Surgeons

President, The Metropolitan Chicago Chapter of The American College of Surgeons

2012 Nominating Committee, American Society of Plastic Surgeons

Program Committee, The World Society for Reconstructive Microsurgery, 2013 Bi-Annual Meeting

President, Illinois Society of Plastic Surgeons

Vice-President, The Illinois Society of Plastic Surgeons (formerly the Chicago Society of Plastic Surgery)

Vice-President, The Metropolitan Chapter of the American College of Surgeons

American Society of Plastic Surgery, Chairman, Patient Safety Committee

2006-2007 Pathways to Leadership, The American Society of Plastic Surgery

2005 & 2006 President, The University of Chicago Plastic Surgery Alumni Association

2003 Leadership Tomorrow Program, The American Society of Plastic Surgery

Senior Residents Mentoring Program, The American Society of Plastic Surgery

American Society of Maxillofacial Surgery, Education Committee

Alternate Councilor, Chicago Medical Society

American Society of Aesthetic Plastic Surgery, Electronic Communications Committee

American Society of Aesthetic Plastic Surgery,
Intranet Steering Committee

American Society of Aesthetic Plastic Surgery,
International Committee

Membership Coordinator, The Chicago Society of
Plastic Surgeons
The Illinois State Medical Society, Governmental
Affairs Council

The Illinois State Medical Society, Council on
Economics

Chicago Medical Society, Physician Review
Committee
-Subcommittee on Fee Mediation

Chairman, Chicago Medical Society, Healthcare
Economics Committee

Secretary/Treasurer, The Metropolitan Chicago
Chapter of the American College of Surgeons

Scientific Committee, 2007 XX Biennial Symposium
WPATH

Local Organizing Committee 2007 WPATH

Secretary, The Chicago Society of Plastic
Surgeons

Treasurer, The Chicago Society of Plastic
Surgeons

Council Member, The Metropolitan Chicago Chapter
of the American College of Surgeons

INTERNATIONAL MEDICAL SERVICE:

Northwest Medical Teams
Manos de Ayuda (Oaxaca, Mexico)

Hospital de Los Ninos (San Juan, Puerto Rico)

COMMUNITY SERVICE:

Alumni Council, The University of Chicago Medical
and Biological Sciences Alumni Association

The University of Minnesota Presidents Club
Chancellors Society

Board of Directors, Chicago Plastic Surgery
Research Foundation

National Center for Gender Spectrum Health
Advisory Council

PREVIOUS COMMUNITY SERVICE:

Board of Directors, Committee on Jewish Genetic
Diseases, Jewish United Fund, Chicago, Illinois

Governing Council, Lutheran General Hospital,
Park Ridge, Il

Lutheran General Hospital Development Council,
Park Ridge, Il

Lutheran General Hospital Men's Association, Park
Ridge, Il

Advisory Board, Committee on Jewish Genetic
Diseases, Cancer Genetics Subcommittee, Jewish
United Fund, Chicago, Illinois

Health Care Advisory Board, Congressman Mark
Kirk, 10th Congressional District, Illinois

Major Gifts Committee, Saint Francis Hospital
Development Council, Evanston, Il

Visiting Professor:

1. University of Utah, Division of Plastic Surgery, November 6-8,
2014.
2. Northwestern University, Division of Plastic Surgery, April 21-
22, 2016.
3. The University of North Carolina, Division of Plastic Surgery,
March 28-29, 2017
4. Georgetown University, Department of Plastic Surgery, May 17-
18, 2017
5. The University of Basel, Basel, Switzerland, August 31-
September 1, 2018

6. The Ochsner Health System, New Orleans, LA January 28-January 30, 2019
7. The University of Toronto, Toronto, Ontario, Canada, February 21-22, 2019
8. The University of Michigan, October 3-4, 2019, Ann Arbor, MI,

Invited Discussant:

1. Department of Defense, Military service by people who are transgender, Invitation from Terry Adirim, M.D., M.P.H. Deputy Assistant Secretary of Defense for Health Services Policy & Oversight, The Pentagon, November 9, 2017
2. Aesthetic Surgery Journal, Invited Discussant May 7, 2019, Journal Club. "What is "Nonbinary" and What Do I need to Know? A Primer for Surgeons Providing Chest Surgery for Transgender Patients."

Research Interests:

1. Role of Omental Stem Cells in Wound Healing (Grant: Tawani Foundation)
2. Robotic-Assisted Bilateral Prophylactic Nipple Sparing Mastectomy with Immediate Tissue Expander/Implant Reconstruction (Pending submission to the FDA for Investigational Device Exemption in association with Intuitive Surgical)
3. Transgender Health and Medicine Research Conference, National Institutes of Health, Bethesda, MD May 7-8, 2015
4. Uterine Transplantation, Rush University Medical Center (IRB pending)
5. Gender Affirmation Surgery Prospective Surveys (Rush University-IRB approved)
6. National Network for Gender Affirming Surgeries: Canadian Institute of Health Research, Training Grant - LGBTQ 2S Stigma Reduction & Life Course Mental Wellness (application in process)

BIBLIOGRAPHY:

PEER REVIEWED ARTICLES:

1. E. Wall, D. A. Schoeller, **L. Schechter**, L.J. Gottlieb: Measured Total Energy Requirements of Adult Patients with Burns. *The Journal of Burn Care and Rehabilitation* 20:329, 1999.

2. David C. Cronin, II, **Loren Schechter**, Somchi Limrichramren, Charles G. Winans, Robert Lohman, and J. Michael Millis, Advances in Pediatric Liver Transplantation: Continuous Monitoring of Portal Venous and Hepatic Artery Flow with an Implantable Doppler Probe. *Transplantation* 74(6):887-889, 2002.
3. Robert F. Lohman, **Loren S. Schechter**, Lawrence S. Zachary, Solomon Aronson: Evaluation of Changes in Skeletal Muscle Blood Flow in the Dog with Contrast Ultrasonography Revisited: Has the Technique Been Useful, and Where are We Headed Now? *The Journal of Plastic and Reconstructive Surgery* 111(4):1477-1480, 2003.
4. Alvin B. Cohn, Eric Odessey, Francis Casper, **Loren S. Schechter**: Hereditary Gingival Fibromatosis: Aggressive Two-Stage Surgical Resection in Lieu of Traditional Therapy, *The Annals of Plastic Surgery* Vol 57, Number 5, November 2006.
5. Eric Odessey, Al Cohn, Kenneth Beaman, and **Loren Schechter**: Mucormycosis of the Maxillary Sinus: Extensive Destruction with an Indolent Presentation, *Surgical Infections*, Vol. 9, Number 1, 2008
6. Iris A. Seitz, MD, David Tojo, MD, **Loren S. Schechter**, MD Anatomy of a Medication Error: Inadvertent Intranasal Injection of Neosynephrine During Nasal Surgery - A Case Report and Review of The Literature *Plast Reconstr Surg.* 2010 Mar;125(3):113e-4e. doi: 10.1097/PRS.0b013e3181cb68f9
7. Iris Seitz, MD Craig Williams, MD, Thomas Weidrich, MD, John Seiler, MD, Ginard Henry, MD, and **Loren S. Schechter, MD**: Omental Free Tissue Transfer for Coverage of Complex Upper Extremity Defects: The Forgotten Flap (N Y). 2009 Dec;4(4):397-405. doi: 10.1007/s11552-009-9187-6. Epub 2009 Mar 25.
8. Michael Salvino and **Loren S. Schechter**: Microvascular Reconstruction of Iatrogenic Femoral Artery Thrombus in an Infant: A Case Report and Review of the Literature *ePlasty* Volume 9 ISSN: 19357-5719, E-location ID: e20
9. Phillip C. Haeck, MD, Jennifer A. Swanson, BS, Med, Ronald E. Iverson, MD., **Loren S. Schechter, MD**, Robert Singer, MD, Bob Basu, MD, MPH, Lynn A. Damitz, MD, Scott Bradley Bradley Glasberg, MD, Lawrence S. Glasman, MD, Michael F. McGuire, MD, and the ASPSP Patient Safety Committee: Evidence-Based Patient Safety Advisory: Patient Selection and Procedures in Ambulatory Surgery, Supplement to *Plastic and Reconstructive Surgery*, Volume 124, Number 4s, October Supplement 2009.
10. Philip C. Haeck, MD, Jennifer A. Swanson, BS, Med, **Loren S. Schechter, MD**, Elizabeth J. Hall-Findlay, MD, Noel B. McDevitt, MD, Gary Smotrlich, MD, Neal R. Reisman, MD, JD, Scot Bradley Glasberg,

MD, and the ASPS Patient Safety Committee: Evidence-Based Patient Safety Advisory: Blood Dyscrasias, Patient Selection and Procedures in Ambulatory Surgery, Supplement to Plastic and Reconstructive Surgery, Volume 124, Number 4s, October Supplement 2009.

11. **Loren S. Schechter, MD**, The Surgeon's Relationship with The Physician Prescribing Hormones and the Mental Health Professional: Review for Version 7 of the World Professional Association of Transgender Health's Standards of Care *International Journal of Transgenderism* 11 (4), p.222-225 Oct-Dec 2009

12. Iris A Seitz, MD, PhD, Craig Williams, MD, **Loren S. Schechter, MD**, Facilitating Harvest of the Serratus Fascial Flap With Ultrasonic Dissection, *Eplasty* 2010 Feb 23;10:e18

13. Seitz, I, Friedewald SM, Rimler, J, **Schechter, LS**, Breast MRI helps define the blood supply to the nipple-areolar complex, *Plastische Chirurgie*, Supplement 1, 10. Jahrgang, September 2010, p. 75

14. Iris A. Seitz, Sally Friedwald, MD; Jonathon Rimler, **Loren S. Schechter**, Breast MRI to Define The Blood Supply to The Nipple-Areolar Complex. *Plast Recon Surg Suppl* 126 (26) p. 27 Oct 2010

15. Kalliainen LK; ASPS Health Policy Committee Evidence-Based Clinical Practice Guidelines: Reduction Mammoplasty, The American Society of Plastic Surgeons *Plast Reconstr Surg*. 2012 Oct;130(4):785-9 **Loren S. Schechter** (member and contributor, ASPS Health Policy Committee)

16. Eli Coleman, Walter Bockting, Marsha Botzer, Peggy Cohen-Kettenis, Griet DeCuyper, Jamie Feldman, Lin Fraser, Jamison Green, Gail Knudson, Walter J. Meyer, Stan Monstrey, Richard K. Adler, George R. Brown, Aaron H. Devor, Randall Ehrbar, Randi Ettner, Evan Eyler, Rob Garofalo, Dan H. Karasic, Arlene Istar Lev, Gal Mayer, Heino Meyer-Bahlburg, Blaine Paxton Hall, Friedmann Pfäfflin, Katherine Rachlin, Bean Robinson, **Loren S. Schechter**, Vin Tangpricha, Mick van Trotsenburg, Anne Vitale, Sam Winter, Stephen Whittle, Kevan R. Wylie & Ken Zucker, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, *International Journal of Transgenderism*, 13 (4) p. 165-232, August 2012.

17. Jonathan Bank, M.D., Lucio A. Pavone, M.D., Iris A. Seitz, M.D., Ph.D., Michelle C. Roughton M.D., **Loren S. Schechter M.D.** Case Report and Review of the Literature - Deep Inferior Epigastric Perforator Flap for Breast Reconstruction after Abdominal Recontouring, *eplasty* Ref.: Ms. No. EPLASTY-D-12-00050R1

18. Seitz IA, Siwinski P, Rioux-Forker D, Pavone L, **Schechter LS** Upper and Lower Limb Salvage with Omental Free Flaps: A Long-Term Functional Outcome Analysis, *Plast Reconstr Surg*. 2014; 134 (4 Suppl 1): 140. Doi:10.1097/01.prs.0000455514.83516.31. No abstract available. PMID: 25254872 [PubMed - in process]
19. Seitz IA, Friedewald S, **Schechter LS**, "NACsomes": A Classification system of the blood supply to the nipple areola complex (NAC) based on diagnostic breast MRI exams, accepted for publication, *Plast Reconstr Aesthet Surg*. 2015 Jun;68(6):792-9. doi: 10.1016/j.bjps.2015.02.027. Epub 2015 Feb 19.
20. **Loren S. Schechter**, Gender Confirmation Surgery: An Update for the Primary Care Provider, *Transgender Health*. Jan 2016, 1(1): 32-40.
21. **Loren S. Schechter**, Mimis N. Cohn, Gender Confirmation Surgery: A New Frontier in Plastic Surgery Education, *Journal of Plastic and Reconstructive Surgery*, October 2016, 138 (4): 784 e
22. Berli JU, Knudson G, Fraser L, Tangpricha V, Ettner R, Ettner FM, Safer JD, Graham J, Monstrey S, **Schechter L**, Gender Confirmation Surgery: What Surgeons Need To Know When Providing Care For Transgender Individuals, *JAMA Surg*. 2017 Apr 1;152(4):394-400. doi: 10.1001/jamasurg.2016.5549
23. Seitz, I.A., Lee, J.C., Sulo, S, Shah, V, Shah, M, Jimenez, M, **Schechter, L**, Common characteristics of functional and adverse outcomes in acute lower-extremity trauma reconstruction, *The European Journal of Plastic Surgery*, (2017) doi:10.1007/s00238-016-1268-5
24. **Loren S. Schechter**, Salvatore D'Arpa, Mimis Cohen, Ervin Kocjancic, Karel Claes, Stan Monstrey, Gender Confirmation Surgery: Guiding Principles *J Sex Med*. 2017 Jun;14(6):852-856. doi: 10.1016/j.jsxm.2017.04.001. Epub 2017 May 3
25. Response to Letter to the Editor: "Gender Confirmation Surgery: Guiding Principles". **Schechter LS**. *J Sex Med*. 2017 Aug;14(8):1067. doi: 10.1016/j.jsxm.2017.06.002. PMID: 28760249
26. Iris A. Seitz, **Loren S. Schechter**, "Successful Tongue Replantation Following Segmental Auto-Amputation Using Supermicrosurgical Technique," *J Reconstr Microsurg Open* 2017; 02(02): e132-e135 DOI: 10.1055/s-0037-1606584
27. Berli JU, Knudson G, **Schechter L**. Gender Confirmation Surgery and Terminology in Transgender Health-Reply. *JAMA Surg*. 2017 Nov 1;152(11):1091. doi: 10.1001/jamasurg.2017.2347. PMID: 28724140
28. Randi Ettner, Fred Ettner, Tanya Freise, **Loren Schechter**, Tonya White, "Tomboys Revisited: A retrospective comparison of childhood

behavioral patterns in lesbian women and transmen" Journal of Child and Adolescent Psychiatry ISSN: 2643-6655 Volume No: 1 Issue No: 1

29. Editor: **Loren S. Schechter**, Bauback Safa, Gender Confirmation Surgery, Clinics in Plastic Surgery, Vol. 45 (3), July 2018

30. **Loren S. Schechter**, Bauback Safa, Preface: Gender Surgery: A Truly Multidisciplinary Field, Gender Confirmation Surgery, Clinics in Plastic Surgery, Vol. 45 (3), p. xiii July 2018 (editors Loren S. Schechter, Bauback Safa)

31. Introduction to Phalloplasty. **Schechter LS**, Safa B.Clin Plast Surg. 2018 Jul;45(3):387-389. doi: 10.1016/j.cps.2018.03.014. Epub 2018 May 1. Review. PMID: 29908627

32. David Whitehead, **Loren S. Schechter**, Cheek Augmentation Techniques, Facial Plastic Surgery Clinics of North America 27 (2019) 199-206

33. Mosser SW, **Schechter LS**, Facque AR, et. al, Nipple Areolar Complex Reconstruction in an Integral Part of Chest Reconstruction in the Treatment of Transgender and Gender Diverse People, The International Journal of Transgenderism, DOI: 10.11080/15532739.2019.1568343

34. Kocjancic E, Jaunarena JH, **Schechter L**, Acar Ö. Inflatable penile prosthesis implantation after gender affirming phalloplasty with radial forearm free flap. Int J Impot Res. 2020 Jan;32(1):99-106. doi: 10.1038/s41443-019-0153-8. Epub 2019 Jun 6.

35. **Loren S. Schechter**, Mimis N. Cohen, "Gender Confirmation Surgery: Moving Forward," The Journal of Craniofacial Surgery, Vol. 30, No. 5, July 2019, P. 1364

36. **Loren S. Schechter**, Rebecca Schechter, "Training Surgeons in Gender Confirmation Surgery," The Journal of Craniofacial Surgery, Vol 30, No 5, July 2019, p. 1380

37. Facque AR, Atencio D, **Schechter LS**. Anatomical Basis and Surgical Techniques Employed in Facial Feminization and Masculinization. J Craniofac Surg. 2019 Jul;30(5):1406-1408. doi: 10.1097/SCS.0000000000005535.PMID: 31299732

38. Walter Pierre Bouman MD PhD, Jon Arcelus MD PhD, Griet De Cuypere MD PhD, M. Paz Galupo PhD, Baudewijntje P.C. Kreukels PhD, Scott Leibowitz MD, Damien W. Riggs PhD, **Loren S. Schechter MD FACS**, Guy T'Sjoen MD PhD, Jaimie Veale PhD, Transgender and gender diverse people's involvement in transgender health research, International Journal of Transgenderism, vol. 19, no. 4, 357-358.

39. Bustos SS, Kapoor T, **Schechter LS**, Ciudad P, Forte AJ, Del Corral G, Manrique OJ."Impact of Social Media Presence on Online Reviews Among Plastic Surgeons Who Perform Gender Affirming Surgeries" *J Plast Reconstr Aesthet Surg*. 2020 Apr;73(4):783-808. doi: 10.1016/j.bjps.2019.11.031. Epub 2019 Nov 28.
40. Wiegmann AL, **Schechter LS**, *Aesthetic Surgery Journal*, Invited Commentary on: "Gender Surgery Beyond Chest and Genitals: Current Insurance Landscape" *Aesthetic Surgery Journal*, sjz318, <https://doi.org/10.1093/asj/sjz318> Published:28 December 2019
41. Rayisa Hontacharuk, Brandon Alba, **Loren Schechter**, *International Journal of Impotence Research*, Invited Commentary on: "Suprapubic Pedicled Phalloplasty in Transgender Men: A Multi-Centric Retrospective Cohort Analysis" (accepted for publication, *The International Journal of Impotence Research*)
42. "The Affordable Care Act and Its Impact on Plastic Surgery and Gender-Affirmation Surgery," *The Journal of Plastic and Reconstructive Surgery*, (accepted for publication)
43. Ara A. Salibian, MD; **Loren S. Schechter, MD**, FACS; William M. Kuzon, MD; Mark-Bram Bouman, MD, PhD; Lee C. Zhao, MD; Rachel Bluebond-Langner, MD "Vaginal Canal Reconstruction in Penile Inversion Vaginoplasty with Flaps, Peritoneum or Skin Grafts: Where Is The Evidence," *The Journal of Plastic and Reconstructive Surgery* (submitted for publication)
44. Devin Coon, MD MSE, Rachel Bluebond-Langner, MD, Pierre Brassard, MD, William Kuzon, MD, Stan Monstrey, MD, **Loren S. Schechter, MD**, "The State of the Art in Vaginoplasty: A Comparison of Algorithms, Surgical Techniques and Management Practices Across Six High-Volume Centers," *The Journal of Plastic and Reconstructive Surgery* (in preparation)
45. Rayisa Hontscharuk, Brandon Alba, Devin Coon, Elyse Pine, Catherine Manno, Madeline Deutsch, **Loren Schechter**, *Perioperative Transgender Hormone Management: Avoiding VTE and other Complications*, *The Journal of Plastic and Reconstructive Surgery* (accepted for publication, *the Journal of Plastic and Reconstructive Surgery*)
46. **Loren S. Schechter** and Rayisa Hontscharuk, Invited Commentary, *Phantom Penis: Extrapolating Neuroscience and Employing Imagination for Trans Male Embodiment*, *Studies in Gender and Sexuality* (accepted for publication)

47. Omer Acar, Ervin Kocjancic, Susan Talamini, and **Loren Schechter**' Masculinizing Genital Gender Affirming Surgery: Metoidioplasty and Urethral Lengthening, *Int J Impot Res.* 2020 Mar 19. doi: 10.1038/s41443-020-0259-z. [Epub ahead of print] Review.PMID: 32203431
48. Norah Oles, BS; Halley Darrach, BS; Wilmina Landford, MD; Matthew Garza; Claire Twose, MLIS; Phuong Tran, MS; Brandyn Lau, MPH; **Loren Schechter**, Devin Coon, MD, MSE Gender Affirming Surgery: A Comprehensive, Systematic Review of All Peer-Reviewed Literature and Methods of Assessing Patient-Centered OutcomesPart 1: Breast/Chest, Face, and Voice (Accepted for publication, *Annals of Surgery*)
49. Siotos, Cheah, Damoulakis, Kelly, Siotou, **Schechter**, Shenaq, Derman and Dorafshar, Trends of Medicare Reimbursement Rates for Common Plastic Surgery Procedures (accepted for publication, *Journal of Plastic and Reconstructive Surgery*)
50. **Loren S. Schechter**, Discussion: Quantifying the psychosocial benefits of masculinizing mastectomy in trans-male patients with patient reported outcomes: The UCSF Gender Quality of Life (QoL) survey, *The Journal of Plastic and Reconstructive Surgery Plastic and Reconstructive Surgery* May 2021; 147(5)
51. Alireza Hamidian Jahromi, **Loren Schechter**, Commentary on: Telemedicine in Transgender Care: A Twenty First-Century Beckoning, *Plastic and Reconstructive Surgery*, May 1; 147 (5): 898e-899e.
52. Jazayeri HE, Lopez J, Sluiter EC, O'Brien-Coon D, Bluebond-Langner R, Kuzon WM Jr, Berli JU, Monstrey SJ, Deschamps-Braly JC, Dorafshar AH, **Schechter LS**, Discussion: Promoting Centers for Transgender Care, *Journal of Oral and Maxillofacial Surgery.* 2021 Jan;79(1):3-4. Doi: 10.1016/j.joms.2020.09.027. Epub 2020 Oct 19. PMID: 33091402
53. Letter to the editor, Body mass index requirements for gender-affirming surgeries are not empirically based. *Transgender Health.*(submitted for publication)
54. Strategies for innervation of the neophallus, Rayisa Hontscharuk, Charalampso Siotos, **Loren S. Schechter**, (accepted for publication, *The Journal of Plastic and Aesthetic Research*)

55. Guiding the Conversation-Types of Regret after Gender-Affirming Surgery and Their Associated Etiologies, (accepted for publication, Annals of Translational Medicine)

56. Alireza Hamidian, Louisa Boyd, Loren Schechter, (accepted for publication, The World Journal of Surgery), An Updated Overview of Gender Dysphoria and Gender Affirmation Surgery: What Every Plastic Surgeon Should Know (accepted for publication, World Journal of Surgery)

57. Alireza Hamidian, Sydney Horen, Amir Dorafshar, Michelle Seu, Asa Radix, Erica Anderson, Jamison Green, Lin Fraser, Liza Johannesson, Giuliano Testa, and Loren S. Schechter, Uterine Transplant and Donation in Transgender Individuals: Proof of Concept (Accepted for Publication, Guest Editorial, International Journal of Transgender Health)

58. Rayisa Hontscharuk, Brandon Alba, Alireza Hamidian, Loren S. Schechter, Penile Inversion Vaginoplasty Outcomes: Complications and Satisfaction, (accepted for publication, Andrology)

59. "Plastic Surgeon Financial Compensation - Incentivization Models in Surgical Care Delivery: The Past, Present & Future" (accepted for publication, Journal of Plastic and Reconstructive Surgery)

60. Alireza Hamidian, Jenna Stoehr, Loren S. Schechter, "Telemedicine for Gender-Affirming Medical and Surgical Care: A Systematic Review and Call-to-Action" (accepted for publication, The Journal of Transgender Health)

NON-PEER REVIEWED ARTICLES:

1. Printen KJ, Schechter HO, Veldenz HE, **Schechter LS**, Otto S, Jaley A, Otto W: Undetected Transport Hypoxia in Major Surgical Procedures. *The Quarterly Bulletin of St. Francis Hospital*, Spring, 1989

2. **Schechter LS**, Memmel H, Layke J: Breast Reconstruction: The Plastic Surgeon as a Member of the Multi-Disciplinary Team. *Chicago Medicine*, 106(15): 34-38, 2003

3. **Schechter LS**: Mission Accomplished: Achieving a Successful Microsurgical Reconstruction of the Head and Neck. *Plastic Surgery Products*, March 2004

4. **Loren S. Schechter, MD**: A Helping Hand. *Plastic Surgery Products*, November 2005.

5. **Loren S. Schechter, MD**: On Guard for DVT. *Plastic Surgery Products*, June 2007.

6. **Loren S. Schechter, MD** and Iris Seitz, MD, PhD: Mission: Possible Achieving a Successful Microsurgical Reconstruction of the Head and Neck, *Plastic Surgery Practice*, May 2009.
7. **Loren S. Schechter, MD** and Iris A. Seitz, MD, PhD: Soft-tissue Reconstruction of Arms and Hands, *Plastic Surgery Practice*, February, 2010.
8. Lucio A. Pavone, MD, Iris A. Seitz, MD, PhD, **Loren S. Schechter, MD**: Current Options in Autologous Breast Reconstruction, *Plastic Surgery Practice*, November, 2010.
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2. **Loren S. Schechter**, Surgery for Gender Identity Disorder, *Plastic Surgery*, Fourth Edition, ed. Neligan, 2013, Elsevier, Vol. Four, Volume Editor (Submitted for publication): David H. Song
3. Nicholas Kim and **Loren S. Schechter**, Plastic Surgery Board Review: Pearls of Wisdom, 3rd Edition, Gender Confirmation Surgery McGraw Hill, 2016
4. **Loren S. Schechter**, Surgical Management of the Transgender Patient (Elsevier, 2016)
5. **Loren S. Schechter** and Rebecca B. Schechter, Pursuing Gender Transition Surgeries, *Adult Transgender Care An Interdisciplinary Approach for Training Mental Health Professionals*, First Edition, published 2018, Taylor and Francis, edited by Michael Kauth and Jillian Shipherd
6. **Loren S. Schechter**, Breast and Chest Surgery in Transgender Patients, *Comprehensive Care of the Transgender Patient* first edition, Elsevier, 2020
7. **Loren S. Schechter** (editor), Gender Confirmation Surgery-Principles and Techniques for an Emerging Field, Springer-Verlag, 2020
8. **Loren S. Schechter**, Bauback Safa, (editors), Gender Confirmation Surgery, *Clinics in Plastic Surgery* 45:3, Elsevier, July 2018

9. **Loren S. Schechter** and Paul Weiss, *Transgender Breast Surgery, Cosmetic Breast Surgery*, edited by Sameer A. Patel and C. Bob Basu, Thieme, 2020
10. **Loren S. Schechter**, Rebecca B. Schechteer, *Surgical Effects of GnRHa Treatment, Pubertal Suppression in Transgender Youth*, Elsevier, 2019
11. **Loren S. Schechter**, *Surgical Anatomy: Phalloplasty*, in *Urological Care for the Transgender Patient: A Comprehensive guide* (in preparation, Springer Nature)
12. **Loren S. Schechter** and Alexander Facque, *Transgender Surgery- Feminization and Masculinization, Tips and Tricks in Plastic Surgery*, edited by Seth R. Thaller and Zubin Panthaki, (Springer Nature, Submitted for publication)
13. **Loren S. Schechter** and Alexander Facque, *Aesthetic Breast Surgery in Transgender Patients: Male to Female*, *Spear's Surgery of the Breast: Principles and Art*, 4e by Allen Gabriel, Wolters Kluwer (in publication)
14. **Loren S. Schechter** and Alexander Facque, *Navigating Problems with Transgender Top Surgery, Managing Common and Uncommon Complication of Aesthetic Breast Surgery*, edited by Dr. John Y.S. Kim, Springer Nature
15. **Loren S. Schechter**, *Gender Affirming Surgery: Bottom Surgery, The Art of Aesthetic Surgery: Principles and Techniques*, edited by Drs. Foad Nahai, Jeffrey Kenkel, Grant Stevens, Farzad Nahai, John Hunter, and William P. Adams, (Thieme, In Publication)
16. **Loren S. Schechter**, Rayisa Hontscharuk, and Amir Dorafshar, *ALT Free Flap with Its Sensory Nerve: Versatility in its Utilization, Reconstructive Principles and Strategies with Neurotization: Current and Future Developments in Nerve Repair, Reconstruction, and Flaps*, edited by Risal Djohan, MD (Springer Nature, in preparation)
17. **Loren S. Schechter**, *Recipient Vessels in Reconstructive Microsurgery*,

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2. E. Wall, **L. Schechter**, L.J. Gottlieb, D. Schoeller: Calculated Versus Measured Energy Requirements in Adult Burn Patients. Proceedings of the ABA 26th Annual Meeting, p. 239, 1994
3. **L. Schechter**, Robert Walton: Plication of the Orbital Septum in Lower Eyelid Blepharoplasty. New Frontiers in Aesthetic Surgery Annual Meeting Program Manual, p.90-91, 1999
4. **Loren Schechter, M.D.**, K. Alizadeh, M.D., M. McKinnon, M.D., Craniofacial Osseo-Distraktion: A Bridge to Eucephaly, Abstracts of the 12th Congress of the International Confederation for Plastic, Reconstructive, and Aesthetic Surgery, p. 63, 1999.
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7. **Loren S. Schechter**, Mark A. Grevious, David H. Song, Risal Djohan, and Robert F. Lohman: Comparing Sural Neurocutaneous and Free Flaps for Reconstruction of Leg Wounds: Indications and Outcomes, The World Society for Reconstructive Microsurgery p.29, 2001
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13. **Loren S. Schechter, MD**, John C. Layke, MD, Wayne M. Goldstein, MD, Lawrence J. Gottlieb, MD: The Gastrocnemius-Achilles Tendon Myocutaneous Flap (GAT Flap) for Single Stage Reconstruction of Combined Soft Tissue and Extensor Mechanism Defects of the Knee: An 18 Year Experience, *Plastic Surgery Forum*, Vol. XXVII, P. 133.
14. Joseph Talarico, MD, Wayne Lee, MD, **Loren Schechter, MD**: When Component Separation Isn't Enough, *American Hernia Society, Inc, Hernia Repair 2005*, P. 194
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17. I.A. Seitz, C.S. Williams, T.A. Wiedrich, **L.S. Schechter**, Omental Free Tissue Transfer for Coverage of Complex Upper Extremity and Hand Defects-The Forgotten Flap, *Plastic Surgery At The Red Sea International Symposium Book Of Abstracts*, March 24-28, 2009, p. 25
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19. Michelle Roughton, MD and **Loren Schechter, MD**, Two Birds, One Stone: Combining Abdominoplasty with Intra-Abdominal Procedures, *The Midwestern Association of Plastic Surgeons Book of Abstracts*, April 18-19, 2009, p.65
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21. Iris A. Seitz, MD, Phd, Craig Williams, MD, Daniel Resnick, MD, Manoj Shah, MD, **Loren Schechter, MD, FACS**, Achieving Soft Tissue

Coverage of Complex Upper and Lower Extremity Defects with Omental Free Tissue Transfer, Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, p. 28

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27. 25th WPATH Symposium, Surgeons Only, November 1, 2018, Buenos Aires, Argentina, IPP Implantation Post-Phalloplasty: The Chicago Experience

28. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, The Role of Pelvic Floor Physical Therapy in Patients Undergoing Gender Confirming Vaginoplasty Procedures

29. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Establishing Guidelines for VTE Prophylaxis in Gender Confirmation Surgery

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PRESENTATIONS:

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2. American Association for the Surgery of Trauma, Sept. 17-19, 1992, Louisville, KY: "Routine HIV Testing in A Burn Center: A Five Year Experience"
3. American Burn Association Poster Session, April 20-23, 1994, Orlando, Fl: "Calculated Versus Measured Energy Requirements in Adult Burn Patients"
4. 48th Annual Senior Scientific Session: The University of Chicago, May 19, 1994: "Calculated Versus Measured Energy Requirements in Adult Burn Patients"
5. Plastic Surgery Senior Residents Conference, April 20-25, 1999, Galveston, TX: "Plication of the Orbital Septum in Lower Eyelid Blepharoplasty"
6. The Chicago Society of Plastic Surgery, May 6, 1999, "Plication of the Orbital Septum in Lower Eyelid Blepharoplasty"
7. The American Society for Aesthetic Plastic Surgery, May 14-19, 1999, Dallas, TX: "Plication of the Orbital Septum in Lower Eyelid Blepharoplasty"
8. XIII Congress of the International Confederation for Plastic, Reconstructive, and Aesthetic Surgery, June 27-July 2, 1999, San Francisco, CA: "Craniofacial Osseo-Distraktion: A Bridge to Eucephaly"
9. XIII Congress of the International Confederation for Plastic, Reconstructive, and Aesthetic Surgery, June 27-July 2, 1999 San Francisco, CA: "Ethnic Aesthetic Analysis and Surgery"
10. Inaugural Congress of the World Society for Reconstructive Microsurgery, October 31-November 3, 2001, Taipei, Taiwan: "Comparing Sural Neurocutaneous and Free Flaps for Reconstruction of Leg Wounds: Indications and Outcomes"
11. American Society for Reconstructive Microsurgery, January 12-15, 2002, Cancun, Mexico: "The Role to Free Tissue Transfer and Sural Neurocutaneous flaps for Reconstruction of Leg Wounds"
12. American Society of Plastic Surgery, 71st Annual Scientific Meeting, November 2-6, 2002, San Antonio, Texas: "Defining the Role for Negative Pressure Therapy in the Treatment Algorithm of Extremity Wounds"
13. American Society of Reconstructive Microsurgery, Annual Scientific Meeting, January 11-15, 2003, Kauai, Hawaii: "Advances in Pediatric Liver Transplantation: Continuous Monitoring of Portal Venous and Hepatic Artery Flow With an Implantable Doppler Probe"

14. The 5th Annual Chicago Trauma Symposium, August 8-10, 2003, Chicago, Illinois: "Soft Tissue Salvage: Where Are We in 2003?"
15. The Midwestern Association of Plastic Surgeons, 42nd Annual Meeting, Chicago, Il May 1-2, 2004: "The Gastrocnemius-Achilles Tendon Myocutaneous Flap (GAT Flap) for Single Stage Reconstruction of Combined Soft Tissue and Extensor Mechanism Defects of the Knee: An Eighteen Year Experience"
16. The 6th Annual Chicago Trauma Symposium, August 12-15, 2004, Chicago, Il "Complex Wound Management"
17. The American Society of Plastic Surgery, October 9-13, 2004, Philadelphia, Pennsylvania: "The Gastrocnemius-Achilles Tendon Myocutaneous Flap (GAT Flap) for Single Stage Reconstruction of Combined Soft Tissue and Extensor Mechanism Defects of the Knee: An Eighteen Year Experience"
18. The American Society for Reconstructive Microsurgery, January 15-18, 2005, Fajardo, Puerto Rico: "Surviving as a Plastic Surgeon"
19. American Hernia Society, Poster Presentation, February 9-12, 2005, San Diego, California: "When Component Separation Isn't Enough"
20. The Midwestern Association of Plastic Surgeons, April 23-24, Chicago, Il: "Hereditary Gingival Fibromatosis in Monozygotic Twins: First Reported Case"
21. The Midwestern Association of Plastic Surgeons, April 23-24, Chicago, Il: "Modified Components Separation Technique for Two Massive Ventral Hernias"
22. The Midwestern Association of Plastic Surgeons, April 23-24, Chicago, Il: "Mucormycosis of the Head and Neck: A Fatal Disease?"
23. The 7th Annual Chicago Trauma Symposium, August 11-14, 2005, Chicago, Il "Management of Complex Injuries"
24. Current Concepts in Advanced Wound Healing: *A Practical Overview*, Rush North Shore Medical Center, Skokie, Il September 18, 2005 "From Flaps to Grafts"
25. Taizoon Baxamusa, M and Loren S.Schechter, MD, Abdominoplasty: Use in Reconstruction of the Mangled Upper Extremity, The American Association For Hand Surgery Annual Scientific Meeting, January 11-14, 2006, Tucson, Arizona.

26. The American Academy of Orthopedic Surgeons 2006 Annual Meeting, March 22-26, 2006, Chicago, Il "Methods of Patella-Femoral and Extensor Mechanism Reconstruction for Fracture and Disruption After Total Knee Arthroplasty"
27. Midwestern Association of Plastic Surgeons 44th Annual Meeting, April 29-30, 2006, Oak Brook, Illinois "Elective Abdominal Plastic Surgery Procedures Combined with Concomitant Intra-abdominal Operations: A Single Surgeon's Four Year Experience"
28. Midwestern Association of Plastic Surgeons 44th Annual Meeting, April 29-30, 2006, Oak Brook, Illinois "Hereditary Gingival Fibromatosis: Aggressive Two-Stage Surgical Resection Versus Traditional Therapy"
29. Midwestern Association of Plastic Surgeons 44th Annual Meeting, April 29-30, 2006, Oak Brook, Illinois "Abdominoplasty Graft & VAC Therapy: Two Useful Adjuncts in Full-Thickness Grafting of the Mangled Upper Extremity"
30. The American Association of Plastic Surgeons 85th Annual Meeting, May 6-9, 2006 Hilton Head, South Carolina "Excision of Giant Neurofibromas"
31. The 8th Annual Chicago Trauma Symposium, July 27-30, 2006, Chicago, Il "Management of Complex Injuries"
32. The American Society of Plastic Surgeons Annual Meeting, October 6-12, 2006, San Francisco, California "Excision of Giant Neurofibromas"
33. The American College of Surgeons Poster Presentation, October, 2006, Chicago, Il "Abdominoplasty: Use in Reconstruction of the Mangled Upper Extremity"
34. American Medical Association-RFS 3rd Annual Poster Symposium, November 10, Las Vegas, NV, 2006 "Abdominal Wall Reconstruction With Alloderm"
35. Advocate Injury Institute: "Trauma 2006: The Spectrum of Care), November 30-December 2, 2006, Lisle, Il, "Pit Bull Mauling: A Case Study"
36. The 9th Annual Chicago Trauma Symposium, August 10-12, 2007, Chicago, Il "Management of Complex Injuries"
37. The World Professional Association for Transgender Health (WPATH) 2007 XX Biennial Symposium, September 5-8. 2007, Chicago, Il Revision Vaginoplasty With Sigmoid Interposition: "A Reliable Solution for a Difficult Problem"

38. Metropolitan Chicago Chapter of the American College of Surgeons, 2008 Annual Meeting, March 15, 2008 "ER Call: Who's Job is it Anyway"
39. The 10th Annual Chicago Trauma Symposium, August 7-10, 2008, Chicago, Il "Management of Complex Injuries"
40. 23rd Annual Clinical Symposium on Advances in Skin & Wound Care: The Conference for Prevention and Healing October 26-30, 2008, Las Vegas, Nevada, poster presentation "Use of Dual Therapies Consisting of Negative Pressure Wound Therapy (NPWT) and Small Intestine Mucosa (SIS) on a Complex Degloving Injury With an Expose Achilles Tendon: A Case Report."
41. The American Society of Plastic Surgeons Annual Meeting, October 31-November 3, 2008, Chicago, Il "Panel: Fresh Faces, Real Cases"
42. The American Association for Hand Surgery Annual Meeting, January 7-13, 2009, Maui, Hawaii, poster session: "Omental Free Tissue Transfer for Coverage of Complex Upper Extremity and Hand Defects-The Forgotten Flap."
43. Plastic Surgery At The Red Sea Symposium, March 24-28, 2009 Eilat, Israel, "Omental Free Tissue Transfer for Coverage of Complex Upper Extremity and Hand Defects-The Forgotten Flap."
44. ASPS/IQUAM Transatlantic Innovations Meeting, April 4-7, 2009 Miason de la Chimie, Paris, France, "Advertising in Plastic Surgery?"
45. ASPS/IQUAM Transatlantic Innovations Meeting, April 4-7, 2009 Miason de la Chimie, Paris, France, "Cost-Effectiveness of Physician Extenders in Plastic Surgery"
46. Midwestern Association of Plastic Surgeons, 47th Annual Meeting, April 18-19, 2009, Chicago, Il, "Microvascular Reconstruction of Iatrogenic Femoral Artery Injury in a Neonate"
47. Midwestern Association of Plastic Surgeons, 47th Annual Meeting, April 18-19, 2009, Chicago, Il, "Two Birds, One Stone: Combining Abdominoplasty with Intra-Abdominal Procedures"
48. The 11th Annual Chicago Trauma Symposium, August 1, 2009, Chicago, Il "Management of Complex Injuries"
49. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Omental Free Tissue Transfer for Coverage of Complex Extremity Defects: The Forgotten Flap."

50. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Challenging Cases."
51. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, "President's Panel: The Future of the Solo Practice-Can We, Should We Survive?"
52. The 12th Annual Chicago Trauma Symposium, August 5-8, 2010, Chicago, Il "Management of Complex Injuries"
53. Breast MRI to Define The Blood Supply to the Nipple-Areolar Complex. German Society of Plastic, Reconstructive and Aesthetic Surgery (DGPRaec), Dresden, Germany, September 2010
54. Roundtable Discussion: Electronic Health Records-Implications for Plastic Surgeons, The American Society of Plastic Surgeons Annual Meeting, October 3, 2010, Toronto, CA
55. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, The American Society of Plastic Surgeons Annual Meeting, October 3, 2010, Toronto, CA.
56. ASPS/ASPSN Joint Patient Safety Panel: Patient Selection and Managing Patient Expectations, The American Society of Plastic Surgeons Annual Meeting, October 4, 2010, Toronto, CA
57. Lunch and Learn: Prevention of VTE in Plastic Surgery Patients, The American Society of Plastic Surgeons Annual Meeting, October 5, 2010, Toronto, CA
58. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, 16th Congress of The International Confederation for Plastic Reconstructive and Aesthetic Surgery, May 22-27, 2011, Vancouver, Canada
59. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland
60. Applications of the Omentum for Limb Salvage: The Largest Reported Series, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland
61. Successful Tongue Replantation Following Auto-Amputation Using Supermicrosurgical Technique, Poster Session, The 6th Congress of The

World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland

62. The 13th Annual Chicago Trauma Symposium, August 25-28, 2011, Chicago, IL "Soft Tissue Defects-Getting Coverage"

63. WPATH: Pre-conference Symposium, September 24, 2011, Atlanta, GA "Surgical Options and Decision-Making"

64. American Society of Plastic Surgeons Annual Meeting, September 27, 2011, Denver, CO Closing Session Lunch and Learn: Pathways to Prevention-Avoiding Adverse Events, Part I: Patient Selection and Preventing Adverse Events in the Ambulatory Surgical Setting

65. American Society of Plastic Surgeons Annual Meeting, September 27, 2011, Denver, CO Closing Session Lunch and Learn: Pathways to Prevention-Avoiding Adverse Events, Part III: Preventing VTE

66. XXIV Congresso Nazionale della Societa Italiana di Microchirurgia congiunto con la American Society for Reconstructive Microsurgery, October 20-22, 2011, Palermo, Sicily: 3 Step Approach to Lower Extremity Trauma

67. XXIV Congresso Nazionale della Societa Italiana Microchirurgia congiunto con la American Society for Reconstructive Microsurgery, October 20-22, 2011, Palermo, Sicily: Applications of the Omentum for Limb Salvage: The Largest Reported Series

68. American Society for Reconstructive Microsurgery, Poster Presentation, January 14-17, 2012, Las Vegas, NV: Neonatal Limb Salvage: When Conservative Management is Surgical Intervention

69. The 14th Annual Chicago Trauma Symposium, August 2-5, 2012, Chicago, IL "Soft Tissue Defects-Getting Coverage"

70. The Annual Meeting of The American Society of Plastic Surgeons, October 25th-30, 2012, New Orleans, LA "Reimbursement in Breast Reconstruction"

71. The Annual Meeting of The American Society of Plastic Surgeons, October 25th-30, 2012, New Orleans, LA "Thriving in a New Economic Reality: Business Relationships and Integration in the Marketplace"

72. The 15th Annual Chicago Trauma Symposium, August 2-5, 2013, Chicago, IL "Soft Tissue Defects-Getting Coverage"

73. 2014 WPATH Symposium, Transgender Health from Global Perspectives, February 14-18, 2014, "Short Scar Chest Surgery."

74. 2014 WPATH Symposium, Transgender Health from Global Perspectives, February 14-18, 2014, "Intestinal Vaginoplasty with Right and Left Colon."
75. 24th Annual Southern Comfort Conference, September 3-7, 2014, Atlanta, Georgia, "Gender Confirmation Surgery: State of the Art."
76. The 15th Annual Chicago Trauma Symposium, September 4-7, 2014, Chicago, Il "Soft Tissue Defects-Getting Coverage"
77. The Midwest Association of Plastic Surgeons, May 30, 2015, Chicago, Il "Gender Confirmation Surgery: A Single-Surgeon's Experience"
78. The Midwest Association of Plastic Surgeons, May 30, 2015, Chicago, Il, Moderator, Gender Reassignment.
79. the American Society of Plastic Surgeons 2015 Professional Liability Insurance and Patient Safety Committee Meeting, July 17, 2015, "Gender Confirmation Surgery."
80. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. From Fee-for-Service to Bundled Payments
81. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. Moderator, Transgender Surgery
82. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. Efficient Use of Physician Assistants in Plastic Surgery.
83. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. Patient Safety: Prevention of VTE
84. The World Professional Association for Transgender Health, Objective Quality Parameters for Gender Confirmation Surgery, June 18-22, 2016, Amsterdam, Netherlands
85. The World Professional Association for Transgender Health, Resident Education Curriculum for Gender Confirmation Surgery, June 18-22, 2016, Amsterdam, Netherlands
86. The World Professional Association for Transgender Health, Urologic Management of a Reconstructed Urethra(Poster session #195), June 18-22, 2016, Amsterdam, Netherlands
87. The World Professional Association for Transgender Health, Construction of a neovagina for male-to-female gender reassignment surgery using a modified intestinal vaginoplasty technique, poster session (Poster session #198), June 18-22, 2016, Amsterdam, Netherlands

88. Aesthetica Super Symposium, The American Society of Plastic Surgeons, Genital Aesthetics: What are we trying to achieve?, Washington, DC June 23-25, 2016
89. Aesthetica Super Symposium, The American Society of Plastic Surgeons, Female to Male Gender Reassignment, Washington, DC June 23-25, 2016
90. Aesthetica Super Symposium, The American Society of Plastic Surgeons, The journal of retractions, what I no longer do, Washington, DC June 23-25, 2016
91. Aesthetica Super Symposium, The American Society of Plastic Surgeons, The three minute drill, tips and tricks, Washington, DC June 23-25, 2016
92. Aesthetica Super Symposium, The American Society of Plastic Surgeons, Moderator, Mini master class: Male genital plastic surgery, Washington, DC June 23-25, 2016
93. The 16th Annual Chicago Trauma Symposium, August 18-21, 2016, Chicago, Il "Soft Tissue Defects-Getting Coverage"
94. USPATH Poster Session, Feb 2-5, 2017, Los Angeles, CA, Partial Flap Failure Five Weeks Following Radial Forearm Phalloplasty: Case Report and Review of the Literature
95. USPATH Poster Session, Feb 2-5, 2017, Los Angeles, CA, Urethroplasty for Stricture after Phalloplasty in Transmen Surgery for Urethral Stricture Disease after Radial Forearm Flap Phalloplasty-Management Options in Gender Confirmation Surgery
96. USPATH, Feb 2-5, 2017, Los Angeles, CA, Patient Evaluation and Chest Surgery in Transmen: A Pre-operative Classification
97. USPATH, Feb 2-5, 2017, Los Angeles, CA Single Stage Urethral Reconstruction in Flap Phalloplasty: Modification of Technique for Construction of Proximal Urethra
98. USPATH, Feb 2-5, 2017, Los Angeles, CA, Use of Bilayer Wound Matrix on Forearm Donor Site Following Phalloplasty
99. USPATH, Feb 2-5, 2017, Los Angeles, CA, Vaginoplasty: Surgical Techniques
100. USPATH, Feb 2-5, 2017, Los Angeles, CA, Positioning of a Penile Prosthesis with an Acellular Dermal Matrix Wrap following Radial Forearm Phalloplasty

101. USPATH, Feb 2-5, 2017, Los Angeles, CA, Principles for a Gender Surgery Program
102. USPATH, Feb 2-5, 2017, Los Angeles, CA, Construction of a Neovagina Using a Modified Intestinal Vaginoplasty Technique
103. The 18th Annual Chicago Orthopedic Symposium, July 6-9, 2017, Chicago, Il "Soft Tissue Defects-Getting Coverage"
104. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, Moderator: Genital Surgery Trends for Women
105. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, Adding Transgender Surgery to Your Practice, Moderator and Speaker
106. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, Transbottom Surgery
107. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018 A Novel Approach to IPP Implantation Post Phalloplasty: The Chicago Experience
108. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018, A Novel Approach for Neovagina Configuration During Vaginoplasty for Gender Confirmation Surgery
109. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018 Development of a Pelvic Floor Physical Therapy Protocol for Patients Undergoing Vaginoplasty for Gender Confirmation
110. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018 Establishing Guidelines for Gender Confirmation Surgery: The Perioperative Risk of Asymptomatic Deep Venous Thrombosis for Vaginoplasty
111. The 19th Annual Chicago Trauma Symposium, August 16-19, 2018, Chicago, Il "Soft Tissue Defects-Getting Coverage"
112. Midwest LGBTQ Health Symposium, September 14-15, 2018, Chicago, Il "Quality Parameters in Gender Confirmation Surgery"
113. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Poster Session, Proposed Guidelines for Medical Tattoo Following Phalloplasty; An Interdisciplinary Approach

114. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Establishment of the First Gender Confirmation Surgery Fellowship
115. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, ISSM Lecture, The Importance of Surgical Training
116. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Tracking Patient-Reported Outcomes in Gender Confirmation Surgery
117. "Theorizing the Phantom Penis," The Psychotherapy Center for Gender and Sexuality's 6th Biannual Conference, Transformations, March 29-March 30, 2019, NY, NY

INSTRUCTIONAL COURSES:

1. Emory University and WPATH: Contemporary Management of Transgender Patients: Surgical Options and Decision-Making, September 5, 2007 Chicago, IL
2. Craniomaxillofacial Trauma Surgery: An Interdisciplinary Approach, February 16-17, 2008, Burr Ridge, IL
3. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, Moderator: Free Papers, Lower Extremity
4. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, Moderator: ASPS/ASPSN Patient Panel: Effective Communication-A Key to Patient Safety and Prevention of Malpractice Claims
5. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, Instructional Course: Strategies to Identify and Prevent Errors and Near Misses in Your Practice
6. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, Roundtable Discussion: Electronic Health Records-Implications for Plastic Surgeons
7. 10th Congress of The European Federation of Societies for Microsurgery, May 2-22, 2010, Genoa, Italy, "The Mangled Lower Extremities: An Algorithm for Soft Tissue Reconstruction."
8. Multispecialty Course for Operating Room Personnel-Craniomaxillofacial, Orthopaedics, and Spine, A Team Approach, AO North American, June 26-27, 2010, The Westin Lombard Yorktown Center.

9. Management of Emergency Cases in the Operating Room, The American Society of Plastic Surgeons Annual Meeting, October 4, 2010, Toronto, CA.
10. Surgical Approaches and Techniques in Craniomaxillofacial Trauma, November 6, 2010, Burr Ridge, Il.
11. The Business of Reconstructive Microsurgery: Maximizing Economic value (Chair)The American Society for Reconstructive Microsurgery, January 14-17, 2012, Las Vegas, Nevada.
12. Strategies to Identify and Prevent Errors and Near Misses in Your Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 25th-30th, 2012, New Orleans, LA
13. Strategies to Identify and Prevent Errors and Near Misses in Your Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 11th-15th, 2013, San Diego, CA
14. Mythbusters: Microsurgical Breast Reconstruction in Private Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 11th-15th, 2013, San Diego, CA
15. Minimizing Complications in Perioperative Care, The American Society for Reconstructive Microsurgery, January 11-14, 2014, Kauai, Hawaii
16. Genitourinary and Perineal Reconstruction, The American Society for Reconstructive Microsurgery, January 11-14, 2014, Kauai, Hawaii
17. Transgender Breast Surgery, The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA
18. Gender Confirmation Surgery, The School of the Art Institute (recipient of American College Health Fund's Gallagher Koster Innovative Practices in College Health Award), October 27, 2015, Chicago, Il
19. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, Il Overview of Surgical Treatment Options
20. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015 Chicago, Il Surgical Procedures
21. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, Il Surgical Complications

22. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, IL Post-operative Care
23. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, IL Case Discussions: The Multidisciplinary Team
24. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, January 20-23, 2016, Atlanta, GA Overview of Surgical Treatment Options
25. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, January 20-23, 2016, Atlanta, GA Surgical Treatment Options
26. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, March 30-April 1, 2016, Springfield, MO, Surgical Treatment Options.
27. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, March 30-April 1, 2016, Springfield, MO, Multi-disciplinary Case Discussion.
28. Introduction to Transgender Surgery, ASPS Breast Surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
29. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course, September 28, 2016, Ft. Lauderdale, FL.
30. Cirugias de Confirmacion de Sexo Paso a Paso, XXXV Congreso Confederacion Americana de Urologia (CAU), Panama City, Panama, October 4-8, 2016.
31. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course, December 3, 2016, Arlington, VA.
32. PSEN (sponsored by ASPS and endorsed by WPATH), Transgender 101 for Surgeons, January 2017-March 2017
33. Surgical Anatomy and Surgical Approaches to M-to-F Genital Gender Affirming Surgery and the Management of the Patient Before, During and After Surgery: A Human Cadaver Based Course, Orange County, CA, Feb. 1, 2017
34. Gender Confirmation Surgery, ALAPP, 2 Congreso Internacional de la Asociacion Latinoamericana de Piso Pelvico, Sao Paulo, Brasil, 9-11 de marzo de 2017

35. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course, Overview of Surgical Treatment, March 31-April 2, 2017, Minneapolis Minnesota.
36. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course, The Multi-Disciplinary Team Case Discussions, March 31-April 2, 2017, Minneapolis Minnesota.
37. Transfeminine Cadaver Course, WPATH, May 19-20, 2017, Chicago, IL
38. Transgender/Penile Reconstruction-Penile Reconstruction: Radial Forearm Flap Vs. Anterolateral Thigh Flap, Moderator and Presenter, The World Society for Reconstructive Microsurgery, June 14-17, 2017, Seoul, Korea
39. Primer of Transgender Breast Surgery, ASPS Breast Surgery and Body Contouring Symposium, San Diego, CA, August 10-12, 2017
40. Confirmation Surgery in Gender Dysphoria: current state and future developments, International Continence Society, Florence, Italy, September 12-15, 2017
41. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, ASPS/WPATH Joint Session, Session Planner and Moderator
42. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course: Overview of Surgical Treatment, Columbus, OH, October 20-21, 2017
43. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course: Medical Care in the Perioperative Period, Aftercare: Identifying Potential Complications, Columbus, OH, October 20-21, 2017
44. Webinar: Gender Affirming Surgeries 101: Explore The Latest Topics in Gender Affirmation Surgery, PSEN, April 18, 2018
45. Course Director: MT. Sinai/WPATH Live Surgery Training Course for Gender Affirmation Procedures, April 26-28, 2018, New York, NY
46. Philadelphia Trans Wellness Conference, Perioperative Care of the Transgender Woman Undergoing Vaginoplasty (Workshop), Philadelphia, PA, August 3, 2018

47. Philadelphia Trans Wellness Conference, Gender Confirmation Surgery (Workshop), Philadelphia, PA, August 3, 2018
48. Gender Confirmation Surgery, 2018 Oral and Written Board Preparation Course, The American Society of Plastic Surgeons, August 16-18, 2018, Rosemont, IL
49. Confirmation Surgery in Gender Dysphoria: Current State and Future Developments, The International Continence Society, Philadelphia, PA August 28, 2018
50. WPATH Global Education Initiative, Foundations Training Course, "Overview of Surgical Treatment," Cincinnati, OH, September 14-15, 2018
51. WPATH Global Education Initiative, Foundations Training Course, "The Multi-Disciplinary Team: Case Discussions," Cincinnati, OH, September 14-15, 2018
52. WPATH Global Education Initiative, Advanced Training Course, "Medical Care in the Perioperative Period After Care: Identifying Potential Complications," Cincinnati, OH, September 14-15, 2018
53. 25th WPATH Symposium, Surgeons Conference, November 1, 2018, Buenos Aires, Argentina, Moderator
54. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Global Education Initiative (GEI): Surgery and Ethics
55. WPATH GEI: Best Practices in Medical and Mental Health Care, Foundations in Surgery, New Orleans, March 22, 2019
56. WPATH GEI: Best Practices in Medical and Mental Health Care, Advanced Surgery, New Orleans, March 22, 2019
57. Program Chair: ASPS/WPATH GEI Inaugural Gender-Affirming Breast, Chest, and Body Master Class, Miami, FL, July 20, 2019
58. Overview of Surgical Management and The Standards of Care (WPATH, v. 7) ASPS/WPATH GEI Inaugural Gender-Affirming Breast, Chest, and Body Master Class, Miami, FL, July 20, 2019
59. Program Director, Gender Affirming Breast, Chest, and Body Master Class, The American Society of Plastic Surgeons, Miami, FL, July 20, 2019
60. Gender Confirmation Surgery, The American Society of Plastic Surgeons Oral and Written Board Preparation Course, August 15, 2019, Rosemont, IL

61. Upper Surgeries (chest surgery & breast augmentation), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
62. Preparing for Upper Surgeries-Case Based (chest surgery & breast augmentation), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
63. Preparing for Feminizing Lower Surgeries-Case Based (vaginoplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
64. Lower Surgeries-Masculinizing (phalloplasty & metoidioplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
65. Preparing for Masculinizing Lower Surgeries-Case Based (phalloplasty & metoidioplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
66. Panel Discussion about Ethics in Surgery and Interdisciplinary Care, WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
67. Discussion about Ethics and Tensions in Child and Adolescent Care, WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
68. Transgender Health: Best Practices in Medical and Mental Health Care Foundation Training Courses, Hanoi, Viet Nam, Jan 14-17, 2020 (Foundations in Surgery, Advanced Medical-surgery and complicated case studies), Planning & Documentation (upper surgeries-chest surgery and breast augmentation, preparing for upper surgeries-case based (chest surgery and breast augmentation), lower surgeries (feminizing-vaginoplasty), preparing for feminizing lower surgeries-case based, lower surgeries-masculinizing (phalloplasty and metoidioplasty), preparing for masculinizing lower surgeries-case-based (phalloplasty and metoidioplasty), Ethics-panel discussion about ethics in surgery and interdisciplinary care)
69. WPATH GEI Panel Cases Discussion, via Webinar, May 29, 30, 31, 2020
70. WPATH GEI: Illinois Dept. of Corrections, Foundations in Surgery, November 20, 2020
71. WPATH GEI: Illinois Dept. of Corrections, Ethical Considerations in Transgender Healthcare, November 20, 2020
72. WPATH GEI: Illinois Dept. of Corrections, Foundations in Surgery, February 26, 2021

73. WPATH GEI: Illinois Dept. of Corrections, Ethical Considerations in Transgender Healthcare, February 26, 2021.

74. Current Concepts in Gender Affirming Surgery for Women in Transition, March 11-12, 2021 (online event), Moderator, Transgender Health.

75. GEI Foundations Course, Live Q&A, March 21, 2021

76. GEI Foundations Course, Live Case Panel Discussion, March 23, 2021

77. GEI Advanced Ethics Workshop; Surgical and Interdisciplinary care ethics panel, May 1, 2021 (virtual)

78. Wpath GEI Foundations course for the Illinois Dept of Corrections, Foundations in Surgery, May 21, 2021

79. Wpath GEI, Foundations course for the Illinois Dept of Corrections, Ethical considerations in Transgender Healthcare, May 21, 2021

SYMPOSIA:

1. Program Director, 2011 Chicago Breast Symposium, October 15, 2011, The Chicago Plastic Surgery Research Foundation and The Chicago Medical School at Rosalind Franklin University, North Chicago, IL,

2. Fundamentals of Evidence-Based Medicine & How to Incorporate it Into Your Practice, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC

3. Understanding Outcome Measures in Breast & Body Contouring Surgery, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC

4. Benchmarking Complications: What We Know About Body Contouring Complication Rates from Established Databases, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC

5. Special Lecture: VTE Prophylaxis for Plastic Surgery in 2011, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC

6. Nipple Sparing Mastectomy: Unexpected Outcomes, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC
7. Program Director, 2011 Chicago Breast Symposium, October 13-14, 2012, The Chicago Plastic Surgery Research Foundation and The Chicago Medical School at Rosalind Franklin University, North Chicago, IL
8. Practice Strategies in a Changing Healthcare Environment, Moderator, Midwestern Association of Plastic Surgeons, April 27-28, 2013, Chicago, IL
9. Moderator: Breast Scientific Paper Session, The Annual Meeting of The American Society of Plastic Surgery, October 12, 2014, Chicago, IL.
10. Moderator: The World Professional Association for Transgender Health, Tuesday, June 21, Surgical Session (0945-1045), June 18-22, 2016, Amsterdam, Netherlands
11. Course Director: Transmale Genital Surgery: WPATH Gender Education Initiative, October 21-22, 2016 Chicago, IL
12. Co-Chair and Moderator: Surgeon's Only Session, USPATH, Los Angeles, CA, Feb. 2, 2017
13. Vascular Anastomosis: Options for Lengthening Vascular Pedicle, Surgeon's Only Session, USPATH, Los Angeles, CA, Feb. 2, 2017
14. Transgender Healthcare Mini-Symposium, Chicago Medical School of Rosalind Franklin University, North Chicago, IL March 10, 2017.
15. Moderator: Penile Transplant: Genito-urinary trauma/penile cancer, The European Association of Urologists, Meeting of the EAU Section of Genito-Urinary Reconstructive Surgeons (ESGURS), London, United Kingdom, March 23-26, 2017
- 16: 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Mini-Symposium: A Comprehensive Approach to Gender Confirming Surgery
17. Program Director, 2nd Annual Live Surgery Conference for Gender Affirmation Procedures, Ichan School of Medicine at Mt. Sinai, NY, NY February 28, 2019-March 2, 2019.
18. Moderator, "Genital Reassignment for Adolescents: Considerations and Conundrums," Discussions on gender affirmation: surgery and beyond, Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019

19. Moderator, "Reconstructive Urology and Genitourinary Options in Gender Affirming Surgery," Discussions on gender affirmation: surgery and beyond, Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
20. Moderator, "Complications in Masculinizing Genital Reconstruction Surgery," Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
21. Moderator, "Preparing for Surgery and Recovery," Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
22. Discussant, "WPATH Standards of Care Version 8 Preview," Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
23. Program Coordinator, Surgeon's Only Course, USPATH, September 5, 2019, Washington, DC
24. Master Series in Transgender Surgery 2020: Vaginoplasty and Top Surgery, course co-director, Mayo Clinic, Rochester, MN, August 7-8, 2020
25. WPATH 2020 Surgeons' Program, Co-Chair, November 6-7, 2020, Virtual Symposium (due to covid-19 cancellation of Hong Kong meeting)

FACULTY SPONSORED RESEARCH:

1. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Free Tissue Transfer in the Treatment of Zygomycosis." Presented by Michelle Roughton, MD
2. Hines/North Chicago VA Research Day, Edward Hines, Jr., VA Hospital, Maywood, Il, April 29, 2010, "Breast MRI Helps to Define the Blood Supply to the Nipple-Areolar Complex." Presented by Iris A. Seitz, MD, PhD.
3. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Breast MRI Helps to Define the Blood Supply to the Nipple-Areolar Complex." Presented by Iris A. Seitz, MD, PhD.
4. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Achieving Soft Tissue Coverage of Complex Upper and Lower Extremity Defects with Omental Free Tissue Transfer." Presented by Iris A. Seitz, MD, PhD.

5. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Facilitating Harvest of the Serratus Fascial Flap with Ultrasonic Dissection." Presented by Iris A. Seitz, MD, PhD.
6. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Patient Safety: Abdominoplasty and Intra-Abdominal Procedures." Presented by Michelle Roughton, MD
7. The Midwestern Association of Plastic Surgeons, 49th Annual Scientific Meeting, May 15th, 2010, "Breast MRI Helps Define The Blood Supply to the Nipple-Areolar Complex." Presented by Iris A. Seitz, MD, PhD.
8. Jonathan M. Hagedorn, BA, **Loren S. Schechter**, MD, FACS, Dr. Manoj R. Shah, MD, FACS, Matthew L. Jimenez, MD, Justine Lee, MD, PhD, Varun Shah. Re-examining the Indications for Limb Salvage, 2011 All School Research Consortium at Rosalind Franklin University. Chicago Medical School of Rosalind Franklin University, 3/16/11.
9. Jonathan Bank, MD, Lucio A. Pavone, MD, Iris A. Seitz, Michelle C. Roughton, MD, Loren S. Schechter, MD Deep Inferior Epigastric Perforator Flap for Breast Reconstruction after Abdominoplasty The Midwestern Association of Plastic Surgeons, 51st Annual Educational Meeting, April 21-22, 2012, Northwestern Memorial Hospital, Chicago, Illinois
10. Samuel Lake, Iris A. Seitz, MD, PhD, Loren S. Schechter, MD, Daniel Peterson, PhD Omentum and Subcutaneous Fat Derived Cell Populations Contain hMSCs Comparable to Bone Marrow-Derived hMSCs First Place, Rosalind Franklin University Summer Research Poster Session
11. J. Siwinski, MS II, Iris A. Seitz, MD PhD, Dana Rioux Forker, MD, Lucio A. Pavone, MD, Loren S Schechter, MD FACS. Upper and Lower Limb Salvage With Omental Free Flaps: A Long-Term Functional Outcome Analysis. Annual Dr. Kenneth A. Suarez Research Day, Midwestern University, Downers Grove, IL, May 2014
12. Whitehead DM, Kocjancic E, Iacovelli V, Morgantini LA, **Schechter LS**. A Case Report: Penile Prosthesis With an Alloderm Wrap Positioned After Radial Forearm Phalloplasty. Poster session presented at: American Society for Reconstructive Microsurgery Annual Meeting, 2018 Jan 13-16; Phoenix, AZ.
13. Whitehead DM, Kocjancic E, Iacovelli V, Morgantini LA, **Schechter LS**. An Innovative Technique: Single Stage Urethral Reconstruction in Female-to-Male Patients. Poster session presented at: American

Society for Reconstructive Microsurgery Annual Meeting, 2018 Jan 13-16; Phoenix, AZ.

14. Whitehead, DM Inflatable Penile Prosthesis Implantation Post Phalloplasty: Surgical Technique, Challenges, and Outcomes, MAPS 2018 Annual Scientific Meeting, April 14, 2018, Chicago, Il

15. Whitehead, DM, Inverted Penile Skin With Scrotal Graft And Omission of Sacrospinal Fixation: Our Novel Vaginoplasty Technique MAPS 2018 Annual Scientific Meeting, April 14, 2018, Chicago, Il

16. S. Marecik, J. Singh. **L. Schechter**, M. Abdulhai, K. Kochar, J. Park, Robotic Repair of a Recto-Neovaginal Fistula in a Transgender Patient Utilizing Intestinal Vaginoplasty, The American College of Surgeons Clinical Congress 2020, October 7, 20

Keynote Address:

1. University of Utah, Gender Confirmation Surgery, Transgender Provider Summit, November 8, 2014

INVITED LECTURES:

1. Management of Soft Tissue Injuries of the Face, Grand Rounds, Emergency Medicine, The University of Chicago, August, 1999

2. Case Report: Excision of a Giant Neurofibroma, Operating Room Staff Lecture Series, Continuing Education Series, St. Francis Hospital, Evanston, Il March 2000

3. Wounds, Lincolnwood Family Practice, Lincolnwood, Il April 2000

4. The Junior Attending, Grand Rounds, Plastic and Reconstructive Surgery, The University of Chicago, June 2000

5. Case Report: Excision of a Giant Neurofibroma, Department of Medicine Grand Rounds, St. Francis Hospital, Evanston, Il June 2000

6. Facial Trauma, Resurrection Medical Center Emergency Medicine Residency, September 2000

7. Plastic Surgery of the Breast and Abdomen, Grand Rounds, Dept. of Obstetrics and Gynecology, Evanston Hospital, September, 2000

8. Change of Face; Is Cosmetic Surgery for You?, Adult Education Series, Rush North Shore Medical Center, October, 2000

9. Reconstructive Surgery of the Breast, Professional Lecture Series on Breast Cancer, St. Francis Hospital, October, 2000

10. Plastic Surgery of the Breast and Abdomen, Grand Rounds, Dept. of Obstetrics and Gynecology, Lutheran General Hospital, December, 2000
11. Change of Face; Is Cosmetic Surgery for You?, Adult Education Series, Lutheran General Hospital and The Arlington Heights Public Library, December, 2000
12. Updates in Breast Reconstruction, The Breast Center, Lutheran General Hospital, January 2001
13. Abdominal Wall Reconstruction, Trauma Conference, Lutheran General Hospital, February 2001
14. Wound Care, Rush North Shore Medical Center, March 2001
15. Breast Reconstruction, Diagnosis and Treatment Updates on Breast Cancer, Lutheran General Hospital, April 2001
16. Wound Care and V.A.C. Therapy, Double Tree Hotel, Skokie, Il October 2001
17. The Role of the V.A.C. in Reconstructive Surgery, LaCrosse, WI November 2001
18. Dressing for Success: The Role of the V.A.C. in Reconstructive Surgery, Grand Rounds, The University of Minnesota Section of Plastic and Reconstructive, Minneapolis, MN January, 2002
19. The Vacuum Assisted Closure Device in the Management of Complex Soft Tissue Defects, Eau Claire, WI February, 2002
20. The Vacuum Assisted Closure Device in Acute & Traumatic Soft Tissue Injuries, Orland Park, Il March, 2002
21. Body Contouring After Weight Loss, The Gurnee Weight Loss Support Group, Gurnee, Il April, 2002
22. An Algorithm to Complex Soft Tissue Reconstruction With Negative Pressure Therapy, Owensboro Mercy Medical Center, Owensboro, Ky, April, 2002
23. Breast and Body Contouring, St. Francis Hospital Weight Loss Support Group, Evanston, Il April, 2002
24. The Wound Closure Ladder vs. The Reconstructive Elevator, Surgical Grand Rounds, Lutheran General Hospital, Park Ridge, Il, May, 2002.

25. An Algorithm for Complex Soft Tissue Reconstruction with the Vacuum Assisted Closure Device, The Field Museum, Chicago, Il, May, 2002
26. The Role of Negative Pressure Wound Therapy in Reconstructive Surgery, Kinetic Concepts, Inc. San Antonio, Texas, July 31, 2002
27. Management of Complex Soft Tissue Injuries of the Lower Extremity, Chicago Trauma Symposium, August 2-5, 2002, Chicago, Illinois:
28. Wound Bed Preparation, Smith Nephew, Oak Brook, Il, August 6, 2002
29. Getting Under Your Skin...Is Cosmetic Surgery for You?, Rush North Shore Adult Continuing Education Series, Skokie, Il August 28, 2002.
30. The Role of Negative Pressure Therapy in Complex Soft Tissue Wounds, Columbia/St. Mary's Wound, Ostomy, and Continence Nurse Program, Milwaukee, Wi, September 17, 2002
31. A Systematic Approach to Functional Restoration, Grand Rounds, Dept. of Physical Therapy and Rehabilitation Medicine, Lutheran General Hospital, September 19, 2002
32. The Role of Negative Pressure Wound Therapy in Reconstructive Surgery, Ann Arbor, Mi September 26, 2002
33. Dressing for Success: The Role of the Vacuum Assisted Closure Device in Plastic Surgery, Indianapolis, In November 11, 2002
34. The Wound Closure Ladder Versus the Reconstructive Elevator, Crystal Lake, Il November 21, 2002
35. A Systematic Approach to Functional Restoration, Grand Rounds, Dept. of Physical Therapy, Evanston Northwestern Healthcare, Evanston, Il February 13, 2003
36. Case Studies in Traumatic Wound Reconstruction, American Association of Critical Care Nurses, Northwest Chicago Area Chapter, Park Ridge, Il February 19, 2003
37. Reconstruction of Complex Soft Tissue Injuries of the Lower Extremity, Podiatry Lecture Series, Rush North Shore Medical Center, Skokie, Il March 5, 2003
38. The Use of Negative Pressure Wound Therapy in Reconstructive Surgery, Kalamazoo, Mi March 19, 2003

39. Updates in Breast Reconstruction, The Midwest Clinical Conference, The Chicago Medical Society, Chicago, Il March 21, 2003
40. Updates of Vacuum Assisted Closure, Grand Rounds, The Medical College of Wisconsin, Department of Plastic Surgery, Milwaukee, Wi March 26, 2003
41. Breast Reconstruction, Surgical Grand Rounds, Lutheran General Hospital, Park Ridge, Il March 27, 2003
42. Decision-Making in Breast Reconstruction: Plastic Surgeons as Members of a Multi-Disciplinary Team, 1st Annual Advocate Lutheran General Hospital Breast Cancer Symposium, Rosemont, Il, April 11, 2003
43. The Wound Closure Ladder Versus The Reconstructive Elevator, Duluth, Mn, April 24, 2003
44. Dressing For Success: The Role of The Wound VAC in Reconstructive Surgery, Detroit, Mi, May 9, 2003
45. Plastic Surgery Pearls, Grand Rounds Orthopedic Surgery Physician Assistants Lutheran General Hospital and Finch University of Health Sciences, Park Ridge, Il, June 5, 2003
46. A Systematic Approach to Complex Reconstruction, 12th Annual Vendor Fair "Surgical Innovations," October 18, 2003, Lutheran General Hospital, Park Ridge, Il 2003
47. Dressing For Success: The Role of the Wound VAC in Reconstructive Surgery, American Society of Plastic Surgery, October 26, 2003, San Diego, CA
48. Beautiful You: From Botox to Weekend Surgeries, 21st Century Cosmetic Considerations, March 21, 2004 Hadassah Women's Health Symposium, Skokie, Il
49. Updates in Breast Reconstruction, The 2nd Annual Breast Cancer Symposium, Advocate Lutheran General, Hyatt Rosemont, April 2, 2004
50. Head and Neck Reconstruction, Grand Rounds, The University of Illinois Metropolitan Group Hospitals Residency in General Surgery, Advocate Lutheran General Hospital, May 6, 2004
51. Abdominal Wall Reconstruction, Surgeons Forum, LifeCell Corporation, May 15, 2004, Chicago, Il
52. 4th Annual Chicagoland Day of Sharing for Breast Cancer Awareness, Saturday, October 2, 2004, Hoffman Estates, Il

53. Abdominal Wall Reconstruction, University of Illinois Metropolitan Group Hospitals Residency in General Surgery, November 19, 2004, Skokie, IL
54. Advances in Wound Care, Wound and Skin Care Survival Skills, Advocate Good Samaritan Hospital, Tuesday, February 8, 2005, Downer's Grove, IL
55. Plastic Surgery: A Five Year Perspective in Practice, Grand Rounds, The University of Chicago, May 18, 2005, Chicago, IL
56. New Techniques in Breast Reconstruction, The Cancer Wellness Center, October 11, 2005 Northbrook, IL
57. Principles of Plastic Surgery; Soft Tissue Reconstruction of the Hand, Rehab Connections, Inc., Hand, Wrist, and Elbow Forum, October 28, 2005, Homer Glen, IL
58. Principles of Plastic Surgery, Lutheran General Hospital Quarterly Trauma Conference, November 9, 2005, Park Ridge, IL
59. Principles of Plastic Surgery, Continuing Medical Education, St. Francis Hospital, November 15, 2005, Evanston, IL
60. Dressing for Success: A Seven Year Experience with Negative Pressure Wound Therapy, Kinetic Concepts Inc, November 30, 2005, Glenview, IL.
61. Breast Reconstruction: The Next Generation, Breast Tumor Conference, Lutheran General Hospital, May 9, 2006.
62. Complex Wound Care: Skin Grafts, Flaps, and Reconstruction, The Elizabeth D. Wick Symposium on Wound Care, *Current Concepts in Advanced Healing: An Update*, Rush North Shore Medical Center, November 4, 2006.
63. An Approach to Maxillofacial Trauma: Grand Rounds, Lutheran General Hospital/Univ. of Illinois Metropolitan Group Hospital Residency in General Surgery, November 9, 2006.
64. "From Paris to Park Ridge", Northern Trust and Advocate Lutheran General Hospital, Northern Trust Bank, June 7, 2007.
65. "Private Practice Plastic Surgery: A Seven Year Perspective," Grand Rounds, The University of Chicago, Section of Plastic Surgery.
66. "Meet the Experts on Breast Cancer," 7th Annual Chicagoland Day of Sharing, Sunday, April 13th, 2008

67. Gender Confirmation Surgery: Surgical Options and Decision-Making, The University of Minnesota, Division of Human Sexuality, May 10, 2008, Minneapolis, Minnesota.
68. "Private Practice Plastic Surgery: A Seven Year Perspective," Grand Rounds, Loyola University, 2008 Section of Plastic Surgery.
69. "Management of Lower Extremity Trauma," Grand Rounds, The University of Chicago, Section of Plastic Surgery, October, 8, 2008.
70. "Concepts in Plastic Surgery: A Multi-Disciplinary Approach," Frontline Surgical Advancements, Lutheran General Hospital, November 1, 2008
71. "Surgical Techniques-New Surgical Techniques/Plastic Surgery/Prosthetics," Caldwell Breast Center CME Series, Advocate Lutheran General Hospital, November 12, 2008
72. "Genetics: A Family Affair" Panel Discussion: Predictive Genetic Testing, 23rd Annual Illinois Department of Public Health Conference, Oak Brook Hills Marriott Resort, Oak Brook, Il, March 18, 2009
73. "Gender Confirmation Surgery" Minnesota TransHealth and Wellness Conference, May 15, 2009, Metropolitan State University, Saint Paul, MN.
74. "The Role of Plastic Surgery in Wound Care, " Practical Wound Care A Multidisciplinary Approach, Advocate Lutheran General Hospital, October 9-10, 2009, Park Ridge, Il.
75. "In The Family," Panel, General Session III, 2009 Illinois Women's Health Conference, Illinois Dept. of Health, Office of Women's Health October 28-29, 2009, Oak Brook, Il.
76. "Patient Safety in Plastic Surgery," The University of Chicago, Section of Plastic Surgery, Grand Rounds, November 18, 2009.
77. "Compartment Syndrome," 6th Annual Advocate Injury Institute Symposium, Trauma 2009: Yes We Can!, November 19-20, 2009.
78. "Maxillofacial Trauma," 6th Annual Advocate Injury Institute Symposium, Trauma 2009: Yes We Can!, November 19-20, 2009.
79. "Management of Complex Lower Extremity Injuries," Grand Rounds, The Section of Plastic Surgery, The University of Chicago, December 16, 2009, Chicago, Il.

80. "Gender-Confirming MTF Surgery: Indications and Techniques," Working Group on Gender, New York State Psychiatric Institute, March 12, 2010
81. "Gender-Confirmation Surgery," Minnesota Trans Health and Wellness Conference, Metropolitan State University, St. Paul Campus, May 14th, 2010
82. "Physical Injuries and Impairments," Heroes Welcome Home The Chicago Association of Realtors, Rosemont, Illinois, May 25th, 2010.
83. "Genetics and Your Health," Hadassah Heals: Healing Mind, Body, & Soul, Wellness Fair, 2010, August 29, 2010, Wilmette, Illinois.
84. "GCS," Southern Comfort Conference 2010, September 6-11, 2010, Atlanta, GA.
85. "Gender Confirming Surgery," The Center, The LGBT Community Center, October 22, 2010 New York, NY.
86. "Gender Confirming Surgery," the Center, The LGBT Community Center, May 20, 2011, New York, NY.
87. "Gender Confirming Surgery," Roosevelt-St. Lukes Hospital, May 20, 2011, New York, NY
88. "Principles of Plastic Surgery," Learn about Ortho, Lutheran General Hospital, May 25, 2011, Park Ridge, Il.
89. "Forging Multidisciplinary Relationships in Private Practice," Chicago Breast Reconstruction Symposium 2011, September 9, 2011, Chicago, Il
90. "Gender Confirming Surgery," Minnesota TransHealth and Wellness Conference, Diverse Families: Health Through Community, September 10, 2011, Minneapolis, Minnesota
91. "Gender Confirming Surgery," University of Chicago, Pritzker School of Medicine, Anatomy Class, September 16, 2011, Chicago, Il
92. "Facial Trauma," 8th Annual Advocate Injury Institute Symposium, Trauma 2011: 40 years in the Making, Wyndham Lisle-Chicago, November 9-10, 2011
93. "Establishing a Community-Based Microsurgical Practice," QMP Reconstructive Symposium, November 18-20, 2011, Chicago, Il

94. "Surgery for Gender Identity Disorder," Grand Rounds, Dept. of Obstetrics and Gynecology, Northshore University Health System, December 7, 2011
95. "Managing Facial Fractures," Trauma Grand Rounds, Lutheran General Hospital, Park Ridge, Il July 17, 2012
96. "Principles of Transgender Medicine," The University of Chicago Pritzker School of Medicine, Chicago, Il, September 7, 2012
97. "State of the art breast reconstruction," Advocate Health Care, 11th Breast Imaging Symposium, January 26, 2013, Park Ridge, Il.
98. "State of the art breast reconstruction," Grand Rounds, Dept. of Surgery, Mount Sinai Hospital, April 25, 2013, Chicago, Il.
99. "Getting under your skin: is cosmetic surgery right for you?" Lutheran General Hospital community lecture series, May 7, 2013, Park Ridge, Il.
100. "Gender Confirming Surgery," University of Chicago, Pritzker School of Medicine, Anatomy Class, September 27, 2013, Chicago, Il
101. "State of the Art Breast Reconstruction," Edward Cancer Center, Edward Hospital, October 22, 2013, Naperville, Il
102. "Transgender Medicine and Ministry," Pastoral Voice, Advocate Lutheran General Hospital, October 23, 2013, Park Ridge, Il
103. "Principles of Transgender Medicine and Surgery," The University of Illinois at Chicago College of Medicine, January 28, 2014, Chicago, Il
104. "Principles of Transgender Medicine and Surgery," Latest Surgical Innovations and Considerations, 22nd Annual Educational Workshop, Advocate Lutheran General Hospital, March 1, 2014, Park Ridge, Il.
105. "Principles of Transgender Medicine: Gender Confirming Surgery," Loyola University Medical Center, March 12, 2014.
106. "Principles of Plastic Surgery," Grand Rounds, Dept. of Obstetrics and Gynecology, Lutheran General Hospital, September 12, 2014.
107. "Gender Confirmation Surgery," The University of Chicago, Pritzker School of Medicine, October 3, 2014

108. "Private Practice: Is There a Future?" The Annual Meeting of The American Society of Plastic Surgical Administrators/The American Society of Plastic Surgery Assistants, Chicago, Il, October 11, 2014.
109. "Private Practice: Is There a Future?" The Annual Meeting of The American Society of Plastic Surgery Nurses, Chicago, Il, October 12, 2014.
110. "Gender Confirmation Surgery" Grand Rounds, The University of Minnesota, Dept. of Plastic Surgery, Minneapolis, MN, October 29, 2014.
111. "Body Contour After Massive Weight Loss," The Bariatric Support Group, Advocate Lutheran General Hospital, February 5, 2015, Lutheran General Hospital, Park Ridge, Il.
112. "Gender Confirmation Surgery," The School of the Art Institute of Chicago, February 1, 2015, Chicago, Il.
113. "Gender Confirmation Surgery," The Community Kinship Life/Bronx Lebanon Department of Family Medicine, Bronx, NY, March 6, 2015
114. "Gender Confirmation Surgery," Educational Inservice, Lutheran General Hospital, Park Ridge, Il, April 20, 2015
115. "Principles of Plastic Surgery, " Surgical Trends, Lutheran General Hospital, Park Ridge, Il, May 16, 2015
116. "Updates on Gender Confirmation Surgery, " Surgical Trends, Lutheran General Hospital, Park Ridge, Il, May 16, 2015
117. "Gender Confirmation Surgery," Lurie Childrens' Hospital, Chicago, Il, May 18, 2015, Chicago, Il 2015.
118. "Gender Confirmation Surgery," TransClinical Care and Management Track Philadelphia Trans-Health Conference, June 5, 2015, Philadelphia, Pa.
119. "Gender Confirmation Surgery: A Fifteen Year Experience," Grand Rounds, The University of Minnesota, Plastic and Reconstructive Surgery and the Program in Human Sexuality, July 30, 2015, Minneapolis, Mn
120. "Gender Confirmation Surgery," Grand Rounds, Tel Aviv Medical Center, Tel Aviv, Israel, August 13, 2015
121. "Gender Confirmation Surgery," Grand Rounds, University of Illinois, Dept of Family Medicine, September 2, 2015

122. "Principles of Plastic Surgery," Grand Rounds, St. Francis Hospital, Evanston, Il September 18, 2015
123. "Gender Confirmation Surgery," Midwest LGBTQ Health Symposium, Chicago, Il, October 2, 2015
124. "Gender Confirmation Surgery," Southern Comfort Conference, Weston, Fl, October 3, 2015
125. "Surgical Transitions for Transgender Patients," Transgender Health Training Institute, Rush University Medical Center, Chicago, Il, October 8, 2015
126. "Gender Confirmation Surgery," The Transgender Health Education Peach State Conference, Atlanta, GA, October 30, 2015
127. "Gender Confirmation Surgery," Weiss Memorial Medical Center, November 4, 2015, Chicago, Il
128. "Gender Confirmation Surgery," University of Illinois at Chicago, Operating Room Staff Inservice, November 18, 2015, Chicago, Il
129. "Gender Confirmation Surgery," University of Illinois at Chicago, Plastic Surgery and Urology Inservice, November 18, 2015, Chicago, Il
130. "Gender Confirmation Surgery," Weiss Memorial Medical Center, November 19, 2015, Chicago, Il
131. "Gender Confirmation Surgery," Section of Plastic Surgery, The University of Illinois at Chicago, January 13, 2016, Chicago, Il
132. "Gender Confirmation Surgery," Dept. of Medicine, Louis A. Weiss Memorial Hospital, February 18, 2016, Chicago, Il
133. "Gender Confirmation Surgery," BCBSIL Managed Care Roundtable March 2, 2016 Chicago, Il
134. "Gender Confirmation Surgery-MtF," Keystone Conference, March 10, 2016, Harrisburg, PA
135. "Gender Confirmation Surgery-FtM," Keystone Conference, March 10, 2016, Harrisburg, PA
136. "Gender Confirmation Surgery," Grand Rounds, Dept. of Ob-Gyn, March 25, 2016, Lutheran General Hospital, Park Ridge, Il 60068

137. "Surgical Management of the Transgender Patient," Spring Meeting, The New York Regional Society of Plastic Surgeons, April 16, 2016, New York, NY
138. "A Three Step Approach to Complex Lower Extremity Trauma," University of Illinois at Chicago, April 27, 2016, Chicago, Il.
139. "Gender Confirmation Surgery," Howard Brown Health Center, July 12, 2016, Chicago, Il
140. "Creating the Transgender Breast M-F; F-M", ASPS Breast surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
141. "Overview of Transgender Breast Surgery," ASPS Breast surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
142. "VTE Chemoprophylaxis in Cosmetic Breast and Body Surgery: Science or Myth", ASPS Breast surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
143. "Gender Confirmation Surgery," Gender Program, Lurie Childrens', Parent Group, September 20, 201, 467 W. Deming, Chicago, Il
144. "Gender Confirmation Surgery," The American Society of Plastic Surgeons Expo, September 24, 2016, Los Angeles, CA
145. Transgender Surgery, Management of the Transgender Patient, Female to Male Surgery, Overview and Phalloplasty, The American College of Surgeons, Clinical Congress 2016 October 16-20,2016 Washington, DC
146. "Gender Confirmation Surgery," The Department of Anesthesia, The University of Illinois at Chicago, November 9, 2016
147. "Gender Confirmation Surgery," The Division of Plastic Surgery, The University of Illinois at Chicago, December 14, 2016
148. "Gender Confirmation Surgery," Nursing Education, The University of Illinois at Chicago, January 10, 2017
149. "F2M-Radial Forearm Total Phalloplasty: Plastic Surgeon's Point of View," The European Association of Urologists, Meeting of the EAU Section of Genito-Urinary Reconstructive Surgeons (ESGURS), London, United Kingdom, March 23-26, 2017
150. "Gender Confirmation Surgery," Grand Rounds, The Department of Surgery, The University of North Carolina, March 29, 2017.

151. "Transgender Facial Surgery," *The Aesthetic Meeting 2017 - 50 Years of Aesthetics* - in San Diego, California April 27- May 2, 2017.
152. "Gender Confirmation Surgery: A New Surgical Frontier," 15th Annual Morristown Surgical Symposium Gender and Surgery, Morristown, NJ, May 5, 2017.
153. "Gender Confirmation Surgery: A New Surgical Frontier," Dept. of Obstetrics and Gynecology, The Medical College of Wisconsin, May 24, 2017
154. "Gender Confirmation Surgery: A New Surgical Frontier," Dept. of Obstetrics and Gynecology, Howard Brown Health Center, August 8, 2017
155. "Current State of the Art: Gynecomastia," ASPS Breast Surgery and Body Contouring Symposium, San Diego, CA, August 10-12, 2017
156. "Gender Confirmation Surgery-An Overview," ASPS Breast Surgery and Body Contouring Symposium, San Diego, CA, August 10-12, 2017
157. "Gender Confirmation Surgery," Grand Rounds, Dept. of Obstetrics and Gynecology, The University of Chicago, August 25, 2017
158. "Gender Confirmation Surgery," Wake Forest School of Medicine, Transgender Health Conference, Winston-Salem, NC, September 28-29, 2017
159. "Phalloplasty," Brazilian Professional Association for Transgender Health, Teatro Marcos Lindenberg, Universidade Federal de São Paulo (Unifesp), November 1-4, 2017
160. "Gender Confirmation Surgery," Brazilian Professional Association for Transgender Health/WPATH Session, Teatro Marcos Lindenberg, Universidade Federal de São Paulo (Unifesp), November 1-4, 2017
161. "Gender Confirmation Surgery," The Division of Plastic Surgery, The University of Illinois at Chicago, December 13, 2017, Chicago, Il
162. "Gender Confirmation Surgery," Gender and Sex Development Program, Ann and Robert H. Lurie Children's Hospital of Chicago, December 18, 2017, Chicago, Il
163. "Transgender Breast Augmentation," 34th Annual Atlanta Breast Surgery Symposium, January 19-21, 2018, Atlanta, GA
164. "Top Surgery: Transmasculine Chest Contouring," 34th Annual Atlanta Breast Surgery Symposium, January 19-21, 2018, Atlanta, GA

165. "Gender Confirmation Surgery," The 17th International Congress of Plastic and Reconstructive Surgery in Shanghai, March 18-25, 2018, Shanghai, China
166. "Gender Confirmation Surgery: Facial Feminization and Metoidioplasty," 97th Meeting of the American Association of Plastic Surgeons, Reconstructive Symposium, April 7-10, 2018, Seattle, WA
167. Moderator: "Gender Confirmation Surgery: Top Surgery", The Annual Meeting of The American Society of Aesthetic Plastic Surgery, April 26-May 1, 2018, New York, NY
168. "Gender Confirmation Surgery," Econsult monthly meeting, Dept. of Veterans' Affairs, May 24, 2018
169. "Gender Confirmation Surgery," Transgender Care Conference: Improving Care Across the Lifespan, Moses Cone Hospital, Greensboro, NC, June 8, 2018
170. "WPATH State of the Art," 1st Swiss Consensus Meeting on the Standardization of Sex Reassignment Surgery, The University of Basel, August 31, 2018-September 1, 2018
171. "Facial Feminization Surgery: The New Frontier?" 1st Swiss Consensus Meeting on the Standardization of Sex Reassignment Surgery, The University of Basel, August 31, 2018-September 1, 2018
172. "Current Techniques and Results in Mastectomies," 1st Swiss Consensus Meeting on the Standardization of Sex Reassignment Surgery, The University of Basel, August 31, 2018-September 1, 2018
173. "Gender Confirmation Surgery," The University of Chicago, Pritzker School of Medicine, September 7, 2018, Chicago, Il.
174. The Business End: Incorporating Gender Confirmation Surgery, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, September 29, 2018, Chicago, Il
175. Body Contouring in Men, Gynecomastia, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, September 30, 2018, Chicago, Il
176. Moderator: Breast Augmentation and Chest Surgery in Gender Diverse Individuals, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, October 1, 2018, Chicago, Il
177. Moderator: Aesthetic Surgery of The Male Genitalia, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, October 1, 2018, Chicago, Il

178. Moderator: Gender Confirmation Surgeries: The Standards of Care and Development of Gender Identity, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, October 1, 2018, Chicago, IL
179. The Center for Gender Confirmation Surgery Lecture Series, "Introduction to Gender Confirmation Surgery," Weiss Memorial Hospital, October 17, 2018, Chicago, IL
180. Institute 3: Gender Dysphoria Across Development: Multidisciplinary Perspectives on the Evidence, Ethics, and Efficacy of Gender Transition, Gender Confirming Care in Adolescence: Evidence, Timing, Options, and Outcomes, The American Academy of Child and Adolescent Psychiatry, 65th Annual Meeting, October 22-27, 2018, Seattle, WA
181. Gender Confirmation Surgery, Combined Endocrine Grand Rounds, The University of Illinois at Chicago, Rush University, Cook County Hospital, January 8, 2019
182. Gender Confirmation Surgery: An Update, Division of Plastic Surgery, The University of Illinois at Chicago, January 23, 2019
183. Gender Confirmation Surgery from Top to Bottom: A 20 Year Experience, Grand Rounds, The Department of Surgery, Ochsner Health System, January 30, 2019, New Orleans, LA
184. Master Series of Microsurgery: Battle of the Masters One Reconstructive Problem - Two Masters with Two Different Approaches, Gender Affirmation, Male-to-Female Vaginoplasty: Intestinal Vaginoplasty, The American Society for Reconstructive Microsurgery, Palm Desert, California, February 2, 2019
185. Gender Confirmation Surgery: From Top to Bottom, The University of Toronto, Toronto, Canada, February 21, 2019
186. Gender Confirmation Surgery: Where are We, The University of Toronto, Toronto, Canada, February 21, 2019
187. Professors' Rounds: Gender Confirmation Surgery: A Twenty Year Experience, Princess Margaret Hospital, Toronto, Canada, February 22, 2019
188. A 3 Step Approach to Lower Extremity Trauma, Plastic Surgery at The Red Sea, Eilat, Israel, March 6-9, 2019.
189. Gender Surgery: Where are We Now?, Plastic Surgery at The Red Sea, Eilat, Israel, March 6-9, 2019.

190. Gender Confirmation Surgery, A Single Surgeon's 20 Year Experience, Plastic Surgery at The Red Sea, Eilat, Israel, March 6-9, 2019.
191. Gender Confirmation Surgery: Where We Have Been and Where We Are Going, Grand Rounds, The University of Chicago, Section of Plastic Surgery, March 13, 2019
192. Gender Confirmation Surgery: From Top To Bottom, Resident Core Curriculum Conference, The University of Chicago, Section of Plastic Surgery, March 13, 2019.
193. "Gender Confirmation Surgery," WPATH/AMSA Medical School Trans Health Elective, Webinar, March 13, 2019
194. Robotic Vaginoplasty: An Alternative to Penile Inversion Vaginoplasty in Cases of Insufficient Skin, Vaginal Stenosis, and Rectovaginal Fistula. The European Professional Association for Transgender Health, April 9-13, Rome, Italy
195. Current State of Gender-Affirming Surgery in the US and Beyond, Gender-affirming genital surgery presented by the American Urologic Association in collaboration with the Society for Genitourinary Reconstructive Surgeons (GURS), May 2, 2019, Chicago, Il
196. Surgical Training-How Can I get it, The Aesthetic Meeting 2019, New Orleans, LA, May 20, 2019
197. What is the Standard of Care in This New Frontier, The Aesthetic Meeting 2019, New Orleans, LA, May 20, 2019
198. The 20th Annual Chicago Orthopedic Symposium, August 15-18, 2019, Chicago, Il "Soft Tissue Defects-Getting Coverage"
199. Gender Confirmation Surgery, The Potocsnak Family Division of Adolescent and Young Adult Medicine, Ann & Robert H. Lurie Children's Hospital of Chicago, August 19, 2019
200. Anatomy, Embryology, and Surgery, The University of Chicago, First Year Medical Student Anatomy Lecture, September 9, 2019, The University of Chicago, Chicago, Il.
201. Gender Confirmation Surgery, Howard Brown Health Center Gender Affirming Learning Series, September 13, 2019, Chicago, Il.
202. Moderator, Patient Selection in Gender Affirming Survey Surgery, 88th Annual Meeting of The American Society of Plastic Surgeons, September 20-23, 2019, San Diego, CA

203. Breast Augmentation in Transwomen: Optimizing Aesthetics and Avoiding Revisions, 88th Annual Meeting of The American Society of Plastic Surgeons, September 20-23, 2019, San Diego, CA
204. Breast Reconstruction, State of the Art, NYU-Langone Health, NYU School of Medicine, Standards of Care and Insurance Coverage, Saturday, November 23, 2019, New York, NY.
205. ASRM Masters Series in Microsurgery: Think Big, Act Small: The Building Blocks for Success, "Building a Microsurgery Private Practice from the Ground Up", 2020 ASRM Annual Meeting, Ft. Lauderdale, Florida, January 10-14, 2020
206. ASPS/ASRM Combined Panel II: Gender Affirmation Surgery: Reconstruction Challenges of Function and Sensation, 2020 ASRM Annual Meeting, Ft. Lauderdale, Florida, January 10-14, 2020
207. Rush University Medical Center, Division of Urology, Grand Rounds, "Gender Confirmation Surgery: A Single Surgeon's Experience," January 22, 2020
208. Rush University Medical Center, Department of General Surgery, Grand Rounds, "Gender Confirmation Surgery: A Single Surgeon's Experience," February 5, 2020.
209. WPATH/AMSA (American Medical Association) Gender Scholar Course, Webinar, March 11, 2020
210. Rush University Medical Center, Division of Plastic Surgery, Weekly Presentation, Gender Confirmation Surgery: Can a Surgeon Provide Informed Consent?, April 29, 2020
211. Legal Issues Faced by the Transgender Community, ISBA Standing Committee on Women and The Law and the ISBA Standing Committee on Sexual Orientation and Gender Identity, Co-Sponsored by the National Association of Women Judges District 8, Live Webinar, May 28, 2020
212. Principles of Transgender Surgery, National Association of Women's Judges, District 8, Webinar, June 4, 2020
213. Gender-Affirming Surgery, National Association of Women's Judges, District 8, Webinar, July 8, 2020
214. Gender-Affirming Surgery, The University of Chicago, Pritzker School of Medicine, 1st year Anatomy, September 15, 2020
215. Gender-Affirming Surgery, Rush University Medical School, 2nd year Genitourinary Anatomy, September 16, 2020.

216. Surgical Management of the Transgender Patient, Rosalind Franklin University, The Chicago Medical School, Plastic Surgery Interest Group, October 7, 2020
217. Breast Augmentation in Transgender Individuals, The American Society of Plastic Surgeons Spring Meeting, March 20, 2021
218. International Continence Society Institute of Physiotherapy Podcast 5-Pelvic Floor Most Common Disorders and Transgender Patients (recorded April 30, 2021)
219. The American Association of Plastic Surgeons Annual Meeting, Reconstructive Symposium, Gender Affirmation Panel, Complications of GCS, Miami, FL, May 15, 2021 (presented virtually)

Exhibit 25

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

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MAXWELL KADEL, et al.,)	
)	
Plaintiffs,)	
)	
-vs-)	Civil Action No.
)	1:19-cv-00272
DALE FOLWELL, in his official)	
capacity as State Treasurer of)	
North Carolina, et al.,)	
)	
Defendants.)	

The videotaped videoconference deposition of RANDI C. ETTNER, Ph.D., reported remotely by JUNE M. FUNKHOUSER, CSR, RMR, and Notary Public, pursuant to the Federal Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, commencing at 9:35 a.m. on October 15, 2021.

1 There were present via videoconference at
2 the taking of this deposition the following counsel:
3

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7 Chicago, Illinois 60606
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11 LAMBDA LEGAL DEFENSE AND EDUCATION
12 FUND, INC. by
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18 on behalf of the Plaintiffs;

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 BELL DAVIS & PITT, P.A. by
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 on behalf of Defendants Treasurer Dale
 Folwell, Administrator Dee Jones, and the
 North Carolina State Health Plan for
 Teachers and State Employees.

ALSO PRESENT: Mr. Dave Young, Videographer.

I N D E X

Witness:	Page
RANDI C. ETTNER, Ph.D.	
Examination by Mr. Knepper	7
Examination by Mr. Gonzalez-Pagan	183
Further Examination by Mr. Knepper	188

E X H I B I T S

	Page
EXHIBIT 1	14
Expert Rebuttal Report of Dr. Randi C. Ettner, Ph.D.	
EXHIBIT 2	14
Exhibit A (Curriculum Vitae) to Expert Rebuttal Report of Dr. Randi C. Ettner, Ph.D.	
EXHIBIT 3	14
Exhibit B (Bibliography) to Expert Rebuttal Report of Dr. Randi C. Ettner, Ph.D.	
EXHIBIT 4	70
Washington Post Article, 8/31/17	
EXHIBIT 5	87
Specialty Guidelines for Forensic Psychology, January 2013, American Psychologist	
EXHIBIT 6	106
WPATH Standards of Care, Version 7	
EXHIBIT 7	125
Article by Tracey, Wampold, Lichtenberg, and Goodyear, April 2014, American Psychologist	
EXHIBIT 8	135
Article by Bränström-Pachankis, American Journal of Psychiatry 177:8, August 2020	

1 provide you with facts or data that you were to
2 consider in forming your opinions in this case?

3 A No.

4 Q Did they present assumptions to you that
5 you were to rely upon in forming your opinions in
6 this case?

7 A No.

8 Q Does your expert reportal -- expert
9 report, rather, contain all of the opinions you
10 wish to present to the Court in this matter?

11 A At this time, yes.

12 Q Are there any changes you wish to make to
13 the opinions expressed in your report?

14 A No.

15 Q Are there any additions you wish to make
16 to the opinions expressed in your report?

17 A No.

18 Q Dr. Ettner, what is gender dysphoria?

19 A Gender dysphoria is a condition that can
20 result from an individual's distress at having a
21 gender identity that doesn't align with the sex
22 they're assigned at birth.

23 Q Is that a psychiatric diagnosis?

24 A No. It's a serious medical condition.

1 Q Do you -- so when -- do you treat
2 individuals with gender dysphoria?

3 A Yes.

4 Q Okay. Do you diagnose individuals with
5 gender dysphoria?

6 A Yes.

7 Q Are there codes you use to diagnose
8 individuals with gender dysphoria?

9 A By codes are you referring to the codes
10 in the ICD or the DSM-5?

11 Q I'm asking if you use codes and then I'm
12 going to follow up with which codes, yes.

13 A Occasionally I use codes if I need to
14 interface with insurance companies.

15 Q And which codes do you use when you
16 interface with insurance companies?

17 A That would depend on the individual and
18 what conditions they're experiencing.

19 Q So your -- do you use the DSM-5 in
20 diagnosing individuals with gender dysphoria?

21 MR. GONZALEZ-PAGAN: Objection; form.

22 You may answer.

23 THE WITNESS: I use the DSM-5 codes if I
24 need to document gender dysphoria for insurance

1 Q And when did you step down as -- and
2 assume the role of immediate past secretary of
3 WPATH?

4 A That -- that position ended in November
5 of last year.

6 I believe it's a two-year term, so I
7 believe I would have served four years in that
8 position.

9 Q What is the purpose of the WPATH Version
10 7 Standards of Care?

11 A The WPATH Standards of Care translated
12 into 18 languages are the guidelines that inform
13 care throughout the world and are accepted by major
14 medical associations and most -- many insurance
15 companies and even some state and federal prisons.

16 Q Dr. Ettner, are you familiar with the
17 National Guidelines Clearinghouse?

18 A No.

19 Q Were the WPATH Version 7 Standards of
20 Care ever submitted for approval as clinical
21 practice guidelines to the National Guidelines
22 Clearinghouse?

23 A I don't know.

24 Q You mentioned that you have a role in the

Exhibit 25(a)

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, *et al.*,

Defendants.

No. 1:19-cv-00272-LCB-LPA

EXPERT REBUTTAL REPORT OF DR. RANDI C. ETTNER, PH.D.

1. My name is Randi C. Ettner. I have been retained by counsel for plaintiffs Maxwell Kadel, Jason Fleck, Connor Thonen-Fleck, Julia Mckeown, Michael D. Bunting, Jr., C.B., Sam Silvaine, and Dana Caraway (collectively, “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 gender identity, the treatment and diagnosis of gender dysphoria, and more specifically, to respond to, rebut, and provide my expert opinion regarding the reports by Dr. Stephen R. Levine, Dr. Paul R. McHugh, Dr. Paul W. Hruz, and Dr. Patrick W. Lappert in this case.

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.

**Exhibit
0001
Ettner**

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 been a consultant to the Center for Gender Confirmation Surgery at Weiss Memorial Hospital and a member of the Medical Staff. 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. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Posttraumatic Stress Disorder (PTSD).

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

7. 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 also 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*.

8. I am the immediate past Secretary of the World Professional Association for Transgender Health (“WPATH”) (formerly the Harry Benjamin Gender Dysphoria Association), as well as a member of the Board of Directors for 12 years. I am 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.

9. 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.

10. 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 House of Representatives on February 5, 2019 recognizing my work for WPATH and on the treatment of gender dysphoria in Illinois.

11. I have treated hundreds of PTSD patients who experience the long-term psychological effects of trauma. As a forensic psychologist, I have been retained as an expert and testified in numerous cases about the harm that befalls victims of criminal victimization, natural catastrophes, and exposure to extremely stressful events.

12. 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.

13. In preparing this report, I have relied on my training and years of research and clinical experience, as set out in my curriculum vitae, and on the materials listed therein. 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 my publications.

14. I have also reviewed the materials listed in the attached bibliography (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.

15. In addition, I have reviewed the Amended Complaint in this case and the reports by Dr. Levine, Dr. McHugh, Dr. Hruz, and Dr. Lappert, as well as the reports by Dr. George Brown, Dr. Loren Schechter, Dr. Dan Karasic, and Dr. Johanna Olson-Kennedy. I may rely on these documents, as well as those cited in curriculum vitae and the attached bibliography, as additional support for my opinions.

16. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

Prior Testimony

17. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Singer v. Univ. of Tennessee Health Sciences Ctr.*, No. 2:19-cv-02431-JPM-cgc (W.D. Tenn. 2021); *Morrow v. Tyson Fresh Meats, Inc.*, No. 6:20-cv-02033 (N.D. Iowa 2021); *Claire v. Fla. Dep't of Mgmt. Servs.*, No. 4:20-cv-00020-MW-MAF (N.D. Fla. 2020); *Williams v. Allegheny Cty.*, No. 2:17-cv-01556-MJH (W.D. Pa. 2020); *Gore v. Lee*, No. 3:19-CV-00328 (M.D. Tenn. 2020); *Eller v. Prince George's Cty. Public*

Sch., No. 8:18-cv-03649-TDC (D. Md. 2020); *Monroe v. Baldwin*, No. 18-CV-00156-NJR-MAB (S.D. Ill. 2020); *Ray v. Acton*, No. 2:18-cv-00272 (S.D. Ohio 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).

Compensation

18. 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. I will be compensated \$500.00 per hour for any pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. I will receive a flat fee of \$2,500.00 for any travel time to attend deposition or trial, and will be reimbursed for reasonable out-of-pocket travel expenses incurred for the purpose of providing expert testimony in this matter. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

II. EXPERT OPINIONS

19. Drs. Levine, McHugh, Hruz, and Lappert all show a lack of familiarity with the nature, diagnosis, and treatment of gender dysphoria. Not only are all of them outside the mainstream of transgender health, but they largely have limited to no experience with the diagnosis and treatment of gender dysphoria.

20. Thus, before setting forth some more specific critiques of their reports, in subsections A-C, I provide some necessary context in the form of an overview of the nature of gender identity, gender dysphoria and its treatments, as well as the benefits of treatment and harms that flow from the denial of such treatment.

21. In addition, the specific critiques in subsections D-G below may apply to more than one expert report.

A. Sex and Gender Identity

22. 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 clinical distress that characterizes the condition of gender dysphoria.

23. Research has identified that determination of sex is far more complex than what is seen as part of a genital exam. Instead, a number of factors go into the determination of a person's sex. Among the factors that comprise a person's sex are their 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); fetal hormones (production of sex hormones by the fetus or exogenous exposure of sex hormones to the developing fetus); pubertal

hormones (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); sexual differentiations in brain development and structure (detectable by functional magnetic resonance imaging studies and autopsy); and gender identity.

24. 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, and is a well established concept in science and medicine. Every person has a gender identity. Like non-transgender people (also known as cisgender people), transgender people do not simply have a "preference" to act or behave consistently with each one's gender identity.

25. 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.

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

27. 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.

28. 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

29. 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 distress that results from the incongruity between various aspects of one’s sex. It is codified in the *International Classification of Diseases* (11th 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.

30. In 1980, the American Psychiatric Association introduced the diagnostic term gender identity disorder (GID) in the third edition of the Diagnostic and Statistical

Manual of Mental Disorders (DSM-III). The diagnosis of GID was maintained in a revised version of DSM, known as DSM-III-R (1987), as well as in the DSM-IV, which was issued in 1994. The gender identity disorder diagnosis presupposed that a person's identity was disordered, and was therefore a permanent condition.

31. In 2013, the American Psychiatric Association removed the GID diagnosis and replaced it with a fundamentally different diagnosis, gender dysphoria. The change was not merely a name change but was based on the evolving scientific understanding that gender incongruence is not a mental illness, but rather a serious, treatable medical condition that creates significant distress. This new diagnostic term, gender dysphoria, is an acknowledgment that gender incongruence, in and of itself, does not constitute a mental disorder. Nor is an individual's identity disordered. Rather, the diagnosis is based on the distress or dysphoria that some transgender people experience as a result of the incongruence between the sex assigned at birth and gender identity, and the social problems that ensue. The critical element of the gender dysphoria diagnosis is the presence of symptoms that meet the threshold of clinical impairment. 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.

32. “Gender Dysphoria” is the name of the diagnosis, and “gender dysphoria” is also the psychiatric term for the severe and unremitting distress that the condition gives rise to.

33. Children as young as three years of age may display gender non-conforming behavior and be diagnosed with “Gender Dysphoria in Childhood” (DSM-5). As these youngsters develop the ability to verbalize their discomfort with their assigned sex and anatomy, they often express the distress as “being trapped in the wrong body.”

34. 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.

35. 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.

36. 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.

37. 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.,* AMA, 2019; American Psychological Association, 2015; Drescher, et al., 2018 (American Psychiatric Association); Hembree, et al., 2017 (Endocrine Society); ACOG, 2021; NCCHC, 2009).

38. 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.

39. The ability to live in a manner consistent with one's gender identity is critical to a person's health and well-being and is a key aspect in the treatment of gender dysphoria. The process by which transgender people come to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth, is known as transition. The steps that each transgender person takes to transition are not identical.

40. Once a diagnosis is established, a treatment plan should be developed based on the individualized assessment of the medical needs of the patient. In other words, whether any particular treatment is medically necessary or even appropriate depends on the medical needs of the individual.

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

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

43. The goals of hormone therapy are (1) to significantly reduce hormone production associated with the person's birth sex, causing the unwanted secondary sex characteristics to recede, and (2) to replace the natal, circulating sex hormones with either feminizing or masculinizing hormones, using the principles of hormone replacement treatment developed for hypogonadal patients (*i.e.*, those born with insufficient sex steroid hormones).

44. The therapeutic effects of hormone therapy are twofold. First, with endocrine treatment, the patient acquires secondary sex characteristics congruent with their gender identity. For transgender women, this means, *inter alia*, breast development, redistribution of body fat, cessation of male pattern baldness, and reduction of body hair. For transgender men, this means, *inter alia*, the voice deepens, growth of facial and body hair, redistribution of body fat, and overall increase in muscle mass. Second, hormones act

directly on the brain, via receptor sites, attenuating the dysphoria and attendant psychiatric symptoms, and promoting a sense of well-being.

45. **Surgical Treatment:** For individuals with severe gender dysphoria, hormone therapy alone is insufficient. In these cases, dysphoria does not abate without surgical intervention.

46. For many transgender women patients, hormones alone will not provide sufficient breast development to approximate the female torso. For these patients, breast augmentation has a dramatic, irreplaceable, and permanent effect on reducing gender dysphoria, and thus unquestionable therapeutic results. Conversely, for many transgender men, hormones alone do not reduce breast tissue and they therefore require surgical intervention, such as a mastectomy and male chest contouring, to eliminate this most obvious typically female sex characteristic.

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

48. For many transgender men, gender confirmation surgery in the form of a hysterectomy—the removal of female reproductive organs, such as the uterus, ovaries,

fallopian tubes and cervix—is a medically necessary procedure for the treatment of gender dysphoria. A hysterectomy confers three therapeutic benefits: First, it eliminates a source of estrogen and preexisting conditions of tumors, cysts, fibroids or endometriosis. Second, it removes the increased risk of ovarian cancer (thought to originate in the fallopian tubes) and other typically female cancers associated with atrophied organs. Finally, a hysterectomy eliminates the need for routine gynecological exams and significantly attenuates gender dysphoria.

49. Decades of methodologically sound and rigorous scientific research have demonstrated that gender confirmation surgery is a safe and effective treatment for severe gender dysphoria and, indeed, for many, it is the only effective treatment. The American Medical Association, the Endocrine Society, the American College of Obstetricians and Gynecologists, the American Psychological Association, and the American Psychiatric Association all endorse surgical therapy, in accordance with the WPATH *Standards of Care*, as medically necessary treatment for individuals with severe gender dysphoria.

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

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

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

53. As a general matter, patient satisfaction is a relevant measure of effective treatment. Achieving functional and normal physical appearance consistent with gender identity alleviates the suffering of gender dysphoria and enables the patient to function in everyday life. Studies have shown that by alleviating the suffering and dysfunction caused by severe gender dysphoria, gender confirmation surgery improves virtually every facet of a patient’s life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehman, et al., 1999; Johansson, et al., 2010; Hepp, et al.; 2002;

Ainsworth & Spiegel, 2010; Smith, et al., 2005); improvement in self-image and satisfaction with body and physical appearance (Lawrence, 2003; Smith, et al., 2005; Weyers, et al., 2009); and greater acceptance and integration into the family (Lobato, et al., 2006).

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

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

C. Harms Resulting from the Denial of Care

56. The overarching goal of treatment for gender dysphoria is to eliminate clinically significant distress by aligning an individual patient's body and presentation with their internal sense of self, thereby consolidating identity. Developing and integrating a positive sense of self-identity formation is a fundamental undertaking for all human beings. Denial of medically indicated care to transgender people signals that such people are "inferior" or "unworthy," and triggers shame.

57. Denying gender affirming care not only frustrates those treatment goals but exacerbates gender dysphoria and its associated depression and suicidality. Conversely, Bauer et al. found a 62% reduction in risk of suicide ideation with the completion of medical transition. That corresponds to a potential prevention of 240 suicide attempts per 1,000 per year. Studies have also shown that gender confirmation surgery has been linked with a reduction in psychological distress and suicidal ideation for transgender patients (Almazan, et al., 2021). Withholding this care results in serious negative health outcomes for transgender patients.

58. More broadly, the negative effects of discrimination impact transgender people throughout their lives. A wealth of research establishes that transgender people suffer from discrimination, stigma, and shame from those external forces. The “minority stress model” explains that the negative impact of the stress attached to being stigmatized is socially based. The stress process can be both external—i.e., actual experiences of rejection and discrimination (enacted stigma)—and because of such experiences, internal—i.e., perceived rejection and the expectation of being rejected or discriminated against (felt stigma). A 2015 survey of 28,000 transgender and gender nonconforming individuals found that 30% reported being fired, discriminated against, or otherwise experiencing mistreatment in the workplace (James, et al., 2016).

59. Experiencing discrimination, including in health care settings, has negative impacts on patients’ mental health and well-being. A 2012 study of transgender adults

found fear of discrimination increased the risk of developing hypertension by 100%, owing to the intersectionality of shame and cardiovascular reactivity. Another 2012 study of discrimination and implications for health concluded that “living in states with discriminatory policies ... was associated with a statistically significant increase in the number of psychiatric disorder diagnoses.” And a 2019 study found that experiencing discrimination in health care settings posed a unique risk factor for heightened suicidality among transgender individuals, a population already at heightened risk compared with the general population (Herman, et al., 2019).

60. Until recently, it was not fully understood that these experiences of shame and discrimination could have serious and enduring consequences. But it is now known that marginalization, stigmatization, and victimization are some of the most powerful predictors of current and future mental health problems, including the development of psychiatric disorders. The social problems that young transgender people face actually create the blueprint for future mental health, life satisfaction, and even physical health. A recent study of 245 gender nonconforming adults found that stress and victimization during childhood and adolescence was associated with a greater risk for post-traumatic stress disorder, depression, life dissatisfaction, anxiety, and suicidality in adulthood (Toomey, et al., 2010). A 2011 Institute of Medicine (IOM) report concurs: “the marginalization of transgender people from society is having a devastating effect on their physical and mental health.” And the American Journal of Public Health recently reported that more than half

of transgender women “struggle with depression from the stigma, shame and isolation caused by how others treat them.”

61. While a growing body of research documents that structural forms of stigma (namely, policies sanctioning discrimination) harm the health of transgender people, a 2010 study was the first to show that structural stigma is associated with all-cause mortality (*i.e.*, deaths from any cause). In other words, stigma—a chronic source of psychological stress—disrupts physiological pathways, increasing disease vulnerability, and leading to premature death.

62. Adding to the corpus of research in this area is a relatively new approach to the investigation of the relationship between discrimination and health. Neuroscientists have discovered that, in addition to causing serious emotional difficulties and physical harms, discrimination, harassment, and verbal abuse permanently alter the architecture of the brain. Deviations in the myelin sheathing of the corpus callosum and damage to the hippocampus cause cognitive difficulties in individuals who have been routinely subjected to humiliation and ostracism (Nickel, 2018; Ohashi, et al., 2017; Teicher, et al., 2010).

D. Dr. Levine’s Report

63. As an expert in this field, I am familiar with Dr. Levine’s opinions on gender confirming treatments. His opinions depart substantially in concerning ways from well-established standards of care for treatment of gender dysphoria and medical and scientific research, and are based largely on his personal views and “reflections.”

64. Dr. Levine utilizes a “kitchen sink approach,” proffering over one hundred pages of commentary aimed at discrediting the scientific and medical consensus regarding transgender healthcare. He makes a number of inaccurate assertions that I will address only briefly, as they do not seem to bear on what I understand to be the subject matter of this case, which is the categorical denial of insurance coverage for care.

65. Dr. Levine implicates several theoretical social factors (social contagion, trauma, anorexia, YouTube, etc.) as influencing the development of gender incongruity. He gives no data to support these, while ignoring the scientific studies indicating that gender identity and gender incongruity have a biological basis, including through genetic and prenatal hormonal influences. Dr. Levine ignores data from several scientific investigations that demonstrate that gender identity has biological underpinnings, such as studies involving endocrine disruption, prenatal hormonal influences, genetic contributions, and neurodevelopmental cortical studies.

66. For example, studies show that prenatal sex hormones have a lasting impact, affecting sexual dimorphism both pre-and-postnatally (Galis, et al., 2010). And follow-up studies have established that decreased prenatal androgen exposure is implicated in the development of gender incongruity in transgender women (Schneider, et al., 2006).

67. In addition, multiple studies of twins demonstrate genetic heritability, and researchers have directly examined gene alleles that influence gender formation. Indeed, several landmark studies have been undertaken to directly assess the role of specific genes

on the androgen and estrogen receptors. For example, Henningsson et al. (2005) found that transgender women differed from controls with respect to the mean length of the estrogen receptor beta (ERb) repeat polymorphism, suggesting lesser effective function of the ER receptor. And Bentz et al. (2008) found transgender men to differ from non-transgender controls in a specific allele distribution pattern, and to display an allele distribution akin to male controls. The identified gene, CYP17, is associated with gender incongruity, as is the loss of the female-specific genotype distribution. In addition, Hare et al. (2009) looked at polymorphisms in genes involved in steroid genesis. Specifically, they examined repeat length variants in the androgen receptor (AR), the estrogen receptor beta (ERb), and aromatase (CYP19) genes. They found a significant association between gender incongruity in birth-assigned males and the AR gene. Fernandez et al. (2014a) looked at a Spanish sample of 442 transgender women and found no significant association with AR, ER or CYP 19. However, in a subsequent study the same group found an association of the ERb gene and transmasculinity (2014b).

68. Furthermore, the advent of sophisticated brain imagery techniques enabled researchers to study large numbers of brains *in vivo*, overcoming the limitation of small sample size in post-mortem studies. Studies pre- and post-hormone treatment reveal that transgender women, transgender men, non-transgender women and non-transgender men present clear and distinct phenotypes, with respect to the gray and white matter of the brain (e.g., Mueller, et al., 2021). For example, transgender people differ from non-

transgender people in the microstructure of the brain bundles that connect the regions of the brain. Transgender women show demasculinization of these bundles (Rametti, et al., 2011a), while transgender men show a masculinization in some bundles (Rametti, et al., 2011b).

69. Thus, while the specific biological genesis of gender incongruity is still a matter of study, scientific study and data point to the inescapable conclusion that gender identity and gender incongruity have biological underpinnings and are not a matter of choice. As a recent review of scientific studies from 1948 to 2019 concluded: “gender identity is one of the most sex-specific human trait[s], and many studies show how brain sexually dimorphic structures are often in line with gender identity rather than with sex assigned at birth.” (Risoti, et al., 2020). The theories set forth by Dr. Levine, on the other hand, have no scientific support.

70. Dr. Levine states that reproductive function cannot be altered, and that at best transgender people “can pass as the opposite gender.” The goal of treatment is not to provide reproductive capacity, it is to alleviate the distress of gender dysphoria. Dr. Levine has further stated that individuals who lack the ability to reproduce are not “really” men or women, and that alterations are only superficial. Dr. Levine dismisses the bedrock importance of identity, opining that due to the inability to “produce sperm,” a transgender person taking testosterone is not “really” male, and “in critical respects, the change is only skin deep.” If this is true, it follows that those men who lack sperm (azoospermia) due to

testicular damage, dysfunction, or disease, are not “complete” men. Conversely, a lack of reproductive organs resulting from hysterectomy, disease or infertility in women reduces their womanhood to the level of being “only skin deep.”

71. Dr. Levine states that the diagnosis of gender dysphoria encompasses “a diverse array of conditions ... with widely different pathways.” As noted above, the diagnosis of gender dysphoria is codified in the DSM-5; published by the American Psychiatric Association, with attendant criteria. However, Dr. Levine doesn’t believe in the legitimacy of the DSM-5 (nor the ICD), an opinion that is eccentric, to say the least, and certainly not in keeping with the overwhelming medical consensus. In rejecting the codified nosology of the DSM and ICD, Dr. Levine has substituted his own theories or “pathways” of development of the condition, and frequently references his own writings to support his theories.

72. Dr. Levine further challenges the scientific and medical consensus: that gender identity is biologically based and has a physiological origin. He erroneously states that there is no difference in brain structure in transgender people. As noted above, differences in brain structure have been documented repeatedly in studies using functional magnetic resonance, differences in smelling odorous steroids, and other means (Guillamon, et al., 2012; Rametti, et al., 2011; Rametti, et al., 2012; Zubiarurre, et al., 2013). Our brains are a network of functionally linked regions. Recent studies display images depicting regional connectivity differences in the functional networks of

transgender and non-transgender individuals' brains. This is yet another of a plethora of studies demonstrating that gender dysphoria is a biologically based condition (Uribe, et al., 2020). Furthermore, brain structure is only one of several indicators of biological evidence.

73. Dr. Levine, whose views are at odds with WPATH, withdrew from WPATH in 2001 (two decades ago), and attempts to discredit the organization by characterizing it as an advocacy—not a professional—association. Preposterously, he states “in my experience most current members have little experience with the mentally ill...” Given that there are more than 2,500 current WPATH members spread throughout the world, this is a patently absurd assertion. In fact, his assertion that there are “competing views” among professionals pits him against the members of the American Medical Association, the Endocrine Society, the European Endocrine Society, the American Psychological Association, the American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, and the American College of Obstetrics and Gynecology, all which support the treatment of gender dysphoria in accordance with the WPATH *Standards of Care*.

74. Regarding Dr. Levine's extensive discussion of gender dysphoria in children, the *Standards of Care* do not recommend medical or surgical interventions for prepubescent children. No medical care is initiated until *after* the onset of puberty.

75. Dr. Levine further states that many people detransition or regret their “bodily transformations.” The authority for this is his own experience and vague references to reports on the Internet. All available research, and my own clinical experience indicate that detransition is a rare event and rates of regret range from no more than 0.3% to 0.6% (Wiepjes, et al., 2018; Danker, et al., 2018; Narayan, et al., 2021).

76. Dr. Levine references a “Transgender Treatment Industry” (TTI) which he claims is providing misleading information to the public. A search of all extant data bases finds no reference to the aforementioned industry. Similarly, Dr. Levine blames the increased prevalence of adolescent gender non-conformity on “rapid onset gender dysphoria,” which was coined by Dr. Lisa Littman in an article. An article in the Journal of Clinical Endocrinology & Metabolism debunks this concept stating “major methodological concerns have been raised ... including the facts that only parents and none of the youth participated in the study and that parents were recruited from web sites, most of which were not supportive ... In fact, a correction was published in the same journal.” (Rosenthal, et al., 2019).

77. Dr. Levine peppers his report with claims that treatment for gender dysphoria is experimental. In 2014, the U.S. Department of Health and Human Services, after reviewing expert testimony and research studies, determined that surgery is an appropriate treatment for gender dysphoria. The Department concluded that “[s]urgical procedures ... are not experimental and, indeed, constitute medically-indicated treatment in appropriate

cases,” and removed an exclusion of such treatment by Medicare. (NCD 140.3 Transsexual Surgery, Docket No A-13-87, Decision No. 2576).

78. Dr. Levine further states that treatment does not improve quality of life, increases suicidality and leads to numerous negative outcomes, such as the inability to form romantic relationships. However, in 2017, Cornell University conducted a systematic review of all peer-reviewed articles between 1991 and 2017, to assess the effect of medical transition on the overall well-being of transgender people. They identified 59 studies of which 93% found improved quality of life. No studies found that surgical treatment was harmful. They concluded: “Among the positive outcomes ... are improved quality of life, greater relationship satisfaction, higher self-esteem and confidence, and reductions in anxiety, depression, suicidality, and substance abuse.”

79. Two recent studies add to the body of literature substantiating the health outcomes and benefits of gender affirming surgery. In a 2021 study published in *JAMA Surgery* researchers compared transgender individuals who underwent gender affirming surgeries during the prior two years with a reference group that desired surgery but had not yet undergone any gender affirming surgery. The respondents drawn from across all 50 states, (n= 27,715) comprise the largest existing data set containing information on the benefits of gender affirming surgery. Of the 27,715 participants, 3,559 had undergone one or more gender affirming surgery in the two years prior, while 16,401 who desired to undergo one or more surgery, had not. After controlling for sociodemographic factors,

those who had undergone surgery had significantly less psychological distress, tobacco use, and suicidal ideation compared to those with no history of surgery. The authors conclude “These findings support the provision of gender affirming surgeries for TGD (transgender and gender diverse) people who seek them.”

80. Similarly, a 2018 study compared transmasculine people who underwent chest reconstruction to a reference group that desired, but had not undergone chest surgery. The cohort that received surgery was a mean of 2.5 years post-surgery, and had a significant decrease in dysphoria, compared to the non-operated group which evidenced an increase in chest dysphoria by 0.33% per month (Olson-Kennedy, et al., 2018).

81. Finally, a systematic meta-analysis on publications performed by German researchers included 1,101 participants post-surgery, suitable for inclusion. Seven different measures of quality of life were employed. The researchers concluded that gender surgery positively affects well-being, sexuality and quality of life, in general (Weinforth, et al., 2019).

82. Denying gender affirming care, however, exacerbates gender dysphoria and its associated depression and suicidality. Bauer et al. (2015) found a 62% reduction in risk of suicide ideation with the completion of medical transition. That corresponds to a potential prevention of 240 suicide attempts per 1,000 per year.

83. Dr. Levine cites Cecilia Dhejne’s 2011 Swedish study, to bolster his opinions on suicidality, but mischaracterizes her work. The study itself warns against drawing any

conclusions regarding the effectiveness of surgery as a treatment for gender dysphoria. Ms. Dhejne has publicly disavowed Dr. Levine's mischaracterization of her investigation, stating "recent studies conclude that WPATH Standards of Care compliant treatment decrease gender dysphoria and improve mental health." I have a professional relationship with Ms. Dhejne, and she has informed me that her study should not be interpreted to mean that gender confirmation surgery leads to an increase in suicide. Any observed trend in suicide rates following gender confirmation surgery cannot be held as evidence that surgery is risky or leads to increased rates of suicide, without a comparison to rates of suicide pre-surgery, which is generally not studied due to the ethical issues of intentionally withholding treatment for the purposes of research. To be clear, Ms. Dhejne's study states "For the purpose of evaluating whether sex reassignment is an effective treatment for gender dysphoria, it is reasonable to compare reported gender dysphoria pre and post treatment. Such studies have been conducted either prospectively or retrospectively, and suggest that sex reassignment of transsexual persons improves quality of life and gender dysphoria."

84. Dr. Levine's assertions that the evidence base for treatment for gender dysphoria is "low scientific quality" belies his lack of knowledge of research methodology. The gold standard in research is randomized clinical trials. Yet, as previously indicated, it is unethical to withhold treatment in the way that would be necessary to conduct randomized clinical trials. The Endocrine Society Guidelines were

constructed in tandem with evidence-based review by the Mayo Clinic. When Dr. Levine denounces transgender treatment as “low quality evidence” it should be pointed out that that is also true for the evidence for Vitamin D, for example. Most medical guidelines have “low quality” evidence.

85. Regarding Dr. Levine’s comments about the complications of surgery, a recent study found that 5.8%-5.9% of 1,047 patients who underwent gender confirming surgeries suffered complications (Lane, et al., 2018). By comparison, women who underwent the common procedure of breast reduction had a complication rate of 43% (Salim & Poh, 2018).

86. Perhaps most concerning is Dr. Levine’s generalizations about those who provide care to transgender patients and those who receive care. He accuses mental health providers of “recommending” social transition. He states that transgender people cannot form relationships. Specifically, Dr. Levine says that, “When a trans person does not pass well, he discovers that the pool of those interested consists largely of individuals looking for exotic sexual experiences rather than genuinely loving relationships.” I have seen over 3,000 transgender patients and the local primary care clinic in Chicago treats 500 patients a year. The majority of these patients are married or partnered. Most have remained in these relationships before, during and after gender affirming treatments.

87. Many of the critiques outlined herein regarding Dr. Levine’s report apply with equal measure to Dr. McHugh’s report, as well as those by Dr. Hruz and Dr. Lappert.

E. Dr. McHugh's Report

88. Dr. McHugh's report begins with a summary of his 1992 essay "Psychiatric Misadventures." He provides a lengthy synopsis of lobotomy, repressed memory syndrome, and multiple personality disorder, referring to these discarded theories and interventions as "industries." This irrelevant preamble is provided as a cautionary tale, as Dr. McHugh warns that transgender care is just the latest "disaster," "a newly proscribed treatment to life's complex problems," and one where patients are "sent down the road towards potential sterility or other damages."

89. To justify his rejection, in entirety, of the expansive body of scientific and medical literature confirming the efficacy of treatment for gender conditions, he denounces the American Psychiatric Association's publication of the DSM-5. He compares the DSM-5 to a "field guide for amateur birders to identify birds." In fact, the DSM-5 is the handbook used by health care professionals in much of the world, and is regarded as the authoritative guide to the diagnosis of mental disorders. It establishes, as does its companion publication, the International Classification of Diseases, a common language to facilitate communication among professionals, aid in research, and study criteria for future revisions. The DSM-5 was preceded by a decade of research evaluation that included 13 scientific conferences, supported by the National Institutes of Health. The Task Force and Work Groups reviewed literature, and a Scientific Committee provided guidance of the strength of evidence of any proposed change from the DSM-IV. It is compatible with HIPAA

approved coding systems used by insurance companies, which update their claim forms to accommodate the DSM-5. Aside from the defendants' experts in this case, I have not encountered a single health care provider who holds these outlier positions regarding the utility of the DSM.

90. In a study published in the non-peer reviewed journal *The New Atlantis* (which he co-authored with Dr. Hruz), Dr. McHugh issued his objection to scientific evidence that homosexuality and gender diversity are biologically based. According to the *Scientific American*, this view, reminiscent of stigmatizing and inaccurate views dating back to the 1990's and earlier, is a result of *The New Atlantis*' dedication to "applying Judeo-Christian moral tradition to critical issues of public policy." In response to the publication, Johns Hopkins' faculty members and 600 researchers and clinicians signed a letter disavowing Dr. McHugh's views, stating that Dr. McHugh "mischaracterizes the current state of science on gender and sexuality." One signatory, geneticist Dean Hamer, condemned Dr. McHugh's misrepresentation of Hamer's own genetic research.

91. Finally, Dr. McHugh concludes his report with eleven opinions referencing the "Transgender Treatment Industry," and even dismisses the American Medical Association, the American Pediatric Association, and the Endocrine Society as not relevant to the discourse. Dr. McHugh cites no scientific basis, citations, or peer-reviewed publications to support any of these opinions, other than his own tenaciously held beliefs.

92. Dr. McHugh has positioned himself as a prognosticator of disastrous treatments, declaring, “An important part of my career has been engaged in observing and warning the public and mental health professions about Psychiatric Misadventures.” Ironically, Johns Hopkins has ignored these “warnings” and disavowed their former faculty member, Dr. McHugh. Instead, the Johns Hopkins Center for Transgender Health has committed to: “providing high-quality, compassionate care that’s in line with the standards of care set by the World Professional Association for Transgender Health.”

93. Dr. McHugh asserts that mental health professionals simply believe what patients tell them. Mental health practitioners are trained to understand human behavior and to determine the meaning of the patient’s experience. The fact that they consider the patient’s reported symptoms, while applying their professional expertise to evaluate and assess the patient, is common in the fields of behavioral health and medicine. Every mental condition, and many physical conditions rely on the patient’s self-expressed disclosure of phenomenology. For example, how would a mental health practitioner verify that an individual often ruminates about suicide? How would a physician verify a report of migraine headache in a patient? Should auditory hallucinations be ignored because the provider does not hear them? All of these things are self-reported and taken into account by a trained mental health professional, who also exercises independent judgment, in order to make a diagnosis.

F. Dr. Hruz's Report

94. I have reviewed Dr. Hruz's credentials. It is my understanding that Dr. Hruz is not a mental health professional nor does he have experience with the diagnosis or treatment of gender dysphoria.

95. In fact, Dr. Hruz is no longer the Division Chief for Endocrinology and Diabetes at Washington University in St. Louis ("WUSTL") as of 2017. And since then, WUSTL has established a transgender center that provides care for adults and minors. See, <https://physicians.wustl.edu/specialties/lgbtq-health/washington-university-transgender-center/>. "In 2017, the Washington University School of Medicine's Division of Endocrinology and Division of Adolescent Medicine came together to form the Transgender Center to better address the needs of transgender patients." <https://www.stlouischildrens.org/conditions-treatments/transgender-center>.

96. In his report, Dr. Hruz propounds at length that sex is binary and conditions of sexual differentiation are not a "third sex." This simplistic view, however, ignores that there is great variance among the multiple sex-related characteristics that a person possesses, including gender identity, and that such variance is a natural phenomenon with biological underpinnings.

97. While conditions of sexual differentiation (i.e., intersex conditions) are not a "third sex," they are indicative of the natural variance regarding certain sex-related characteristics. These are rare conditions with an estimated aggregate incidence of 0.1-

0.5% of live births (Arboleda, et al., 2013). In mammals, gonads are controlled by the presence of XX or XY chromosomes, and gonadal secretions in turn regulate formation of female or male reproductive tissues, and characteristics that differ in typical males or females. These characteristics include external genitalia, uterus and oviducts, sperm ducts, and secondary sexual characteristics such as facial hair and pitch of voice. However, many people cannot make either eggs or sperm, yet are recognized as female or male based on *other* sex-related characteristics.

98. In addition, according to scientists at Los Alamos National Laboratory, the intrauterine environment has profound effects on the embryo, pre- and post-implantation. Epigenetic programming contributes to sex differentiation and estrogen and progesterone receptors are epigenetically programmed. The researchers have been investigating the etiology of gender identity, from DNA to brain differences, and conclude that there is a multitude of karyotypes, that there are many sex differences in the brain, and that epigenetics permanently program DNA, including brain development. As such, there are indications that gender identity results from a complex interplay between karyotype, genetics, epigenetics, hormone signaling, the womb and the placenta (McCarthy & Arnold, 2011).

99. Dr. Hruz makes reference to an article that purportedly identified 60,000 people who had detransitioned worldwide. However, the claim that 60,000 people have detransitioned worldwide is not only wrong based on the article cited (the actual number

appears to be 16,000), it is also inconsistent with methodologically sound studies of regret and points to the questionable means of identifying “detransitioners” via the internet. Take for example that an estimated 0.6% of adults, about 1.4 million, identify as transgender in the United States (Williams Institute, 2016) and that the world population is over 7.7 billion (<https://www.census.gov/popclock/>). Based on those numbers, it could be roughly estimated that the transgender population *worldwide* is around 46,200,000 (i.e. 0.6% of the world population). The identification of 60,000 detransitioners worldwide based on internet reports is therefore unremarkable, as it would still represent 0.1% of the very roughly estimated world transgender population. Of course, this exercise does not represent the appropriate way to estimate the total number of transgender people worldwide or of purported detransitioners, but it illustrates that the number of 60,000 detransitioners worldwide based on internet reports that is propounded by Dr. Hruz would still show that detransition is an incredibly rare phenomenon, as actual scientific studies and clinical experience demonstrate.

100. Additionally, there are multiple and complicated reasons that may lead a person to detransition, as acknowledged by the very article Dr. Hruz relies on (Expósito-Campos, et al., 2021). Turban et al. (2021) report that people who detransitioned were primarily driven by external pressures, and that these patients may seek gender affirmation in the future.

101. Cognitive behavioral therapy (CBT) is a form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcoholism, sleep problems and eating disorders. It involves the skillful assistance of guiding a client in cognitive reappraisal. Dr. Hruz wonders why CBT is not used to change gender identity, apparently confusing CBT with conversion therapy. The formulation of this argument buttresses the fact that he is not a mental health professional, and should avoid opining on mental health treatments or the scientific literacy of mental health professionals. CBT cannot be used to change a patient's gender identity because gender identity is innate and not subject to voluntary change. Moreover, efforts to change a person's gender identity have been shown to be unsuccessful and harmful, and are considered to be unethical. Psychiatrists and psychologists hold advanced degrees in medicine or behavioral science, and maligning an entire profession does not bolster Dr. Hruz's credibility.

G. Dr. Lappert's Report

102. Dr. Lappert has no experience in transgender health, nor does he have experience in mental health and making diagnoses using the DSM-5.

103. The critiques outlined above regarding the reports by Dr. Levine, Hruz, and McHugh apply in equal measure to Dr. Lappert's report.

104. However, I briefly address Dr. Lappert's clear misunderstanding of how DSM-5 diagnoses are made. Psychiatrists, psychologists, and other mental health

professionals take histories from patients and use their years of training to make diagnoses. DSM-5 diagnoses are the basis of the medical treatment of depression, anxiety, schizophrenia, and other mental disorders, and well as for psychotherapy treatments.

105. In addition, the provision of gender affirming care occurs in interdisciplinary settings, as recommended by the *WPATH Standards of Care* (Coleman, et al., 2012). The various health providers involved, from different fields, are well trained to conduct clinical interviews and to assess a patient's report to determine whether they meet the diagnostic criteria for gender dysphoria, and to determine what care is medically indicated for the patient.

III. CONCLUSION

106. The overwhelming medical and scientific consensus is that gender affirming care is medically necessary, non-experimental, and beneficial for transgender people with gender dysphoria, while the denial of gender affirming care is harmful to transgender people, as it exacerbates gender dysphoria and leads to negative health outcomes.

107. By contrast, the views expressed by Drs. Levine, McHugh, Hruz, and Lappert are outside the mainstream of the medical and scientific community. Unlike their misguided views suggesting that transgender people are disordered and should be counseled to live in accordance with the sex assigned at birth, gender identity has a strong biological basis and cannot be voluntarily changed. Indeed, efforts to do so are ineffective, harmful, and unethical.

108. In sum, scientific study and clinical experience demonstrate that the provision of medical and surgical care in accordance with the *Standards of Care* for transgender people with gender dysphoria is effective and leads to an improvement in general health, well-being, and quality of life.

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

Executed this 10 day of June, 2021.

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

CERTIFICATE OF SERVICE

I hereby certify that on June 11, 2021, I caused a copy of the foregoing document and all attachments to be served upon the following parties via email:

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Exhibit 25(b)

Exhibit A

Curriculum vitae of Dr. Randi C. Ettner, Ph.D.



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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 for Transgender Health (WPATH)
Chair, Committee for Institutionalized Persons, WPATH
Global Education Initiative Committee, WPATH
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 Transgender Health*
Editorial Board, *Transgender Health*
Television and radio guest (more than 100 national and international appearances)
Internationally syndicated columnist on women's health issues
Private practitioner
Medical staff; Department of Medicine: Weiss Memorial Hospital, Chicago, IL
Advisory Council, National Center for Gender Spectrum Health

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 School of Professional 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

INVITED PRESENTATIONS AND HOSPITAL GRAND ROUNDS

Care of the Older Transgender Patient, Weiss Memorial Hospital, Chicago, IL, 2021

Working with Medical Experts, The National LGBT Law Association, webinar presentation, 2020

Legal Issues Facing the Transgender Community, Illinois State Bar Association, Chicago, IL, 2020

Providing Gender Affirming Care to Transgender Patients, American Medical Student Association, webinar presentation, 2020

Foundations in Mental Health for Working with Transgender Clients; Advanced Mental Health Issues, Ethical Issues in the Delivery of Care, Center for Supporting Community Development Initiatives, Vietduc University Hospital, Hanoi, Vietnam, 2020

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; Orange Isn't the New Black Yet- WPATH symposium, Amsterdam, Netherlands, 2016.

Can two wrongs make a right? Expanding models of care beyond the divide, 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; Columbia, MO, 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

Transgender surgery- Midwestern Association of Plastic Surgeons, Chicago, 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, Chicago, 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, 2013

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

Grand Rounds: Evidence-based care of transgender patients- North Shore University Health Systems, University of Chicago, Illinois, 2011

Grand Rounds: Evidence-based care of transgender patients Roosevelt-St. Vincent Hospital, New York, 2011

Grand Rounds: Evidence-based care of transgender patients Columbia Presbyterian Hospital, Columbia University, New York, 2011

Hypertension: Pathophysiology of a secret. Atlanta, GA, 2011

Exploring the Clinical Utility of Transsexual Typologies Oslo, Norway, 2009

*Children of Transsexuals-*International Association of Sex Researchers, Ottawa, Canada, 2005

Children of Transsexuals Chicago School of Professional Psychology, Chicago, 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.

Grand Rounds: 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

Narayan, S., Danker, S Esmonde, N., Guerriero, J., Carter, A., Dugi III, D., Ettner, R., Radix A., Bluebond-Langner, R., Schechter, L., Berli, J. (2021) Guiding the conversation: Types of regret after gender-affirming surgery and their associated etiologies. *Annals of Translational Medicine*.

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"Compensation for Mental Injury," *Chicago Daily Law Bulletin*, 1994.

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"Transsexualism- The Phenotypic Variable," Proceedings of the XV Harry Benjamin International Gender Dysphoria Association Symposium; Vancouver, Canada, 1997.

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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

University of Minnesota, Program of Human Sexuality 50 *Distinguished Sex and Gender Revolutionary* award, 2021
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 25(c)

Exhibit B

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Exhibit 26

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

3
4 _____
5 MAXWELL KADEL, et al.,)
6 Plaintiffs,)
7 v.) Civil Action No. 1:19-cv-00272
8 DALE FOLWELL, in his)
9 official capacity as)
10 State Treasurer of North)
11 Carolina, et al.,)
12)
13 Defendants.)

14 _____
15 DEPOSITION OF JOHANNA OLSON-KENNEDY, MD
16 _____

17 9:00 a.m.
18 September 27, 2021
19 Los Angeles, California

20 YOM Full Service Reporting
21 1200 5th Avenue, #1820
22 Seattle, Washington 98101
23 800.831.6973
24 206.622.6875
25 File #4811319

Reported By: Judy Robinson, CCR #2171

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Public Safety

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I N D E X

WITNESS	EXAMINATION	PAGES
JOHANNA OLSON-KENNEDY, MD		
	BY MR. KNEPPER.....	5-118
	BY MR. GONZALEZ-PAGAN.....	119-122

E X H I B I T S

NO.	DESCRIPTION	PAGE
Exhibit 1	Expert Rebuttal Report	7
Exhibit 2	Dr. Johanna Olson-Kennedy's Curriculum Vitae	7
Exhibit 3	Bibliography	7
Exhibit 4	Gender Dysphoria	92
Exhibit 5	Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults	20
Exhibit 6	2021 SINGH ZUCKER.pdf	20
Exhibit 7	2014 DUTCH deVries, et al.	20
Exhibit 8	2020 BRANSTROM	20
Exhibit 9	2019 Kolbuck.pdf	20
Exhibit 10	2020 FINLAND Document	99
Exhibit 11	2021 SWEDEN Document	101
Exhibit 12	7/9/2021 Tavistock	104
Exhibit 13	ENGLAND NICE Reviews	104
Exhibit 14	ENGLAND NICE Review	107
Exhibit 15	CARMICHAEL Document	108
Exhibit 16	2018 Owen-Smith Study	114

1 BY MR. KNEPPER:

2 Q And -- and -- and what does -- what -- what does --
3 what are the responsibilities of a principal investigator on a
4 federal grant?

5 A So I can answer what I do as the principal
6 investigator. I can't answer what everybody does a principal
7 investigator.

8 Q Okay.

9 A In my case, I -- I wrote the majority of the grant.
10 The principal investigator is -- my understanding is usually
11 responsible for the overseeing of the grant. So what that means
12 is, you know, making sure that the team is up-to-date on what
13 the grant entails, making sure that people have the information
14 that they need about how to conduct the business of the
15 research.

16 Some -- I'm a pretty involved PI. So I also have been
17 looking and analyzing the data myself and with my team. I'm
18 also responsible for disseminating any findings that come out
19 for -- not solely responsible, but for overseeing these
20 activities.

21 It's really to understand what's in the grant, and what
22 we're looking at, what we're measuring, making sure over time
23 that the measures that we're using are appropriate and
24 disseminating the findings.

25 Q So Dr. Olson-Kennedy, what is gender dysphoria?

1 A Gender dysphoria has a broad definition, and it also
2 has a criteria list out -- outlined by the DSM. So there's a
3 broad definition that includes -- that basically is the distress
4 that arises for people when they have an incongruence between
5 their gender and their designated sex or assumed sex at birth
6 based on their genitals.

7 Q Okay. And you said that's the broad definition; is
8 that correct?

9 A Yes.

10 Q Now, is -- is that broad definition a diagnosis?

11 A Yes. It's also an experience.

12 Q Okay. So -- so -- so what is the -- you said the broad
13 definition is a diagnosis.

14 What's that diagnosis?

15 A It corresponds to the diagnostic criteria that are
16 outlined in the DSM V, but it's broader than that because it
17 also includes things that are not outlined in the DSM.

18 Q So -- so how -- how does one -- diagnose and treat -- I
19 guess I'm -- I'm trying to -- you said -- you said that -- this
20 is where I want to make sure I understand how the terms are
21 being used.

22 You said there's -- there's gender dysphoria as -- as
23 identified in the -- well, I tell you what. Before -- before we
24 even get any further, let me -- let me just introduce the DSM V
25 so we have a common frame of reference.

1 Q Okay. So -- so gender incongruence is a different
2 diagnosis; is that correct?

3 A I think that it would be necessary to talk about
4 the ICD, and how that looks right now and what it -- what it's
5 going to look in 11.

6 So ICD 11 specifies gender incongruence as diagnosis,
7 but ICD 10 does not.

8 Q So -- so then -- then let's -- let's finish up with the
9 DSM V, and then let's talk about ICD 10 and 11.

10 So for I -- for -- for adults and adolescents, looking
11 at the top of page 50 -- 453, does -- does the DSM require for
12 adults and adolescents suffering from gender dysphoria that they
13 -- that the condition be associated with clinically-significant
14 distress or impairment in social, occupational or other
15 important areas of functioning?

16 A Yes.

17 Q Okay. So the -- the DSM definition of gender
18 dysphoria, does that require more than an individual's effective
19 or cognitive discontent with assigned gender in order to be a
20 diagnosed medical condition?

21 A For the diagnosis of gender dysphoria, as -- as we're
22 looking at it in the DSM, the criteria B has to be met.

23 Q And is it possible to have effective or cognitive
24 discontent with one's assigned gener, but not meet criteria B?

25 A Yes.

1 concept of desistance?

2 A He has.

3 MR. GONZALEZ-PAGAN: Objection to form.

4 BY MR. KNEPPER:

5 Q What is -- what is the concept of desistance as you
6 understand it in Dr. Zucker's research?

7 A I understand it to mean a group of people who were
8 diagnosed with Gender Identity Disorder or subthreshold for
9 Gender Identity Disorder in childhood who then did not go on to
10 have a -- a trans identity beyond childhood.

11 Q And -- but you -- you -- in -- in paragraph 29, you --
12 you criticized the applicability of research to -- to -- by the
13 defense experts.

14 I wondered if you could explain your -- your views?
15 And feel -- feel free to look at your -- your report. I'm not
16 trying to add new views, I just want you to know this isn't a
17 quiz. I -- I just want to make sure I -- I have -- I have a
18 chance to gage with you on your -- on your criticism.

19 A I have to go back into my report. But is it -- was it
20 -- what was the paragraph number again?

21 Q 29 on page 8.

22 A Okay. My issues are as follows: The first one is this
23 data is looking at prepubertal children. So prepubertal
24 children do not get any -- there's no -- there are medical
25 interventions that are appropriate or warranted for prepubertal

1 children across the board. There are zero people practicing
2 this care that provide medical interventions for prepubertal
3 children. That's the first thing.

4 So the applicability of this study to young people who
5 are seeking services beyond their puberty, it's -- it's -- it's
6 not relevant to talk about people who are presenting in
7 childhood. That's an applicability issue.

8 The second one has to do with the time that these
9 studies took place, and the manifestation of the DSM at the time
10 and the way that this situation was -- was categorized. So at
11 the time that these studies were done, we had an entity called
12 Gender Identity Disorder and that is no longer an entity. And
13 so, because some of the criteria change, the applicability is in
14 question.

15 But the biggest thing that I get concerned about are
16 things that -- that creates an applicability issue is that this
17 is a cohort of prepubertal children and not adolescents or young
18 adults or adults.

19 Q So just a -- couple -- couple things to un -- a few
20 things. You identified prepubertal children as prepubertal at
21 Tanner Stage 2 -- children of prepubertal development; is that
22 correct?

23 A That's correct.

24 Q Okay. And so -- if -- if an in -- if a child has
25 reached -- entered Tanner Stage 2, how do you describe that

1 Q Sure. Yeah.

2 A Okay.

3 Q I was going -- let's -- let's -- actually, you're
4 right. Let's define terms. If I use the term puberty blockers,
5 would you understand that to mean GNRH analogues used to delay
6 the onset of puberty?

7 A If we -- I mean, if we define it that way, yes.

8 Q Sure.

9 A Yes.

10 Q Okay. Is there a different definition? I want to make
11 sure I'm being fully --

12 A Well, I think even just puberty blockers is kind of a
13 -- in some ways a problematic term because that's -- that's not
14 a specific entity for GNRH analogues. Which GNRH analogues are
15 used to shut down the production of sex steroids, but -- but
16 they're used in -- in -- in, like, different time points I guess
17 if that -- they're used for different clinical entities. They
18 are used in different age populations.

19 So I think lumping them all together is puberty blocker
20 because sometimes we use GNRH analogues when we're not blocking
21 puberty, but we're blocking the production of sex steroids.

22 Q Okay. So when do you use GNRH analogues for the
23 treatment of gender dysphoria?

24 A There are -- again, so let me -- let me break it down
25 by cohorts because that's a little bit easier to understand.

1 So in some young people with gender dysphoria, we are
2 using GNRH analogues so that they can put a pause on their
3 prepubertal development. I think that's what people mean when
4 they say puberty blockers.

5 But there are other indications to use GNRH analogues
6 as well. So sometimes, for example, when there are folks who
7 are further along or done with their prepubertal development, we
8 might use GNRH analogues for other specific reasons, maybe to
9 induce amenorrhea. Maybe so that they're used in conjunction
10 with gender firming hormones.

11 So I just want to have a lot of clarity about what --
12 what we're talking about because they don't just have a singular
13 use.

14 Q So let's -- let's -- let's -- let's identify -- let's
15 -- let's just start with -- and I think this is -- this is a
16 trick question, but I want to make sure I understand it.

17 If -- if an individual is at Tanner Stage 1, the
18 prescription of GRN -- GNRH analogues is not appropriate.

19 Is that your testimony?

20 A That's correct.

21 Q Okay. If an individual is --

22 A There's only -- hang on. I -- I need to add to that
23 because if -- if someone in Tanner Stage 1, they're -- they have
24 not had any prepubertal changes, so there's nothing to block.
25 So there would be no reason to use them.

Exhibit 26(a)

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, *et al.*,

Defendants.

No. 1:19-cv-00272-LCB-LPA

**Exhibit
0001
Olson-Kennedy**

EXPERT REBUTTAL REPORT OF DR. JOHANNA OLSON-KENNEDY, M.D., M.S.

1. My name is Johanna Olson-Kennedy. I have been retained by counsel for plaintiffs Maxwell Kadel, Jason Fleck, Connor Thonen-Fleck, Julia Mckeown, Michael D. Bunting, Jr., C.B., Sam Silvaine, and Dana Caraway (collectively, “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 gender identity, the treatment and diagnosis of gender dysphoria, particularly as it pertains to children and adolescents, and to respond to, rebut, and provide my expert opinion regarding the reports by Dr. Stephen R. Levine, Dr. Paul R. McHugh, Dr. Paul W. Hruz, and Dr. Patrick W. Lappert in this case.

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 received my Doctor of Medicine (M.D.) degree from the Chicago Medical School in 1997. In 2000, I completed my residency in pediatrics at the Children’s Hospital of Orange

County, California, and from 2000 to 2003, I was a Fellow in adolescent medicine at the Children's Hospital of Los Angeles.

5. I have been a licensed physician in California since 2000 and am Double Board Certified by the American Board of Pediatrics in Pediatrics and in Adolescent Medicine. I specialize in the care of transgender youth and gender diverse children, and am currently the Medical Director of the Center for Transyouth Health and Development, in the Division of Adolescent Medicine at the Children's Hospital in Los Angeles, California. The Center is the largest clinic in the United States for transgender youth and provides gender diverse youth with both medical and mental health services, including consultation for families with gender diverse children and routine use of medications to suppress puberty in peri-pubertal youth (i.e., youth at the onset of puberty), gender affirming hormone use for masculinization and feminization as well as surgical referrals. Under my direction, the Center conducts rigorous research aimed at understanding the experience of gender diversity and gender dysphoria from childhood through early adulthood.

6. Over the course of my work with this population during the past 15 years, I have provided services for approximately 1000 young people and their families, and currently have an active panel of around 650 patients of varying ages, up to 25 years old.

7. I have been awarded research grants to examine the impact of early interventions including puberty blockers and gender affirming hormones on the physiological and psychosocial development of gender diverse and transgender youth I have lectured extensively on the treatment and care of gender diverse children and transgender adolescents, the subjects including pubertal suppression, gender affirming hormone therapy, transitioning teens and the adolescent experience, age considerations in administering hormones, and the needs, risks, and outcomes of hormonal

treatments. I have published numerous articles and chapters, both peer reviewed, and non-peer reviewed, on transgender health-related issues.

8. I am currently the principal investigator on a multisite NIH grant which recently received funding to continue, for an additional 5 years, an ongoing study examining the impact of gender affirming medical care for transgender youth on physiologic and psychological health and well-being. The first five years have already been completed. This is the first study of its kind in the US to determine longitudinal outcomes among this population of vulnerable youth. The study to date has yielded approximately 26 manuscripts.

9. I am an Associate Professor at the Keck School of Medicine at the University of Southern California and attending physician at Children's Hospital of Los Angeles. I have been a member of the World Professional Association for Transgender Health (WPATH) since 2010, and a Board Member of the US Professional Association for Transgender Health (USPATH) since 2017. I am also a member of the Society for Adolescent Health and Medicine and the American Academy of Pediatrics. In addition, I serve on the Executive Board of Transyouth Family Allies and am a member of the LGBT Special Interest Group of the Society for Adolescent Health and Development.

10. I am the 2014 Recognition Awardee for the Southern California Regional Chapter of the Society for Adolescent Health and Medicine.

11. In 2019, I was invited by the University of Bristol as a Benjamin Meaker visiting professor, the purpose of which is to bring distinguished researchers from overseas to Bristol in order to enhance the research activity of the university.

12. In preparing this report, I have relied on my training and years of research and clinical experience, as set out in my curriculum vitae, and on the materials listed therein. 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.

13. I have also reviewed the materials listed in the attached bibliography (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.

14. In addition, I have reviewed the Amended Complaint in this case; the reports by Dr. Levine, Dr. McHugh, Dr. Hruz, and Dr. Lappert; and the reports by Dr. George Brown and Dr. Loren S. Schechter. I may rely on these documents, as well as those cited in curriculum vitae and the attached bibliography, as additional support for my opinions.

15. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

Prior Testimony

16. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *In the interest of JA.D.Y. and JU.D.Y., Children*, Case No. DF-15-09887 (255th Jud. District Ct., Dallas Cty., Tex.); and *Paul E. v. Courtney F.*, No. FC2010-051045 (Superior Ct., Maricopa Cty., Ariz.).

Compensation

17. I am being compensated for my work on this matter at a rate of \$200.00 per hour for preparation of declarations and expert reports, as well as any pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

II. EXPERT OPINIONS¹

A. Gender Identity

18. Gender identity, often simply termed “gender,” is a distinct characteristic and is defined as one’s internal sense of being male, female, both, neither, or some other gender identity. It has a strong biological basis. Every person has a gender identity. The term cisgender refers to a person whose gender identity matches their sex assigned at birth. The term transgender refers to a person whose gender identity does not match their sex assigned at birth.

19. Historically, “gender” was equated with a person’s sex assigned at birth, which refers to the sex assigned to a person when they are born, generally based on external genitalia. However, a more contemporary understanding of gender shows that one’s gender identity may differ from one’s sex assigned at birth.

20. While both gender identity and sex are often assumed and treated as binary and oppositional, they are more accurately experienced as along a spectrum. For example, there are multiple sex characteristics, such as genitalia, chromosomal makeup, hormones, and variations in brain structure and function. For some of these characteristics there is significant variance as

¹ Subsections A and B of this report explain several concepts and provide some necessary background information that is necessary to understand the more specific critiques of the reports by Drs. Hruz, Levine, Lappert, and McHugh that I lay out on subsection C.

reflected by the dozens of intersex mechanisms and varying gender identities. Additionally, not all sex characteristics, including gender identity, are always in alignment. Accordingly, the Endocrine Society Guidelines, state that, “As these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.”

21. As early as 1966 it has been understood that gender identity cannot be changed. Efforts to do so have been shown to be unsuccessful and harmful.

22. “Conversion” or “reparative” therapy refers to the practice of attempting to change an individual’s sexual orientation and attractions from members of the same sex to those of the opposite sex. A similar model of therapy for individuals with a transgender identity or experience has historically been an approach promoted by some individuals, such as the defense experts, notwithstanding its ineffectiveness and harmful effects. Accordingly, 20 states and the District of Columbia have banned reparative therapy for youth, and major medical organizations have issued statements deeming the practice to be unethical.

23. A Williams Institute report published in 2018 estimates that just under 700,000 LGBT individuals in the United States have undergone “conversion therapy” at some point in their lifetime, about half of those during adolescence. Because some psychiatrists and sexologists working in the 1960’s and 70’s perpetuated the idea that being transgender was likely the result of a pathological early childhood experience, many professionals and lay community members continue to believe that gender is malleable. Tactics have ranged from simple redirection, thought pattern alteration or hypnosis to aversion techniques including induction of vomiting, nausea, paralysis or electric shocks have been employed in order to change the expression, behavior, and assertion of one’s authentic gender. (Mallory, et al., 2019). However, multiple studies show that

gender identity has a strong biological basis and cannot be changed. As such, reparative therapy is both ineffective and harmful for transgender and gender diverse youth.

B. Gender Dysphoria and its Treatment

24. Gender Dysphoria (GD) is a serious medical condition characterized by distress due to a mismatch between assigned birth sex and a person's internal sense of their gender. GD was formerly categorized as Gender Identity Disorder (GID) but the condition was renamed in May 2013, with the release by the American Psychiatric Association (APA)'s fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). In announcing this change, the APA explained that in addition to the name change, the criteria for the diagnosis were revised "to better characterize the experiences of affected children, adolescents, and adults." The APA further stressed that "gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition."

25. On May 25, 2019, the World Health Assembly approved International Classification of Diseases (ICD) version 11 that had been published by the World Health Organization in 2018. In this newest version of the ICD, all trans-related diagnostic codes were removed from the chapter "Mental and Behavioral Disorders," and the code "Gender incongruence" was included in a new chapter "Conditions related to sexual health." These codes replaced the outdated "Gender Identity Disorder of childhood" (F64.2), "Gender Identity Disorder not otherwise specified" (F64.9), "transsexualism" (F64.0), and "Dual-role transvestism" (F64.1) codes which perpetuated the idea that patients seeking and undergoing medical interventions for a medical condition are mentally ill. (Suess Schwend, 2020).

26. For a person to be diagnosed with GD, there must be a marked difference between the individual's expressed/experienced gender and the gender others would assign to the

individual, present for at least six months. In children, the desire to be of the other gender must be present and verbalized.² The condition must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

27. The World Professional Association of Transgender Health (WPATH) has clear recommendations for the health of transsexual, transgender, and gender non-conforming people in what is now the Standards of Care version 7. The SOC are based on the best available science and expert professional consensus. They are currently under revision to create an updated version 8. The WPATH Standards of Care have been endorsed and cited as authoritative by most major medical associations in the United States, including the American Medical Association, the American Psychiatric Association, the American Psychological Association, the Endocrine Society, the Pediatric Endocrine Society, the American College of Physicians, and the American Academy of Family Physicians, among others.

28. The UCSF Center for Excellence in Transgender Care as well as the Endocrine Society have both published comprehensive guidelines for the care of transgender and non-binary individuals that are largely consistent with the WPATH Standards of Care.

29. There are a significant number of *pre-pubertal* children who demonstrate an interest or preference for clothing, toys, and games that are stereotypically of interest to members of the “other” gender. Some of these children are transgender and some are not. It is the study of such *pre-pubertal* children that has created confusion about the persistence of gender dysphoria into adolescence and adulthood. Specifically, the *pre-pubertal* children who were the subject of

² Notably, the DSM-IV included a separate diagnosis for GID in children, which required the child to display a number of behaviors stereotypical of the non-natal gender. That diagnosis, and its list of behavioral requirements, have been deleted from the DSM-V and replaced by updated and more precise diagnostic criteria.

research endeavors in the late 20th century included both of these groups of children, those that would have met current criteria for a diagnosis of “Gender Dysphoria in Children” and those who would be considered “sub-threshold” for this diagnosis. At the time of these studies, criteria B had not yet been added to the diagnosis, which is “the presence of clinically significant distress associated with the condition.” In addition, the criteria for then-used “gender identity disorder in children” diagnosis did not require a child to have “a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender),” which the current “gender dysphoria in children” diagnosis does. Thus, given the broader criteria used at the time, it is unsurprising that some of the research undertaken toward the end of the 20th century demonstrated that most children who exhibited gender-nonconforming behavior did not go on to have a transgender identity in adolescence. Yet, notwithstanding its inapplicability and faulty underpinnings, this “evidence” has been used to argue against gender affirmation for children and adolescents.

30. In any event, these arguments are wholly irrelevant to the question of coverage and provision of medical care as treatment for GD. That is because research to date shows that if transgender identification persists into adolescence, then desistance is incredibly rare, and no medical or surgical treatments are recommended for *pre-pubertal* children.

31. Additionally, no studies have ever demonstrated that gender affirmation in childhood “leads to” a child being transgender who otherwise might not have been. Studies have demonstrated that the majority of youth whose GD and cross-gender identity continue to be present, or those whose GD emerges in adolescence, are highly unlikely to identify and live as cisgender individuals. Youth with GD, particularly those who are unaffirmed and denied care, are

at high risk for depression, anxiety, isolation, self-harm and suicidality at the onset of puberty-related changes that feel wrong to them.

32. In their reports, Dr. Levine and Dr. Hruz discuss a number of approaches to care, though they fail to properly describe them and to discuss their limitations.

33. One of the approaches discussed by Dr. Levine and Dr. Hruz is “reparative” or “corrective” therapy. As discussed above, this so-called “therapy” has proven to be ineffective and harmful, and has been deemed to be unethical.

34. **“Redirection”** – Under this approach, advocated by people like Dr. Levine and Dr. Hruz, a mental health therapist would encourage caregivers to use positive reinforcement to try to “redirect” children toward behavior that is more typical of their birth-designated sex or less gender specific. Underlying this approach is the assumption that a child’s gender identity is malleable through social interventions. The goal of redirection is thus to eliminate gender-diverse desires and expressions over time, and to try to prevent the transgender child from being transgender. This approach is not recommended because negative reinforcement (e.g., shaming the child for gender diverse expression) has substantial negative mental and social health consequences. (Turban and Ehrensaft, 2018; Ehrensaft, 2017). It also ignores that gender identity is innate and cannot be changed.

35. **Wait-and-see** – The wait-and-see approach (also called watchful waiting) involves waiting to see if the child’s gender identity will change as the child gets older. This approach typically recommends that caregivers prohibit a prepubertal social transition, but may allow cross-gender play and clothing within the home or support both masculine and feminine activities as the child explores their interests in other social settings. The wait-and-see approach assumes that gender is binary and becomes fixed at a certain age; it pathologizes gender diversity and fluidity.

It is distinguished from following the child's lead, an affirming approach that allows the child to present in the gender role that feels correct and moves at a pace that is largely directed by the child. This approach ignores evidence that young children thrive when given permission to live in the gender that is most authentic to them and are at risk for symptomatic behaviors if prevented from doing so. (Ehrensaft, 2017).

36. **Affirmation** - The affirmative approach considers no gender identity outcome: transgender, cisgender, or otherwise, to be preferable. (Turban and Ehrensaft, 2018). It permits a child to explore gender development and self-definition within a safe setting. A fundamental concept of this approach is that gender diversity is not a mental illness. The gender affirmative model is defined as a method of therapeutic care that includes allowing children to speak for themselves about their self-experienced gender identity and expressions and providing support for them to evolve into their authentic gender selves, no matter at what age. Under this model, a child's self-report is embedded within a collaborative model with the child as subject and the collaborative team including the child, parents, and professionals. Support is not characterized by "encouraging" children or youth to be transgender or not, but rather by allowing children who express a desire to undergo a social transition (which may include changing names, pronouns, clothing, hairstyles, etc.) to do so. **For children who have not yet reached puberty, medical intervention is unnecessary and unwarranted.** After the onset of puberty medical interventions such as puberty blockers, and later hormones and surgery may be appropriate.

37. While some argue that gender affirmation leads a child or adolescent down a path of inevitable transgender identity, no such evidence exists, either in the scientific or the clinical setting. To the contrary, studies show that gender identification does not meaningfully differ before and after social transition. (Rae, et al., 2019).

38. Under both the “wait and see” and affirmative care models, as understood in the scientific literature, medical care is recommended following the onset of puberty. (Ehrensaft, 2017).

39. The most effective treatment for adolescents and young adults with GD, in terms of both their mental and medical health, contemplates an individualized approach. Medical and surgical treatment interventions are determined by the care team (usually a medical and mental health professional) in collaboration with the patient, and the patient’s family. These medical decisions are made by the care team in conjunction with the patient and the patient’s family and consider the patient’s social situation, the level of gender dysphoria, developmental stage, existing medical conditions, and other relevant factors. Sometimes treatment begins with puberty delaying medications (also referred to as puberty blockers), later followed by gender affirming hormones. Most youth accessing treatment are already well into or have completed puberty. Gender-affirming genital surgeries are generally sought after hormone treatment.

40. *Puberty blockers:* The beginning signs of puberty in transgender youth (the development of breast buds in assigned birth females and increased testicular volume in assigned birth males) is often a painful and sometimes traumatic experience that brings increased body dysphoria and the potential development of a host of comorbidities including depression, anxiety, substance abuse, self-harming behaviors, social isolation, high-risk sexual behaviors, and increased suicidality. Puberty blocking, which involves the administration of gonadotrophin-releasing hormone analogues (GnRH), essentially pauses puberty, thereby allowing the young person the opportunity to explore gender without having to experience the anxiety and distress associated with developing the undesired secondary sexual characteristics. In addition, for parents/guardians uneducated about gender diversity and/or who have only recently become aware

of their child's transgender identity, puberty blockers provide additional time and opportunity to integrate this new information into their own experience and to develop skills to support their child. Puberty suppression also has the benefit of potentially rendering obsolete some gender-affirming surgeries down the line, such as male chest reconstruction, tracheal shave, facial feminization, and vocal cord alteration, which otherwise would be required to correct the initial "incorrect" puberty.

41. Puberty suppression has been used safely for decades in children with other medical conditions, and is a reversible intervention. If the medication is discontinued, the young person continues their endogenous puberty a handful of months after puberty suppression is discontinued. The "Dutch protocol," developed from a study conducted in the Netherlands and published in 2006, calls for the commencement of puberty blockers for appropriately diagnosed and assessed gender dysphoric youth as early as 12 years of age. (de Vries, et al., 2014). Both the Endocrine Society and the WPATH's Standards of Care, however, recommend initiation of puberty suppression at the earliest stages of puberty (usually, Tanner 2) (assuming someone has engaged in services before or around this time), regardless of chronological age, in order to avoid the stress and trauma associated with developing secondary sex characteristics of the natal sex.

42. A growing body of evidence that demonstrates the positive impact of pubertal suppression in youth with GD on psychological functioning including a decrease in behavioral and emotional problems, a decrease in depressive symptoms, and improvement in general functioning. (Turban, et al., 2020; de Vries, et al., 2014).

43. Puberty blockers, thus, afford youth the opportunity to undergo a single, correct pubertal process and avoid many of the surgical interventions previously necessary for assimilation into an authentic gender role. It is a simple reversible intervention that has the capacity to improve

health outcomes and save lives. Over the course of my work in the past fifteen years with gender diverse and transgender youth, I have prescribed hormone suppression for over 200 patients. All of those patients have benefitted from putting their endogenous puberty process on pause, even the small handful who discontinued GnRH analogues and went through their endogenous puberty. Many of these young people were able to matriculate back into school environments, begin appropriate peer relationships, participate meaningfully in therapy, and family functions. Children who had contemplated or attempted suicide or self-harm (including cutting and burning) associated with monthly menstruation or the anxiety about their voice dropping were offered respite from those dark places of despair. GnRH analogues for puberty suppression are, in my opinion, a sentinel event in the history of transgender medicine, and have changed the landscape almost as much as the development of synthetic hormones.

44. *Gender affirming hormones:* Cross-gender or gender affirming hormone therapy involves administering steroids of the experienced sex (i.e., their gender identity) (estrogen for transfeminine individuals and testosterone for transmasculine individuals). The purpose of this treatment is to attain the appropriate masculinization or feminization of the transgender person to achieve a gender phenotype that matches as closely as possible to their gender identity. Gender affirming hormone therapy is a partially reversible treatment in that some of the effects produced by the hormones are reversible (e.g., changes in body fat composition, decrease in facial and body hair) while others are irreversible (e.g., deepening of the voice, decreased testicular mass). Eligibility and medical necessity should be determined case-by-case, based on an assessment of the youth's unique cognitive and emotional maturation and ability to provide a knowing and informed consent. The decision would be made only after a careful review with the youth and parents/guardians of the potential risks and benefits of hormone therapy. The youth's primary care

provider, therapist, or another experienced mental health professional can help document and confirm the patient’s history of gender dysphoria, the medical necessity of the intervention, and the youth’s readiness to transition medically.

45. *Gender-affirming surgeries:* Some transgender individuals need surgical interventions to help bring their phenotype into alignment with their gender. Surgical interventions may include vaginoplasty, tracheal shave, liposuction, breast implants, and orchiectomy for transfeminine individuals and chest reconstruction, hysterectomy, oophorectomy, salpingectomy, construction of neoscrotum, and metoidioplasty or phalloplasty for transmasculine individuals.

46. The current WPATH Standards of Care recommend that genital surgery – i.e., surgery which will render the individual sterile – not be carried out until the individual reaches the legal age of majority to give consent for medical procedures, while acknowledging that care is individualized. In addition, the Standards recommend that the other surgical interventions (e.g., chest surgery for transgender males and breast augmentation for transgender females) may occur earlier than the legal age of consent, preferably after ample time living in the desired gender role and after one year of hormone therapy. The Standards of Care, however, further recognize that these are individual determinations and that “different approaches may be more suitable, depending on an adolescent’s specific clinical situation and goals for gender identity expression.”

47. Gender affirming medical interventions are considered medically necessary, and are recognized as such by many major professional organizations. The denial of this care results in negative health consequences.

48. There are those, like Drs. Hruz, Levine, Lappert, and McHugh, who would make the argument that the recent uptick in youth presenting for services related to GD is the result of “social contagion.” But if social contagion theory applied to gender and gender identity, there

would be zero transgender people, because of the consistent exposure to an overwhelming majority of cisgender people. The social contagion argument that is posited by some confuses the relationship between one's recognition of their gender and their exposure to gender related information and community, particularly with regard to internet activity, asserting that youth are declaring themselves to be transgender or gender diverse because they were exposed to this online, or they have multiple friends who are also experiencing GD. Adolescent development includes finding like groups of peers, which extends to finding friend groups who are also gender diverse. Finally, attributing GD to "social contagion" is a simplistic perspective that discounts that the process of doing something about one's gender dysphoria is complex and difficult and involves parental consent for minors.

49. There is no scientific evidence that one develops gender dysphoria from being exposed to people with GD. To the contrary, most evidence shows that gender identity has a biological basis (Korpaisarn, et al., 2019; Saraswat, et al., 2015) and is affixed by early childhood (Slaby, et al., 1975).

C. Specific Critiques

50. Overall, Drs. Hruz, Levine, McHugh, and Lappert show a lack of familiarity and understanding regarding the existing research about gender identity and gender dysphoria, as well as the clinical experience surrounding the treatment of gender dysphoria, particularly regarding transgender youth. This lack of familiarity and understanding makes sense, as Dr. Hruz and Dr. Lappert have no experience working with transgender patients suffering from gender dysphoria, and Dr. McHugh's experience is fairly limited, at best, and dates to approximately 40 years ago. Finally, Dr. Levine has very limited experience working with transgender youth and has not been a member of WPATH for decades.

51. These doctors have critiqued and opposed the provision of gender affirming care as treatment for gender dysphoria for years, and in the case of Drs. Levine and McHugh, decades. Yet, in all of these years, they have not undertaken the research they call for to answer the questions they raise. Rather it seems their primary goal is opposing affirming care for transgender people, instead of finding answers to questions and providing the best care for transgender people suffering from gender dysphoria.

52. Below I outline additional, more specific critiques regarding the reports by Drs. Hruz, Levine, McHugh, and Lappert. Some of the critiques apply to more than one report.

Dr. Hruz's Report

53. Dr. Hruz has no publications regarding transgender individuals, either adults or youth. While he appears to have experience in the care of intersex patients, he does not have any cited experience in the clinical care of children, adolescents or adults with gender dysphoria.

54. On paragraph 16 of his report, Dr. Hruz says that “The reliability and validity of the term ‘gender identity’ is controversial and not accepted by the relevant scientific community.” This is false. Dr. Hruz consistently positions the advancement of our understanding about gender and gender dysphoria as controversial, untested and unethical, yet he has little to no experience clinically with treating transgender youth or even communicating with transgender youth. The term gender identity was originally coined in 1964 by American psychiatrist Robert J. Stoller, a noted psychoanalyst who studied sexual orientation, gender identity, and differences in sexual development. Gender identity is defined as a personal conception of oneself as male or female (or rarely, both or neither). The concept of gender identity is contemporaneously understood both colloquially and within the domain of science and medicine to denote someone’s gender. It is a concept well-understood and accepted in medicine and science. Indeed, gender identity

information is commonly collected and reported on within the context of scientific research. (Clayton, et al., 2016).

55. Dr. Hruz accuses some of Plaintiffs' expert witnesses of perpetuating the "transgender treatment industry," a made-up entity that does not exist. Given that this terminology is not based in science, it appears to be an attempt to use politically-charged language to trigger an emotional response to the false accusation of treating youth for financial benefit. To be clear, gender affirming care is supported by every mainstream medical organization in the United States. Dr. Hruz's views run counter to the established medical and scientific consensus.

56. In paragraphs 27 and 28 of his report, Dr. Hruz inaccurately suggests that diagnosis of gender dysphoria is done solely through a patient's self-report. His critique demonstrates a fundamental misunderstanding of how gender affirming care is provided. While we have continued to attain a greater understanding about the etiology of gender incongruence, patients do not "self-diagnose," as Dr. Lappert suggests. However, it is not unusual or extraordinary in medicine for a provider to consider patients' reports of their symptoms as part of the medical assessment. Much like the diagnosis of many clinical conditions, providers rely on self-report to ascertain accurate diagnoses. Consider the diagnosis of chronic fatigue. The diagnostic criteria for this diagnosis include the following: fatigue so severe that it interferes with the ability to engage in pre-illness activities; of new or definite onset (not lifelong); not substantially alleviated by rest; worsened by physical, mental or emotional exertion. Like gender dysphoria, these diagnostic criteria are a subjective telling of an individual's personal experience. It is incumbent upon providers of gender affirming care to acquire skills that help them ascertain many details about their patient's gender experience including but not limited to the history, developmental trajectory and expectations regarding treatment options.

57. The provision of gender affirming care occurs in multi-disciplinary settings, and indeed, the Standards of Care recommend such an approach. (Chen, et al., 2016; Coleman, et al., 2012). The multiple health providers involved, from various fields, are well trained to conduct clinical interviews and to assess a patient’s report to determine whether they meet the diagnostic criteria for GD.

58. In paragraph 29 of his report, Dr. Hruz says that “SOCIAL MEDIA ‘INFLUENCERS’ ARE REPORTEDLY TRAINING PATIENTS TO FABRICATE SYMPTOMS TO GAIN RAPID ACCESS TO ‘TRANSITION’ INTERVENTIONS.” (The all caps are his.) Dr. Hruz cites to no authority for this claim, let alone a scientifically reliable one. Again, Dr. Hruz inaccurately assumes that what everyone wants is “rapid” access to services. For most transgender individuals seeking care, nothing about their process has been rapid, even when they are young. Most individuals with gender dysphoria have engaged in a long, arduous and private process of understanding their gender to be different from the one assumed at birth. Without any scientific basis, Dr. Hruz gives no credibility to adolescents regarding their right to bodily autonomy nor their capacity to make sound and informed decisions.

59. Dr. Hruz also discusses the increase in numbers of youth presenting for care related to GD, stating that the numbers are far higher than they were prior. For one, varying estimates of prevalence are the result of inconsistent measures of transgender populations. Some studies have assessed the fraction of a population which had received the DSM-IV diagnosis of GID or the ICD 10 diagnosis of transsexualism, both of which were limited to clinical populations who sought a binary transition (male-to-female or female-to-male). For example, the prevalence reported in DSM-5 (0.005–0.014% for birth-assigned males; 0.002–0.003% for birth-assigned females) are based on people who received a diagnosis of GID or transsexualism, and were seeking hormone

treatment and surgery from gender specialty clinics, and, therefore, do not reflect the prevalence of all individuals with gender dysphoria or who identify as transgender. Other studies have reported on those who self-identified as transgender or gender incongruent, and found that measuring self-identity yields much higher numbers. In 2016, data from the Center for Disease Control’s Behavioral Risk Factor Surveillance System suggested that 0.6% of U.S. adults identify as transgender, double the estimate utilizing data from the previous decade. (Byne, et al., 2018). Ultimately, there is nothing surprising about the fact that more transgender people have begun identifying themselves to others as societal stigma has started to abate, and nothing about that lends support to the “social contagion” theory that Defendants’ experts espouse.

60. Dr. Hruz further misrepresents the affirmative model of care (paragraphs 52 and 53 of his report), stating that it is characterized by “actively encouraging children to embrace transgender identity and social transition.” As noted above, the gender affirmative model is defined as a method of therapeutic care that includes allowing children to express their gender identity without fear of shame or coercion to change it, and providing support for them to evolve into their authentic gender selves regardless of age. Support is not characterized by “encouraging” children or youth to be transgender or not.

61. Dr. Hruz also says (paragraph 55) that scientific studies in support of treatments for gender dysphoria are of low quality. The care of transgender individuals has a long history, and cannot be equated to the sorts of things that Dr. Hruz likens it to, however, including eugenics, the Tuskegee experiments, or the relatively short phase of unlocking “repressed memories.” Between 1963 and 1979, over 20 university-based gender identity clinics opened in the United States. These clinics provided interdisciplinary care that included psychiatrists and other mental health professionals and played an important role in the provision of medical services to transgender

people and in promoting research to improve their care. The majority of these clinics closed following a 1981 decision of the U.S. Department of Health and Human Services (HHS) that labeled sex reassignment surgery as experimental, and for which Dr. McHugh was a major advocate.³ That decision was overturned by HHS in 2014 in a determination that concluded that the 1981 decision was “unreasonable and contrary to contemporary science and medical standards of care.” (Byne, et al., 2018). Over the last four decades: research has continued to occur in the United States and internationally; WPATH (formerly the Henry Benjamin International Gender Dysphoria Association) published the first iteration of the Standards of Care, which is now in its 7th version and for which the 8th version is in development; the DSM and ICD stopped classifying transgender identification as a mental disorder; the American Psychological Association and Endocrine Society, as well as other medical organizations, adopted clinical guidelines consistent with the WPATH Standards of Care; and dozens of interdisciplinary gender clinics associated with research institutions and teaching hospitals have been providing gender affirming care for transgender youth and adults across the United States. Indeed, in 2017, Dr. Hruz’s own Washington University in St. Louis opened a Transgender Center that provides gender affirming care for children, adolescents, and adults.

62. To be sure, as with all medical care, there is a range of quality in the existing data regarding the treatment of gender dysphoria (see UCSF Guidelines), and there is certainly a need for additional studies of a longitudinal nature. But again, that is true with most medical care. One of the intrinsic elements of rating the quality of evidence is the study design. Randomized controlled studies are considered the highest quality in the grading of evidence. Given the length

³ In this way, Dr. McHugh actively attempted to suppress the research that he complains is lacking in this field of care.

of time that gender affirming medical interventions have been around and vast amount of clinical knowledge about their efficacy, having untreated control groups of patients with gender dysphoria is unethical. That said, we have a large de facto group of untreated individuals with gender dysphoria who experience significant psychiatric symptoms because of widespread barriers to access to care. Clinicians who are competent in the care of transgender individuals practice according to a “first do no harm” ethic which understands that doing nothing is not a neutral option for those with gender dysphoria. Multiple studies have demonstrated the safety of gender affirming hormones, and a growing body of evidence does the same with regards to the safety of GnRH analogs. (Kuper, et al., 2020; Chew, et al., 2018; Colton-Meier, et al., 2011). The same is true with regards to surgery. (Marano, et al., 2021; Olson-Kennedy, et al., 2018; Murad, et al., 2010; Smith, et al., 2005; Pfafflin & Junge, 1998).

63. In paragraph 57 of his report, Dr. Hruz wrongly asserts that hormone treatments provided to children with gender dysphoria are “risky, scientific and unethical,” as well as “often irreversible.” Dr. Hruz shows a clear misapprehension of transgender youth and the treatments for gender dysphoria. First, Dr. Hruz conflates children having discomfort with gender roles with transgender children. These are not the same populations. As noted above, the studies on which Dr. Hruz relies to argue a particular percentage of desistance included *pre-pubertal* children some of whom were neither transgender nor would have met the criteria for the diagnosis “Gender Dysphoria in Children.” Second, Dr. Hruz is conflating the data regarding pre-pubertal children with the treatments provided to adolescents, for whom it may be appropriate to treat with puberty delaying treatments or gender affirming hormones. To clarify, there are no medical treatments recommended for pre-pubertal children. Children who are prepubertal do not receive puberty blocking medication or gender affirming hormones. Medical treatment is not initiated until the

onset of puberty. Before commencing any medical intervention, patients (and their parents/caregivers if they are minors) are provided with extensive information about the medication(s) being considered including both known and potentially unknown effects, desired effects and potentially undesired side effects, timeline of expected changes, and administration options.

64. Dr. Hruz also misrepresents the science surrounding medical treatments for gender dysphoria, in particular the provision of puberty delaying GnRH analogues. Indeed, as Dr. Hruz should well know, GnRH analogues have been used safely for decades in children with other medical conditions, like those experiencing precocious puberty, and is a reversible intervention. (Mul, et al., 2008). If the medication is discontinued, the young person continues their endogenous puberty a handful of months after puberty suppression is discontinued.

65. Dr. Hruz's testimony (paragraph 63) evinces a poor understanding of the treatment approach for pre-pubertal vs. peri-pubertal and later pubertal youth, as demonstrated with his consistent conflation of these three cohorts. Additionally, he conflates gender affirmation with medical intervention when it is merely one potential element of gender affirmation. Finally, there are many medications that are used off label in the pediatric population. The majority of drugs prescribed have not been tested in children and safety and efficacy of children's medicines are frequently supported by low quality of evidence. This is explained by the lack of clinical research in this population, caused by ethical, scientific, and technical issues, besides commercial priorities. Therefore, most of the therapies prescribed to children are on an off-label or unlicensed basis. (Allen, et al., 2018). Common medications that are used "off-label" in pediatrics include antibiotics, antihistamines, and antidepressants.

66. Dr. Hruz's assertion that treatment for gender dysphoria is experimental and unproven is simply a statement of opinion, and not fact. We have decades of research and clinical experience on gender dysphoria and its care. The majority of studies investigating the impact of gender affirming medical interventions are observational because an untreated control group in a randomized controlled trial is unethical. This is not uncommon. For example, "Despite GnRH analogue treatment being used in precocious puberty for more than 20 years, there are no randomized controlled trials to evaluate the effect of GnRHa on a final height compared with untreated controls." (Mul, et al., 2008). However, there are several studies which demonstrate the safety and positive impact of gender affirming medical interventions. Additionally, larger longitudinal studies are currently underway to help substantiate the significant existing data we have. (de Vries, et al, 2021; Weinand, 2015).

Dr. Levine's Report

67. Dr. Levine demonstrates a poor understanding of the affirmative care model, and it is clear that he lacks a contemporaneous perspective on the care of transgender youth and youth with gender dysphoria. Additionally, his practice with minors suffering with gender dysphoria is minimal.

68. Dr. Levine claims that there is a lack of consensus among psychiatrists and psychotherapists about the cause of, and therapeutic response to gender dysphoria and because of this, the field is experimental. The entire field of medicine is dynamic, growing as more information becomes available. This does not preclude professionals from providing interventions and necessary care. For example, in the field of cancer care a more complete understanding of how cancer is acquired, spread, and contained leads to improvement in chemotherapy, as well as other modalities for intervention. Whether or not individuals consider the field of cancer to be

experimental or not is irrelevant and does not preclude practitioners from providing available treatment.

69. Dr. Levine claims that the fact that a small percentage of the population has a gender that is not aligned with their sex assigned at birth “begs for understanding.” Although Dr. Levine claims he has been evaluating transgender adults for years, it is unclear what research he has undertaken to attain a better understanding. The ideas that Dr. Levine goes on to state about the etiology of gender incongruence are all rooted in a pathological model, i.e. “a deficient mother,” “an absent father,” “trauma based rejection of maleness or femaleness,” or “some other emotional disturbance.” Many of these hypotheses have been investigated and none have been validated. (Turban and Ehrensaft, 2018). Not only is this perspective undergirded by the idea that transgender experience is one of “wrongness” or pathological, but there is also simply no commonality for any of these explanations across every transgender person. It also runs counter to the understanding of every major medical organization that being transgender is not pathological. Additionally, these ideas discount the rich history of transgender people across time and culture. Indeed, years of research and study show that there is a strong biological basis for gender identity, even if not fully understood, and that gender identity is innate, resistant to change, and fixed at an early age.

70. In 1966, Harry Benjamin wrote in his book “The Transsexual Phenomenon” the following: “Allegedly, transsexualism, although basically a psychiatric condition, is paradoxically resistant to psychiatric help.” In this statement, Harry Benjamin acknowledges that psychiatric intervention cannot alter people’s gender, nor does it lead to a diminishing of the distress that arises from gender incongruence. The statements of Defendants’ witnesses, which treat transgender people as inherently disordered, are not helpful in the evolution of the practice.

71. In his discussion about “biology,” Dr. Levine makes several assertions that bear examination. First, Dr. Levine references that no matter how many endocrinological or surgical procedures an individual undergoes, they can never be made a “complete man” or “complete woman” reserving that label to those who possess the germinal cells of ovaries or testes and can reproduce. Terms like “complete man” or “complete woman” are not scientific, as even recognized by the work of Magnus Hirschfeld over a century ago, and ignore the current scientific understanding of sex. Note that, as described above, there are multiple sex characteristics. Indeed, aside from its offensiveness, Dr. Levine’s opinion would mean that people born with differences in sex development (DSD) conditions could not also be considered a “complete man” or “complete woman.”

72. Dr. Levine continues to assert that medical interventions should not be undertaken because nothing can change the underlying biology of maleness or femaleness. He speaks as if it is solely the biology of genitals, reproductive tract, and sex chromosomes that determine the gender of an individual – failing to recognize that those characteristics do not always align. Additionally, he ignores the growing body of research examining the role of brain structure (both in size of nuclei, as well as connectivity of neurons) in gender identity.

73. Dr. Levine asserts that transgender people aspire to become “complete males” or “complete females” which is not only binary, thereby overlooking those with non-binary gender identities, but also underestimates the capacity of transgender people to comprehend what changes are and are not possible with hormones and surgery.

74. In his statement about those youth whose gender dysphoria emerges in adolescence, he states that this is commonly referred to as “rapid onset gender dysphoria.” First and foremost, this pattern of emersion of gender dysphoria is not commonly referred to as “rapid onset gender

dysphoria.” This is a fabricated name for a fabricated entity that arose out of a deeply flawed research endeavor that gathered parents of youth with gender dysphoria from distinctly anti-gender affirming websites. Investigators and clinicians who practice in this area of expertise do not utilize this terminology. Dr. Levine’s speculation regarding youth whose GD emerges at puberty are neither scientifically supported, nor are they supported by clinical experience. Dr. Levine and the other witnesses proffered by the defense utilize language designed to shock, but poorly characterizes the relative rarity of gender incongruence. For example, in the UK, the Tavistock program reported that in 2015-2016 there were 969 youth under 18 years referred to the clinic, as compared to 94 in 2009-2010. This change is described as an alarming nearly 1000% increase in the number of youth presenting for care. There are an estimated 14 million youth in the UK under the age of 18 years. Even using the conservative prevalence estimate of gender incongruence at 0.6%, the numbers tell us that there are potentially 84,000 transgender or non-binary youth under the age of 18 in the UK. These numbers highlight the enormous gap that exists for provision of care, not an out of control run on identifying as transgender and seeking services. As information becomes more readily available and community becomes more accessible via the internet, it is not hard to understand why increasing numbers of young people are better able to understand their gender at younger ages.

75. Dr. Levine (paragraph 18) references his own article, which is not a scientific study, as support for his recommendations for addressing gender dysphoria in children, and categorizes gender dysphoria as a “complex behavioral problem.” Again, Dr. Levine has minimal experience working with transgender youth. He asserts that many children and adolescents are not aware of the many “adaptive possibilities” for how to live as a man or a woman. This assertion is not supported by scientific data, nor by clinical experience. The framing of his discussion is

undergirded by the distorted perspective that individuals (in this case, children and adolescents) are considering “adopting a transgender identity.” My clinical experience does not correlate with this framework.

76. Children who assert a gender identity in childhood tell us who they are with their interests, and often their words. Indeed, the “Gender Dysphoria in Children” diagnosis requires which requires a child to have “a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender).” Youth who come out at, or whose gender dysphoria emerges with, the onset of puberty have tremendous awareness about the challenges of being gender discordant, as well as awareness about the myriad gender identities that exist. On the one hand Dr. Levine asserts that youth are not aware of these possibilities, and on the other acknowledges the increasing numbers of young people who are emerging asserting non-binary identities.

77. Dr. Levine also recommends that alternative approaches should be used for children with gender dysphoria including teaching them “coping and resilience skills.” If this model were applied to other medical conditions, it would be considered malpractice. Consider the intervention for someone with diabetes teaching them coping and resiliency. The model of holding off on medical interventions and equating it to a neutral option was not effective for transgender adults, and it is not effective for transgender youth.

78. Dr. Levine implies that anyone who is considered a specialist in the field of gender medicine is biased, rather than informed. When a pediatric rheumatologist sees an increasing number of patients and accumulates a growing body of knowledge from both their clinical experience and by remaining up to date with current research, they grow into the role of a

specialist. They are not considered biased; they are considered educated and experienced. Only in the field of gender care does this inaccurate characterization occur.

79. Dr. Levine also argues that gender affirming care is based on confirmation bias. His assertion is predicated on the idea that gender dysphoria is trendy, and “politically correct.” As a provider, I have directly witnessed the improved health of hundreds of youth with gender dysphoria as a result of gender affirming medical interventions. The arduous process of being assessed, diagnosed, and receiving care is not fashionable, but rather medical treatment that provides much-needed relief for a medical condition. Moreover, scientific study and years of research bear out the aforementioned observations based on decades of clinical experience. When there is an overlap between medical care and human rights, it is inevitable that practitioners providing care will become advocates for their patients when they witness firsthand the improvement of their patients in response to interventions. This is one of the hallmarks of medicine, we rely on both clinical experience and research for the evolution of the field. Dr. Levine, however, cites to no clinical experience or scientific study to bolster his “alternatives,” they are based solely on his own pre-conceived notions and bias against gender affirming care and the nature of gender identity.

80. Dr. Levine (paragraph 21) asserts that a disproportionate number of children from communities of color are diagnosed with gender dysphoria. This is patently untrue across the United States. In fact, the opposite is true. The youth seeking puberty suppression do not deviate significantly from general demographics; indeed, the preponderance of youth seeking puberty suppression are white. In any event, this is irrelevant. Many medical conditions impact some communities more than others. (Manton, et al., 1997). That is not a reason to deny medically necessary health care.

81. Dr. Levine simultaneously asks the court not to consider the DSM as a reliable source, and states that gender dysphoria is *only* a psychiatric diagnosis (that is outlined in the DSM). Dr. Levine misuses the data, specifically, the Cecilia Djhene manuscript about suicidality among transgender women who underwent genital surgery compared to the entire population statistics. This research has been consistently misused, much to the dismay of the first author, whom I have communicated with about this very issue. The Dhejne study specifically states that, “For the purpose of evaluating whether sex reassignment is an effective treatment for gender dysphoria, it is reasonable to compare reported gender dysphoria pre and post treatment. Such studies have been conducted either prospectively or retrospectively, and suggest that sex reassignment of transsexual persons improves quality of life and gender dysphoria.” Dr. Levine’s characterization of the Dhejne research is misleading, because the two comparison groups were transgender women who underwent surgery and aged matched individuals from the general population of Sweden. It is well known that transgender individuals have a higher suicide rate than cisgender individuals. That is explained by the fact that transgender people, even after obtaining gender affirming care, suffer from large and disproportionate rates of discrimination, harassment, family rejection, and violence, all of which could contribute to larger suicidality rates when compared to the general population. Additionally, the data in the Dhejne study was gathered from patients seeking surgery between 1973 and 2003. The political and cultural context is vastly different in 2021 and the surgical techniques are improved.

82. Dr. Levine further equates participants who are lost to follow up as a potential indicator of desistance and/or who regretted undergoing medical interventions, but he provides no support for his assertions.

83. Dr. Levine and others who espouse similar “concern” about gender affirming medical procedures have had decades to test their own recommendations about how gender dysphoria should be managed. Dr. Levine suggests that mental health providers should approach gender dysphoria as the result of a psychopathological process that first manifested as a failure to establish a comfortable and conventional sense of self in early childhood. He refers to this as a utilizing a developmental lens, and through this lens, identify the underlying cause, and ameliorate suffering if the cause cannot be identified. Nothing scientific has come from those efforts, except several accountings of the negative sequelae experienced by many who underwent conversion therapy. Dr. Levine also assumes that “gender specialist” mental health providers focus only on moving youth down some kind of a transgender “pathway,” without spending any time or effort addressing the mental health of their clients. Both of these claims are false. Mental health practitioners who are practicing an affirming model of care are providing a safe space in which mental health symptoms or issues can be identified and addressed. Conversion therapy is not supported by any scientific evidence or rigorous data.

84. In his report, Dr. Levine seems to endorse an approach he likens to the “watchful waiting” approach. If Dr. Levine is defining the “wait and see” approach in pre-pubertal children as one that does not employ medical intervention, that is literally the standard of care everywhere and is indeed what is done under the gender affirming approach, as medical interventions for pre-pubertal youth are not appropriate nor are they warranted. If Dr. Levine seems to be implying that the “watchful waiting” approach requires the withholding of medical care after the onset of puberty, then that *is not* the “watchful waiting” approach that is recognized in scientific literature.

85. As outlined above, the “watchful waiting” approach is deficient in that it ignores evidence that young children thrive when given permission to live in the gender that is most

authentic to them and are at risk for symptomatic behaviors if prevented from doing so. (Ehrensaft, 2017). “Research consistently demonstrates that gender diverse youth who are supported to live and/or explore the gender role that is consistent with their gender identity have better mental health outcomes than those who are not.” (AACAP, 2019).

86. However, under either the “watchful waiting” and gender affirmative approach, medical care is provided to transgender youth with gender dysphoria following the onset of puberty. (Ehrensaft, 2017; de Vries, et al., 2014; de Vries, et al., 2011). As such, any debate about the “watchful waiting” and gender affirmative approaches is irrelevant to the questions at issue in this case, which concern the coverage of *medical* care for gender dysphoria.

87. Dr. Levine also references a manuscript entitled “A Typology of Detransitions and Its Implications for Healthcare Providers” proclaiming that there are 60,000 cases of detransitioners on a subreddit thread. The source document actually states 16,000 not 60,000. Again, this is an example of presenting what feels like giant numbers to alarm audiences, but relative to the number of people who have successfully undergone phenotypic transition, this is a low number.

88. It is concerning that Dr. Levine consistently misrepresents the affirmative model of care, particularly in pre-pubertal children. Affirming approaches promote exploration of gender development and self-definition within a safe setting. A fundamental concept of this approach is that gender diversity is not a mental illness. The gender affirmative model is defined as a method of therapeutic care that includes allowing children to speak for themselves about their gender identity and expressions and providing support for them to evolve into their authentic gender selves. Support is not characterized by “encouraging” children or youth to be transgender or not. Interventions may include social transition, the changing of one’s presentation to more closely

align with one's gender, as well as later medical interventions after the onset of puberty, such as puberty blockers, hormones, or surgery. Because care is individualized, it also may not.

89. Dr. Levine asserts that there is a growing body of evidence that suggests that affirmation of gender diverse children results in a higher likelihood of persistence of gender incongruence. He cites an article entitled "The myth of persistence: Response to 'A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children'" by Temple Newhook et al. (2018) written by Ken Zucker. This is not a research article. It simply provides a rebuttal by Dr. Zucker to a previous manuscript. In it Dr. Zucker reviews some of the existing literature about persistence and desistance of gender incongruence among children over time. As previously noted, though, the studies upon which Dr. Zucker relies were based on the now obsolete and overly broad categorizations contained in the diagnosis for "Gender Identity Disorder in Children." None of the studies use the current DSM-5 "Gender Dysphoria in Children" diagnosis. Thus, the desistance rates of which Dr. Levine speaks include children who did not identify as transgender to begin with or would be considered "sub-threshold" for a Gender Dysphoria diagnosis. In addition, research shows that children who identify as transgender into adolescence, which is when any medical treatment begins, persist in their transgender identity. (de Vries, et al., 2011).

90. Dr. Levine attempts to create a causal relationship by asserting that gender affirmation (social transition specifically) in childhood *causes* children to continue to assert a gender incongruent with the sex they assigned at birth and that they would not have done so had they not undergone social transition. There is a failure to consider the clinical observation that children who end up socially transitioning are often experiencing the greatest distress about their gender incongruence, a discussed predictor of persistence. He presents an argument against

affirmation, social transition in particular, in light of the data that suggests the majority of children with gender non-conforming behaviors in childhood grow out of those behaviors and feelings as they move into adolescence. However, research shows that that gender identification does not meaningfully differ before and after social transition. (Rae, et al., 2019).

91. Even if we fully embrace the idea that most children who are gender non-conforming in childhood do not go on to assert gender incongruence in adolescence, it has no relevance to the medical treatment of adolescents and adults who do have gender incongruence, which is the subject of this case. The question is not “should we provide access to medical interventions for people who had GD in childhood that dissipated in adolescence?” because that population is not the population presenting for treatment and in any event, medical care is not indicated for that population of children. Transgender adolescents and adults with gender dysphoria are the patients we are discussing.

92. Dr. Levine asserts that the statements of professional organizations are not legitimate because they are, according to him, not supported by science, and therefore the statements that support gender affirmation from WPATH, AAP, APA, and the Endocrine Society should be disregarded. Dr. Levine also dismisses the guidelines from WPATH and the Endocrine Society for similar reasons. Across all domains of medicine standards of care and guidelines are developed by the professional consensus model, which is absolutely informed by available science. The development of reliable guidelines is a key priority for health care providers and commissioners to promote best care for patients and are updated as the science expands. All of these guidelines and statements are workshopped in groups and cite to scientific, peer-reviewed literature. That Dr. Levine disagrees with them does not mean they are not supported by science.

93. Dr. Levine and other witnesses in this case make reference to another made up entity, the Transgender Treatment Industry, with the direct accusation that there is an entire industry that is raking in monetary benefit from gender affirmation models. This is not supported by any data and seems to simply be a way to try to undermine the treatment being provided by thousands of health care professionals seeking to provide the best care for their patients, as well as the overwhelming medical consensus.

94. Dr. Levine claims that puberty blockers have the potential to alter the natural course of someone's gender identity development. This is not supported by any data. Furthermore, this issue has never been raised regarding children who are given puberty blockers to treat central precocious puberty often at younger ages and for longer periods of time.

It is not a "novel" developmental trajectory that gender dysphoria emerges or intensifies at puberty as Dr. Levine suggests, as that is the stage at which changes in the body diverge more intensely from the adolescent's gender identity. The only aspect of recent trajectories that is "novel" is the fact that more information is available for youth who are suffering with gender dysphoria, and that there is much greater societal acceptance that facilitates accessing services earlier.

95. Dr. Levine goes on to discuss the lack of quality evidence regarding the impact of gender affirming interventions. Like all areas of medicine, clinical care often outpaces the science, as is the case with transgender youth care. But the current evidence base for treatment of transgender youth is commensurate with the evidence base for many other types of treatment for adolescents. Additionally, the increase in younger patients seeking services is being paralleled by the increase in data collection, with the promise of the creation of a rich database to better answer some of the still unanswered questions. Nothing about that is unique to gender dysphoria. Additionally, many existing studies have small numbers of participants because transgender

experience is uncommon, there exist multiple barriers to accessing services, and there is a historical mistrust of medical institutions based on an unimaginable amount of harm that such institutions have perpetuated upon this vulnerable community. (Sharman, 2016).

96. Dr. Levine criticizes the existing data and recommendations for using medications off label. As addressed above, it is common for medications to be used “off label” across all domains of medicine. In addition to there being fewer studies in children and adolescents, pharmaceutical companies often do not want to spend the money to get an FDA indication for use in a very small population.

97. In paragraph 73 of his report, Dr. Levine discusses an article I co-authored that makes reference to the need for more research in the field of gender affirming care. I stand by what I wrote in this article. More research is necessary to support and test what we have learned from a clinical perspective, and from the extant scientific data. This is true of all medicine. Medicine is characterized by continuous research and an ever-expansive knowledge base. Finally, that paper is five years old and since its publication, the NIH has invested many millions of dollars to support the very research that myself and my co-authors recommended and that many of us are undertaking. In other words, the research called for in my 2016 article is happening right now, and unfortunately, it is opinions like those of Dr. Levine that attempt to obstruct the research from happening.

98. Dr. Levine asserts that there is no data to suggest that affirmation will lower suicide deaths more than a psychotherapeutic model or watchful waiting. However, there is evidence that youth who have been exposed to both a psychotherapeutic model and/or a watchful waiting approach, which deny affirmation and withhold medical care from adolescents, have died by suicide. It does not seem logical to keep employing a method that has been unsuccessful in

preventing such deaths. His criticism of Jack Turban’s manuscript includes that there was a high level of suicidality (both ideation and attempts) among both those who wanted and received blockers and those who wanted and did not receive blockers. That was not the thrust of the article. The article was demonstrating a decrease of suicidal ideation among the cohort that got blockers. While it is true that the raw data indicates that a higher percentage of the group that had access to puberty blockers had hospitalizations related to suicide attempts (n=5), this difference was not statistically significant, whereas lifetime suicidal ideation was statistically significantly lower in that cohort.

99. Dr. Levine also states that gender affirming medical interventions may lessen the “relatively minor pain of gender dysphoria” in the short term, but that long term debilitating suffering will ensue. The pain of gender dysphoria is only characterized as “relatively minor” by those individuals who do not sit in rooms with youth experiencing gender dysphoria such as Dr. Levine. Gender dysphoria is debilitating for many, creating functional impairment across multiple domains (one of the DSM 5 criteria required for the diagnosis of GD). There is no data to support that there are people who experience long term suffering because they were provided gender affirming interventions in adolescents. The high-profile cases of such individuals could be more easily attributed to political undertakings than those accused of political agendas who support of gender affirmation by Dr. Levine in his report.

100. Dr. Levine attests to a host of potential risks from genital surgeries and gender affirming hormone care, none of which are above and beyond the risk profile commonly encountered for many procedures and medications in the medical field. He presents an unattainable goal of “controlled, reliable-valid research” to determine something is “completely true” which is not a standard applied to any area of medicine, particularly newer fields such as transgender youth

care. His suggestion that providers of such care do not thoroughly inform patients and families about the potential side effects and impact on future fertility is likewise uninformed.

101. Dr. Levine opines on purportedly “High level” of regret rates but conflates dissipation of gender non-conforming behavior in children to regret, cites a case study of seven individuals, and misrepresents a manuscript referring to a subreddit thread of 16,000 members as having 60,000 individuals characterized as detransitioners. There is irony in Dr. Levine’s inclusion of the 60,000 number (besides it being incorrect by a significant amount) because the entire manuscript is devoted to talking about the difference between individuals who detransition because their dysphoria has allegedly dissipated and those who detransition because of other issues not related to re-identification with gender concordant with sex assigned at birth. (Expósito-Campos, 2021). A recent study confirms that the vast majority of people who detransition do so because of external factors such as pressure from family and societal stigma. (Turban, et al., 2021). In addition, studies show that regret rates for those who have undertaken gender affirming care are extremely low. (Narayan, et al., 2021; Wiepjes, et al., 2018).

102. As for informed consent, I can speak for myself and the practices of our center regarding informed consent. Our center takes the process of informed consent very seriously. We provide both verbal and written information that discusses the desirable and undesirable side effects of puberty blockers, androgen antagonists, and hormones. The consent form covers the known and the unknown about these medications, including fertility, psychological and physiological impact. Extensive conversations regarding options for care (including no medical intervention) occur. Both the patient and the parent/caregiver must demonstrate an understanding. Additionally, we do not consider consent a singular process. Frequent follow up, laboratory evaluations, and developmentally relevant conversations occur throughout treatment duration. In

other words, Dr. Levine's representations about informed consent are not based on any real understanding of how interdisciplinary gender clinic, like our center, operate.

Dr. Lappert's Report

103. Dr. Lappert has no research experience in treating gender dysphoria, and does not specify the numbers of patients he has treated for specific issues related to GD.

104. Dr. Lappert asserts that supporting a child with affirmation of their process will lead them down a road of intentional or unintentional sterility. Aside from this being an overly simplistic perspective about a significantly long and complicated process, it is wholly divorced from the reality of care for transgender people. First, like all health care, gender affirming care for every transgender person is individualized. There simply is no one specific route. Second, there is no evidence that affirmation of pre-pubertal children in their identity or the provision of puberty blockers lead to sterility. Indeed, the effects of puberty blockers are reversible. To the extent a person desires and needs hormone treatment or surgery, such care is not provided until well into maturity and after discussion of the effects of such. In addition, patients who may need a procedure or treatment that will result in the side-effect of sterility are informed of such consequences and are provided with alternative options such as fertility preservation before initiating such care. (Chen, et al., 2017).

105. While Lappert asserts that youth who transition in childhood with the use of puberty blockers go on to face significantly diminished sexual response and are unable to ever experience orgasm, he follows this sentence with the fact that no research has endeavored to answer this question. When data are lacking, we rely on clinical experience gathered from patient care and conversations as well as existing data on extrapolatable cases. While there is a body of research on the capacity of minors for sexual arousal and orgasm, there is no data to support the idea that

gender affirmation diminishes sexual capacity. More commonly youth with GD experience dysphoria from the act of masturbation, and often even the possibility or thoughts around sexual intimacy. In fact, there is data that demonstrates improved satisfaction with sexual intimacy after gender affirming interventions.

106. Informed consent is the legal embodiment of the concept that each individual has the right to make decisions affecting his or her health. Physicians engaged in patient-physician relationships involving medical informed consent have a moral responsibility to identify the best treatments for each patient on the basis of available medical evidence and to discuss with patients the hoped-for benefits and the potential risks. Physicians must allow for patients' questions about the proposed treatments, benefits, and risks and must answer those questions from the available medical literature and their professional experience. This exchange of information and ideas is the foundation of the patient-physician partnership and promotes informed decision making in the most complex medical situations. (Paterick, et al., 2008). As noted above, speaking from own clinical experience, at our center we strive to ensure that we are obtaining informed consent from every patient (and their parent/guardian) throughout the course of treatment.

Dr. McHugh's Report

107. The actions of Paul McHugh in getting the Johns Hopkins transgender clinic closed down resulted in a significant set-back in the care of transgender individuals. While still woefully behind Europe (Germany in particular), the United States began forging forward in the field of transgender care between 1969 and 1979. But services at Hopkins and a number of prestigious hospitals abruptly shut down in 1979. The main trigger was a study by Jon Meyer, who ran the hospital's Sexual Behaviors Consultation Unit. In the study, Meyer concluded that although "sex-change" surgery was "subjectively satisfying" for the small sample surveyed, the operations they

underwent conferred “no objective advantage in terms of social rehabilitation.” Dr. McHugh publicized his views that providing transgender individuals (particularly transfeminine) with medical interventions was essentially aiding and abetting a psychiatric illness. What could have been the beginning of an unparalleled opportunity to determine the impact of affirming interventions over a longitudinal timeline instead came crashing down. Transgender care went underground until around the early 1990’s when it re-emerged in the context of HIV related services. Dr. McHugh is largely responsible for this inexcusable, but thankfully not permanent, halting of transgender care in the academic world. In 2017, Johns Hopkins re-opened its transgender clinic, re-affirming its commitment to the LGBTQ community. Dr. McHugh continues to promote his perspective, which remains largely uninformed. Dr. McHugh has no noted experience in the treatment of adolescents or children with gender dysphoria.

108. Meyer’s study was widely criticized for the arbitrary nature of its rating scale, as well as for its value judgments: individuals who did not improve their socio-economic standing, who continued to see a therapist, or who were unmarried or with a same-sex partner were deemed to be less well-adjusted. In addition, noticeably absent was any measure of the participants’ satisfaction or happiness, despite Meyer admitting that only one of the individuals who underwent gender-affirming surgery expressed any regrets at having done so (and in this person’s case, because the surgery had been performed poorly). (Beemyn, 2014; Fleming, et al., 1980). Other studies from the period found much more positive outcomes from surgery. (Bullough, et al., 1998; Pauly, 1981).

109. There is no evidence to support that affirmation of gender in pre-pubertal children “halts the healing process,” as McHugh suggests. Medical interventions are not recommended and are not appropriate for pre-pubertal children. If one’s gender could be impacted by the role of

rearing, there would be few transgender people who transition in adulthood, as most were reared in the gender role that corresponded with their sex assigned at birth. It is not logical to think that while we have been epically failing at convincing transgender people to be cisgender that we would be able to make someone who is cisgender into someone who is transgender, a directionality that may correspond with higher rates of discrimination, harassment, and even violence. It must be absolutely clear when we are discussing interventions that three distinct cohorts are identified: pre-pubertal children, peri-pubertal youth, and later/post pubertal adolescents. The conflation of the trajectories as well as the recommended and available interventions by all of the defense experts in such a way as to create confusion. Finally, there is no data to support any such notion that children who are socially transitioned in a pre-pubertal time period who then go on to embrace their assumed gender at birth are damaged. I know several such young people who are healthy and happy.

III. CONCLUSION

110. Gender affirming medical and surgical care is effective, beneficial, and necessary for transgender people suffering with gender dysphoria, including transgender youth after the onset of puberty. It is well documented and studied, through years of clinical experience, observational scientific studies, and even some longitudinal studies. It is also the accepted standard of care by all major medical organizations in the United States.

111. The denial of gender affirming care, on the other hand, is harmful to transgender people. It exacerbates their dysphoria and may cause anxiety, depression, and suicidality, among other harms.

112. Drs. Hruz, Levine, Lapper, and McHugh all fail to understand what gender affirming care consists of and share the following issues:


- a. They possess very little clinical experience and expertise in the care of transgender youth, or children and youth with gender dysphoria which deprives them of the knowledge gleaned from clinical observation.
- b. They consistently misuse of the desistence data describing the trajectories of gender nonconforming children diagnosed with GID by applying it to opinions about medical interventions for transgender adolescents diagnosed with GD.
- c. They adhere to a nonscientific theory of “social contagion” to explain the increase in younger patients presenting for medical services related to gender dysphoria but show little to no acknowledgment of the changing socio-cultural context that has created increased access to health care as well as information and mischaracterizes this as groupthink.
- d. They simultaneously demand more high-quality data, but recommend no medical interventions, two situations that cannot co-exist.
- e. They discount the experience and expertise of gender health experts, and instead paint them as reckless and politically motivated, ignoring that it is their own opinions which run counter to the prevailing medical consensus.
- f. They apply an unrealistic standard to the practice of gender affirming medical care in order to categorize it as non-experimental, while ignoring that their same critiques could be applied to virtually all medical care.

113. I do not disagree that, as with every field of medicine, there is more to learn in the field of transgender youth care. That is why I became an investigator. However, there is room to provide gender affirming medical interventions in a thoughtful manner that extrapolates from relevant fields of science and medicine, existing data and clinical expertise while simultaneously

carrying out necessary investigations. The denial of much needed care only serves to harm transgender people.

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

Executed this 30th day of May, 2021.



Johanna Olson-Kennedy, M.D., M.S.

CERTIFICATE OF SERVICE

I hereby certify that on June 1, 2021, I caused a copy of the foregoing document and all attachments to be served upon the following parties via email:

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Counsel for Plaintiffs

Exhibit 26(b)

Exhibit A

Curriculum vitae



CURRICULUM VITAE
JOHANNA OLSON-KENNEDY MS, MD
MAY 8, 2021

EDUCATION AND PROFESSIONAL APPOINTMENTS

EDUCATION:

<i>Year</i>	<i>Degree, Field, Institution, City</i>
1992	BA, Mammalian Physiology, UC San Diego, San Diego
1993	MS, Animal Physiology, The Chicago Medical School, Chicago
1997	MD, Medical Doctor, The Chicago Medical School, Chicago
2015	MS, Clinical and Biomedical Investigations in Translational Science, USC, Los Angeles

POST-GRADUATE TRAINING:

<i>Year-Year</i>	<i>Training Type, Field, Mentor, Department, Institution, City</i>
1997-1998	Internship, Pediatrics, Children's Hospital Orange County, Orange
1998-2000	Residency, Pediatrics, Antonio Arrieta, Children's Hospital Orange County, Orange
2000-2003	Fellowship, Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles
2012-2015	Master's Degree, Clinical and Biomedical Investigations in Translational Science, USC

ACADEMIC APPOINTMENTS:

<i>Year-Year</i>	<i>Appointment</i>	<i>Department, Institution, City, Country</i>
2012-present	Medical Director	The Center for Transyouth Health and Development, Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, USA
2008-2012	Fellowship Director	Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, USA
2006-2016	Assistant Professor of Clinical Pediatrics	Division of Adolescent Medicine, Children's Hospital Los Angeles/USC Keck School of Medicine, Los Angeles, USA
2016 - Present	Associate Professor of Clinical Pediatrics	Division of Adolescent Medicine, Children's Hospital Los Angeles/USC Keck School of Medicine, Los Angeles, USA

LICENSURE, CERTIFICATIONS

LICENSURE:

<i>Year</i>	<i>License number, State, Status</i>
2000	A-67352, California, Active

BOARD CERTIFICATION OR ELIGIBILITY:

<i>Year</i>	<i>Board, State, Status</i>
2001, 2009, 2015	Pediatrics, California, active

SPECIALTY CERTIFICATION:

<i>Year</i>	<i>Specialty Certification, Status</i>
2003, 2013	Adolescent Medicine, California, active

HONORS, AWARDS:

<i>Year</i>	<i>Description</i>	<i>Awarding agency, address, city</i>
2019	Benjamin Meaker Visiting Professorship	University of Bristol, Bristol UK
2015	The Champion Award	The Division of Adolescent Medicine; CHAMPION FUND 5000 Sunset Blvd. Los Angeles
2014	Recognition Award for Outstanding Compassionate and Innovative Service	SoCal Society for Adolescent Health and Medicine Regional Chapter, Los Angeles
2014	Anne Marie Staas Ally Award	Stonewall Democratic Club; 1049 Havenhurst Drive #325, West Hollywood
2012	Extraordinary Service Award	Equality California, 202 W 1st St., Suite 3-0130 Los Angeles
2010	Clinical Research Academic Career Development Award	Saban Research Center TSRI Program: Community Health Outcomes and Intervention, Los Angeles
2009	Health Care Advocacy Champion	Democratic Advocates for Disability Issues, Los Angeles

TEACHING**UNDERGRADUATE, GRADUATE AND MEDICAL STUDENT (OR OTHER) MENTORSHIP:**

<i>Year-Year</i>	<i>Trainee Name</i>	<i>Trainee Type</i>	<i>Dissertation/Thesis/Project Title</i>
2020-Present	Richard Mateo Mora	MD	Fertility Preservation Among Transgender Women
2019-2021	Laer Streeter	MD	Comparison of Histrelin Implants
2016-Present	Jonathan Warus	MD/KL2	Affecting Pre-Exposure Prophylaxis (PreP) Decision Making to Improve Youth Engagement in HIV Prevention Services
2015-2020	Shannon Dunlap	PhD	Developmental Aspects of Gender Non-Conformong Youth
2015-2016	David Lyons	MD	Transgender Youth Clinical Clerkship
2014-2015	Michael Haymer	MD	Transgender Youth Clinical Clerkship

POSTGRADUATE MENTORSHIP:

<i>Year-Year</i>	<i>Trainee Name</i>	<i>If past trainee, current position and location</i>
2020-Present	Marianela Gomez-Rincon	Adolescent Medicine Fellow
2015-2018	Jonathan Warus, MD	Faculty, CHLA/USC Keck School of Medicine
2015-2017	Patrick Shepherd, MD	CHLA Endocrinology Fellow
2014	Julie Spencer, MD	Adolescent Medicine Provider Kaiser Hospital
2013	Shelley Aggarwal, MD	Clinical Instructor – Stanford University School of Medicine
2012-2013	Lisa Simons, MD	Clinical Instructor – Lurie Children’s Hospital

SERVICE**DEPARTMENT SERVICE:**

<i>Year-Year</i>	<i>Position, Committee</i>	<i>Organization/Institution</i>
2010-2015	Secretary, The CHAMPION Fund Executive Board	The Division of Adolescent Medicine, Children’s Hospital Los Angeles

PROFESSIONAL SERVICE:

<i>Year-Year</i>	<i>Position, Committee</i>	<i>Organization/Institution</i>
2012-present	Member, LGBT Special Interest Group	Society for Adolescent Health and Medicine

CONSULTANTSHIPS AND ADVISORY BOARDS:

<i>Year</i>	<i>Position, Board</i>	<i>Organization/Hospital/School, Institution</i>
2017 - Present	Board Member	US Professional Association of Transgender Health
2021	Member, Advisory Board	The National LGBTQIA+ Health Education Center
2010-2017	Member, Advisory Board	Transyouth Family Allies
2017-present	Member, National Medical Committee	Planned Parenthood

PROFESSIONAL SOCIETY MEMBERSHIPS:

<i>Year- Year</i>	<i>Society</i>
2017 - present	US Professional Association for Transgender Health
2014-present	Society for Pediatric Research
2010-present	World Professional Association for Transgender Health
2006-2011	Los Angeles Pediatric Society (Past president 2010)
2005-2012	American Academy of Pediatrics
2003-present	Society for Adolescent Health and Medicine

MAJOR LEADERSHIP POSITIONS: (E.G., DEAN, CHAIR, INSTITUTE DIRECTOR, HOSPITAL ADMINISTRATION, ETC.)

RESEARCH AND SCHOLARSHIP

EDITORSHIPS AND EDITORIAL BOARDS:

<i>Year-Year</i>	<i>Position</i>	<i>Journal/Board Name</i>
2015-present	Associate Editor	Journal of Transgender Health

MANUSCRIPT REVIEW:

<i>Year-Year</i>	<i>Journal</i>
2018-present	Journal of Transgender Health
2018 - present	Clinical Child Psychology and Psychiatry
2018 - present	Journal of Sexual Medicine
2015-present	Journal of Transgender Health
2014-present	International Journal of Transgenderism
2014-present	LGBT Health
2014-present	Journal of Adolescent Health
2014-present	Pediatrics

MAJOR AREAS OF RESEARCH INTEREST

Research Areas
1. Gender diverse children, transgender youth and young adults
2. HIV medication adherence

GRANT SUPPORT - CURRENT:

<i>Grant No. (PI) 2R01HD082554-06A1</i>	<i>Dates of Award: 2021-2026</i>
<i>Agency: NICHD</i>	<i>Percent Effort 25%</i>
<i>Title: The Impact of Early Medical Treatment in Transgender Youth</i>	
<i>Description: This is the continuations of a multicenter study, the first of its kind in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.</i>	
<i>Role: Principle Investigator</i>	
<i>Total Direct Costs: \$4,918,586</i>	

<i>Grant No. (PI) 1R01HD097122-01</i>	<i>Dates of Award: 2019-2024</i>
<i>Agency: NICHD</i>	<i>Percent Effort 10%</i>
<i>Title: A Longitudinal Study of Gender Nonconformity in Prepubescent Children</i>	
<i>Description: The purpose of this study is to establish a national cohort of prepubertal transgender/gender nonconforming (TGNC) children (and their parents), and longitudinally observe this cohort to expand the body of empirical knowledge pertaining to gender development and cognition in TGNC children, their mental health symptomology and functioning over time, and how family-initiated social gender transition may predict or alleviate mental health symptoms and/or diagnoses.</i>	
<i>Role: Co-Investigator</i>	
<i>Total Direct Costs: \$2,884,950</i>	

GRANT SUPPORT - PAST:

<i>Grant No. (PI)</i> 1R01HD082554-01A1	<i>Dates of Award:</i> 2015-2020
<i>Agency:</i> NICHD	<i>Percent Effort</i> 45%
<i>Title:</i> The Impact of Early Medical Treatment in Transgender Youth	
<i>Description:</i> This is a multicenter study, the first of its kind in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.	
<i>Role:</i> Principle Investigator	
<i>Total Direct Costs:</i> \$4,631,970	
<i>Grant No. (COI)</i> R01AI128796-01	<i>Dates of Award:</i> 2/24/17-1/31/18
<i>Agency:</i> NIAID	<i>Percent Effort:</i> 5%
<i>Title:</i> Maturation, Infectibility and Trauma Contributes to HIV Susceptibility in Adolescents	
<i>Description:</i> This proposal explores the overarching hypothesis that fluctuations in sex steroid levels and mucosal trauma (sexual activity) are key determinants of mucosal immune activation and epithelial integrity, and that microbial communities are central to these processes. We will pursue this hypothesis by examining longitudinal changes in the anogenital microbiome as well as protein expression at these mucosal sites during sexual maturation (cisgender youth) and in hormonally-controlled sexual maturation (transgender youth). Associations between sex steroid levels, microbial community composition, mucosal trauma, and vaginal proteins will be determined and modeled.	
<i>Role:</i> Co-Investigator	
<i>Total Direct Costs:</i> \$44,816	

<i>Grant No. (PI)</i> U01HD040463	<i>Dates of Award</i> 2006 – 2016
<i>Agency:</i> NIH/NICHD	<i>Percent Effort:</i> 10%
<i>Title:</i> Adolescent Medicine Trials Network for HIV/AIDS	
<i>Description:</i> Adolescent Medicine Trials Network for HIV/AIDS	
<i>Role:</i> Co-Investigator	
<i>Total Direct Costs:</i> 2,225,674	

<i>Grant No. (PI)</i> SC CTSI 8KL2TR000131	<i>Dates of Award:</i> 2012-2014
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<i>Agency:</i> KL2 Mentored Career Research Development Program of the Center for Education, Training and Career Development	<i>Percent Effort:</i> 37.5%
<i>Title:</i> The Impact of Hormone Blockers on the Physiologic and Psychosocial Development of Gender Non-Conforming Peri-Pubertal Youth	
<i>Description:</i> This study aimed to understand the impact of puberty blocking medications on mental health and physiologic parameters in peri-pubertal transgender youth.	
<i>Role:</i> Principal Investigator	
<i>Total Direct Costs:</i> 191,525	

Invited Lectures, Symposia, keynote addresses

<i>Year</i>	<i>Type</i>	<i>Title, Location</i>
2021	Invited Lecture	Approach to the Care of Gender Diverse Children and Transgender Youth, USC Keck Medical School, Virtual Lecture
2021	Invited Lecture	Caring for Gender Diverse and Transgender Youth. SLO Acceptance, Cal Poly, Virtual Presentation
2020	Symposium	Trans Youth Care, Chico Transgender Week, Virtual Presentation
2020	Invited Lecture	Gender Nonconforming and Transgender Youth, Novartis, Virtual Presentation
2020	Invited Lecture	Advanced Hormones; More than Just T and E, CHLA, Virtual Presentation
2020	Invited Lecture	Video Telehealth and Transgender Youth, Telehealth Best Practices for the Trans Community, The Central Texas Transgender Health Coalition, Virtual Presentation
2020	Invited Lecture	Caring for Gender Diverse and Transgender Youth , Center for Juvenile Justice Reform Supporting the Well-Being of LGBTQ Youth Certificate Program, Virtual Presentation
2020	Invited Lecture	Gear Talk, Transforming Families, Virtual Lecture
2020	Invited Lecture	Tips for Parenting a Trans or Gender Diverse Youth, Models of Pride, Virtual Presentation
2020	Invited Lecture	Caring for Gender Diverse and Transgender Youth, LGBTQ+ Clinical Academy, Palo Alto University, Virtual presentation
2020	Invited Lecture	Approach to the Care of Gender Non-conforming Children and Transgender Youth, USC Medical School, Los Angeles, CA
2020	Invited Lecture	Medical Interventions for transgender youth, Cal State Los Angeles, Los Angeles
2020	Plenary Session	Understanding Issues Involving Gender Non-Conforming and Transgender Individuals Coming to a Courtroom Near You, Mid-Winter Workshop for Judges of the Ninth Circuit, Palm Springs, CA
2019	Keynote	Transgender Youth Care, SickKids, Toronto, Canada

2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Cal State Los Angeles, California
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Claremont Colleges, California
2019	Symposium	TransYouth Care; Flagstaff, AZ
2019	Keynote	Future Directions, USPATH, Washington DC
2019	Invited Lecture	Just a Boy, Just a Girl, Gender Odyssey San Diego, San Diego, CA
2019	Invited Lecture	Hormonas que Affirman el Genero pasa Juventud y Adultos Menores Trans, Transformando Desde el Amor y Las Familias, Colombia
2019	Invited Lecture	Infancia Trans y da Genero Diverso, Transformando Desde el Amor y Las Familias, Colombia
2019	Invited Lecture	Gender Dysphoria; A Deeper Dive Beyond the Diagnosis, Keynote address, Inaugural LGBTQ summit, Santa Clara CA
2019	Invited Lecture	Transgender and Gender Non-conforming Youth, Ascend Residential Treatment, Utah
2019	Invited Lecture	Gender Diverse and Transgender Youth; What Pediatricians Should Know, Common Problems in Pediatrics Conference, Utah AAP, Utah
2019	Invited Lecture	Gender Diverse and Transgender Youth; What Pediatricians Should Know, Common Problems in Pediatrics Conference, Utah AAP, Utah
2019	Invited Lecture	Caring for Gender Diverse and Transgender Youth, Grand Rounds, UCLA Olive View, CA
2019	Invited Lecture	Caring for Gender Diverse and Transgender Youth, Grand Rounds, Good Samaritan, CA
2019	<i>Invited Lecture</i>	Gender Dysphoria; A Deeper Dive Beyond the Diagnosis, Advance LA Conference, California
2019	Invited Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, USC Keck School of Medicine Reproductive Health Section. Los Angeles, CA
2019	Invited Lecture	Transgender Youth: Medical and Mental Health Needs, Bristol, United Kingdom
2019	Invited Lecture	Rethinking Gender, University of Bristol, United Kingdom
2019	Invited Lecture	Puberty Suppression in Youth with Gender Dysphoria, Fenway Trans Health Program, Boston
2019	Invited Lecture	Recognizing the Needs of Transgender Youth, California Department of Corrections And Rehabilitation, Ventura, CA
2019	Invited Lecture	Gender Dysphoria; Beyond the Diagnosis, Gender Education Demystification Symposium, GA
2019	Invited Lecture	Caring for Gender Nonconforming and Transgender Youth, Los Angeles Superior Court/Los Angeles Bar Association Training, CA
2019	Invited Lecture	Supporting Gender Diverse and Transgender Youth; A Deeper Look at Gender Dysphoria, Oakwood School, CA

2018	Invited Lecture	Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults: Comparison of Nonsurgical and Postsurgical Cohorts, Buenos Aires, Argentina
2018	Invited Lecture	Transyouth Care – An NIH Multisite Study About the Impact of Early Medical Treatment in Transgender Youth in the US, Buenos Aires, Argentina
2018	Invited Lecture	Transgender Youth and Gender Affirming Hormones; A 6-8 year follow-up, Buenos Aires, Argentina
2018	Invited Lecture	Supporting Gender Diverse and Transgender Youth: A Deeper Look at Gender Dysphoria, Studio City, CA
2018	Invited Lecture	Gender Dysphoria: Beyond the Diagnosis, Washington DC
2018	Invited Lecture	Uso de Hormonas Reafirmantes de Genero en Adolescentes Transgenero, Trans Amor Congreso Nacional de Transexualidad Juvenil y Infantes, Monterey, Mexico
2018	Invited Lecture	Bloqueadores de la Pubertad, Trans Amor Congreso Nacional de Transexualidad Juvenil y Infantes, Monterey, Mexico
2018	Invited Lecture	Working with Trans and Gender Non-Conforming Youth, Children’s Hospital Orange County, CA
2018	Invited Lecture	Caring for gender Non-conforming and Transgender Youth and Young Adults, Ascend Residential, Encino CA
2018	Invited Lecture	Gender Dysphoria; Beyond the Diagnosis; Midwest LGBTQ Health Symposium, Chicago, IL
2018	Invited Lecture	Caring for gender Non-conforming and Transgender Youth and Young Adults, California State University Northridge, Northridge, CA
2018	Invited Lecture	Puberty Suppression and Gender Affirming Hormones, Gender Fest, Las Vegas, NV
2018	Invited Lecture	Gender Google; Gender Odyssey Family Conference, Seattle WA
2018	Invited Lecture	Gender Dysphoria; Beyond the Diagnosis, Gender Odyssey Family Conference, Seattle WA
2018	Invited Lecture	Puberty Suppression: What, When, and How, Gender Odyssey Family Conference, Seattle WA
2018	Invited Lecture	Gender Dysphoria; School Nurse Organization of Idaho Annual Conference, Idaho
2018	Invited Lecture	Understanding Gender Dysphoria, Gender Spectrum Family Conference, Moraga, CA
2018	Invited Lecture	Puberty Suppression and Gender Affirming Hormones, Gender Odyssey Family, Los Angeles, CA
2018	Invited Lecture	Gender Dysphoria – Beyond the Diagnosis, Gender Odyssey Family, Los Angeles, CA
2018	Invited Lecture	Gender and What You Should Know, Archer School for Girls, Brentwood, CA
2018	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Oceanside, CA

2018	Invited Lecture	Gender Dysphoria: Beyond the Diagnosis, Advance LA, Los Angeles, CA
2018	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Andrology Society of America Clinical Symposium, Portland, OR
2018	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Los Angeles, CA
2018	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Center for Early Education, Los Angeles, CA
2017	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Santa Barbara, CA
2017	Invited Lecture	Gender Dysphoria, Beyond the Diagnosis, Pink Competency, Oslo Norway
2017	Invited Lecture	“Just a Boy, Just a Girl” Gender Infinity, Houston TX
2017	Invited Lecture	Caring for Gender Non-Conforming Children and Transgender Adolescents:
		A United States Perspective, Pink Competency, Oslo Norway
2017	Invited Lecture	Gender Dysphoria; Beyond the Diagnosis, Models of Pride, Los Angeles, CA
2017	Invited Lecture	Puberty Delay and Cross Hormones for Trans* Youth, Models of Pride, Los Angeles, CA
2017	Invited Lecture	Healthcare for TGNC Youth, Expanding Competency for LGBT Youth in the System, Washington DC
2017	Invited Lecture	Gender Non-conforming and Transgender Children and Youth; Center for Early Education, West Hollywood, CA
2017	Invited Lecture	Rethinking Gender, University of Massachusetts
		Annual Convocation Welcome Luncheon, Worcester, MA
2017	Invited Lecture	Puberty Delay and Cross Hormones for Trans* Youth, Gender Odyssey Family Conference, Seattle, WA
2017	Invited Lecture	Puberty Suppression; What, When and How, Gender Odyssey Family Conference, Seattle, WA
2017	Invited Lecture	Just a Boy, Just a Girl, Gender Odyssey, Los Angeles, California
2017	Invited Lecture	Puberty Blockers and Cross Sex Hormones, Gender Odyssey, Los Angeles, California
2017	Invited Lecture	Caring for Gender Non-conforming and Transgender youth and Young Adults, Diverse Families Forum: The Importance of Family Support In The Trans And LGBT Children, Organized by COPRED and The International Association Of Families For Diversity (FDS), Mexico City, Mexico
2017	Invited Lecture	Gender Non-Conforming Children and Transgender Youth, Board of Behavioral Sciences, Orange, CA
2017	Invited Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, Santa Monica Rape Treatment Center, Santa

		Monica, CA
2017	Invited Lecture	Gender Nonconforming and Transgender Youth, CSU Fullerton, Fullerton, CA
2017	Invited Lecture	Rethinking Gender, Chico TransGNC Week, Chico, California
2017	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Chico TransGNC Week, Chico, California
2017	Invited Lecture	Transgender Youth Care in the New Millennium, USC Law and Global Health Initiative, Los Angeles, CA

Invited Grand Rounds, CME Lectures

<i>Year</i>	<i>Type</i>	<i>Title, Location</i>
2021		
2020	CME Lecture	Histrelin Implants for Suppression of Puberty in Youth with Gender Dysphoria: a Comparison of 50 mcg/day (Vantas) and 65 mcg/day (SupprelinLA), WPATH Conference, Virtual Presentation
2020	CME Lecture	Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults, Comparison of Post-surgical and Non-surgical Cohorts, WPATH Conference, Virtual Presentation
2020	CME Lecture	Gender Affirmation Through a Social Justice Lens, SAHM Conference, Virtual Presentation
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, AAP Conference, Virtual Lecture
2020	CME Lecture	Conversations with LGBTQ youth; the role of the pediatrician, AAP Conference, Virtual Lecture
2020	Grand Rounds	Creating Affirming Environments for Trans and Gender Diverse Patients, USC OB/Gyn Grand Rounds, Virtual Presentation
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Resident Lecture, CHLA
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Facey Medical Group, Los Angeles, CA
2020	Plenary Lecture	Reframing Gender Dysphoria, LEAH Conference, Los Angeles, CA
2020	CME Lecture	Gender Affirming Care for Pre and Peri-pubertal Trans and Gender Diverse Youth, LEAH Conference, Los Angeles, CA
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Division of Endocrinology, USC, Los Angeles, CA
2020	Plenary Session	Understanding Issues Involving Gender Non-Conforming and Transgender Individuals Coming to a Courtroom Near You, Mid-Winter Workshop for Judges of the Ninth Circuit, Palm Springs, CA
2019	Symposium	Recognizing the Needs of Transgender Youth, California Department of Corrections and Rehabilitation, Stockton, CA

2019	Keynote	Transgender Youth Care, SickKids, Toronto, Canada
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Cal State Los Angeles, California
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Claremont Colleges, California
2019	CME Lecture	Gender Diverse and Transgender Youth, Harbor UCLA Medical Center Grand Rounds, Torrance, CA
2019	CME Lecture	Gender Dysphoria – Beyond the Diagnosis, Gender Odyssey San Diego, San Diego, CA
2019	CME Lecture	Hormones 201 – Beyond T and E, Gender Odyssey San Diego, San Diego, CA
2019	<i>Grand Rounds</i>	Transgender Youth; What's New in 2019?, Children's Hospital Los Angeles, CA
2019	Oral Presentation	Male Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults, European Professional Association of Transgender Health, Rome Italy
2019	Oral Presentation	Transgender Youth and Gender Affirming Hormones; 5-7 Year Follow Up, European Professional Association of Transgender Health, Rome Italy
2019	CME Educational Lecture	Gender Dysphoria; Beyond the Diagnosis, European Professional Association of Transgender Health, Rome Italy
2019	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Children's Hospital Orange County, CA
2019	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Stanislaus County Behavioral Health and Recovery Services, CA
2019	CME Educational Lecture	Rethinking Gender, Olive View Medical Center Grand Rounds, CA
2018	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Glendale Unified School District, CA
2018	CME Educational Lecture	Caring for Gender Non-Conforming Children and Transgender Youth, CME by the Sea, CA
2018	CME Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Austin, TX
2018	CME Educational Lecture	Gender Affirming Hormone Therapy for Transmasculine Adolescents and Young Adults, Gender Infinity, Houston, Texas
2018	CME Educational Lecture	Outside of the Binary; Care for Non-Binary Adolescents and Young Adults, Gender Infinity, Houston, Texas
2018	CME Educational Lecture	Chest Dysphoria and the Impact of Chest Reconstruction, Gender Infinity, Houston, Texas
2018	CME Educational Lecture	Just a Girl, Just a Boy, Gender Infinity, Houston, Texas
2018	CME Educational Lecture	Hormones 201: More than Testosterone and Estrogen, Gender Odyssey Professional Symposium, WA
2018	CME Educational Lecture	Male Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults, Gender Odyssey Professional Symposium,

		WA
2018	CME Educational Lecture	Chest Surgery, Gender Spectrum, Moraga, CA
2018	CME Educational Lecture	Understanding Gender Dysphoria, Gender Spectrum, Moraga, CA
2018	CME Educational Lecture	Puberty Suppression and Gender Affirming Hormones, Gender Odyssey, Los Angeles, CA
2018	CME Educational Lecture	Gender Dysphoria – Beyond the Diagnosis, Gender Odyssey, Los Angeles, CA
2018	CME Educational Lecture	Approach to the Care of Gender Non-Conforming Children and Transgender Youth, Desert Oasis Healthcare, Palm Desert, CA
2018	CME Educational Lecture	Puberty Blockers and Gender Affirming Hormones for Transgender Youth: What Do We Know, and What Have We Learned, Pediatric Academic Societies, Toronto, Canada
2018	CME Workshop	Mental and Medical Healthcare for Transgender Adolescents, California Association of Marriage and Family Therapists, Garden Grove, CA
2018	CME Educational Lecture	Approach to the Care of Gender Non-Conforming Children and Transgender Youth, Keck School of Medicine, Los Angeles, CA
2018	Grand Rounds	Caring for Gender Non-Conforming Children and Transgender Adolescents, Primary Children’s Hospital, Salt Lake City, UT
2018	CME Educational Lecture	Caring for Transgender Youth, Chico Trans Week, Chico, CA
2018	CME Educational Lecture	Rethinking Gender, UCSD Medical School, San Diego, CA
2018	CME Educational Lecture	Rethinking Gender, UCLA Medical School, Los Angeles, CA
2018	CME Educational Lecture	Transyouth Care – Self-reflection On Personal Biases and Their Impact On Care, Society for Adolescent Health and Medicine, Seattle WA
2018	CME Educational Lecture	Rethinking Gender, Society for Adolescent Health and Medicine, Seattle WA
2018	CME Educational Lecture	Providing 360 degree transgender hormone therapy: beyond the protocols, Medical Directors Council (MeDC) 14th Annual Clinical Update in Reproductive Health and Medical Leadership, Snowbird, Utah
2018	CME Educational Lecture	Gender Dysphoria: Beyond the Diagnosis, Gender Education and deMystification Symposium, Salt Lake City, Utah
2018	CME Educational Lecture - Keynote	Rethinking Gender, SoCal LGBTQIA health conference, Los Angeles, CA
2017	CME Educational Seminar	The Care of Gender Non-Conforming children and Transgender Youth; Orange County Health Care Agency, Orange County, CA
2017	CME Educational Lecture	Rethinking Gender, Adolescent Grand Rounds, Children’s Hospital Los Angeles, Los Angeles, CA
2017	CME Educational Lecture	“Just a Boy, Just a Girl” Gender Infinity, Houston TX
2017	CME Educational Lecture	Chest Dysphoria – The Impact of Male Chest Reconstruction, Gender Infinity, Houston TX

2017	CME Educational Lecture	Outside of the Binary; Care for Non-Binary Adolescents and Young Adults, Gender Infinity, Houston TX
2017	CME Educational Lecture	Puberty Blockers; What, When and How, Gender Infinity, Houston TX
2017	CME Educational Lecture	Gender Non-Conforming Children and Transgender Youth, Pasadena CA
2017	CME Educational Lecture	Gender Non-Conforming Children and Transgender Youth; Integrated Care Conference, Los Angeles, CA
2017	CME Educational Lecture	Gender Non-Conforming and Transgender Children and Adolescents; A Multidisciplinary Approach, California Psychiatric Association Annual Conference, Yosemite, CA
2017	CME Educational Lecture	Gender Non-Conforming and Transgender Children and Adolescents, Developmental Pediatrics continuing education lecture, Children's Hospital Los Angeles, CA
2017	CME Educational Lecture	Masculinizing Hormones, Central Texas Transgender Health Conference, Austin, TX
2017	CME Educational Lecture	Children, Youth, Families and Hormone Blockers, Central Texas Transgender Health Conference, Austin, TX
2017	CME Educational Lecture	Chest Dysphoria – The Impact of Male Chest Reconstruction, Gender Odyssey Professional Symposium, Seattle, WA
2017	CME Educational Lecture	Puberty Delay and Cross Hormones for Transyouth, Gender Odyssey Professional Symposium, Seattle, WA
2017	CME Invited Lecture	Just a Girl, Just a Boy, Gender Odyssey Professional Symposium, Seattle, WA
2017	CME Educational Lecture	Gender Dysphoria, Gender Spectrum Family Conference, Moraga, CA
2017	CME Educational Lecture	Care of Gender Non-Conforming Children and Transgender Adolescents, Lopez Family Foundation Educational Lecture, Los Angeles, CA
2017	CME Educational Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, USC Keck School of Medicine Reproductive Health, Los Angeles, CA
2017	CME Educational Seminar	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, San Diego, CA
2017	CME Educational Lecture	Puberty Suppression in the United States; practice models, lessons learned, and unanswered questions, US Professional Association of Transgender Health, Los Angeles, CA
2017	CME Educational Lecture	The Impact of Male Chest Reconstruction on Chest Dysphoria in Transmasculine Adolescents and Young Men; A Preliminary Study, US Professional Association of Transgender Health, Los Angeles, CA
2017	CME Educational Lecture	Outside of the Binary; Care for Non-Binary Adolescents and Young Adults, US Professional Association of Transgender Health, Los Angeles, CA

PUBLICATIONS:

*** INDICATES TRAINEES**

**** INDICATE YOURSELF AS CO-FIRST OR CO-CORRESPONDING OR SENIOR AUTHORS**

REFEREED JOURNAL ARTICLES:

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Exhibit 27

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
Civil Action No. 1:19-cv-00272

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MAXWELL KADEL, et al.,)
)
Plaintiffs,)
)
vs.)
)
DALE FOLWELL, in his official)
capacity as State Treasurer of)
North Carolina, et al.,)
)
Defendants,)
_____)

DEPOSITION OF DAN H. KARASIC, M.D.
Remote
September 20, 2021
9:00 a.m. Pacific Time

Prepared by:
Vicki L. O'Ceallaigh Champion, CR
Certificate No. 50534

Prepared for:

(Certified copy)

I N D E X

WITNESS:

DAN H. KARASIC, M.D.	PAGE
Examination by Mr. Knepper	5
Examination by Mr. Haskel.....	Xx

E X H I B I T S

NO.	DESCRIPTION	PAGE
1	Dr. Karasic's Curriculum Vitae.....	13
2	Dr. Karasic's Expert Report.....	29
3	Bibliography.....	30
4	Article: International Clinical Practice Guidelines For Gender Minority/Trans People: Systematic Review And Quality Assessment	44
5	Article: Expertise In Psychotherapy.....	51
6	Branstrom and Pachankis Study.....	56
7	Letters To The Editor, American Journal of Psychiatry	69
8	A Follow-Up Study of Boys With	78
	Gender Identity Disorder	
9	Short-Term Outcomes Of Pubertal Suppression In A Selected Cohort Of 12 To 15 Year Old Young People With Persistent Gender Dysphoria In The UK	80
10	Puberty Blockers and Suicidality in	91
	Adolescents Suffering from Gender Dysphoria	

1 DEPOSITION OF DAN H. KARASIC, M.D.
2 commenced at 9:00 a.m. on September 20, 2021, via
3 Zoom, before VICKI L. O'CEALLAIGH CHAMPION, a
4 Certified Reporter, CR No. 50534, for the State of
5 Arizona.

6
7 * * *

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9

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22
23
24 Also Present:

25 Mr. Braden Bates, Legal Videographer

1 A. No.

2 Q. Have you served as a principal investigator
3 on any private grants?

4 A. No.

5 Q. Dr. Karasic, what is gender dysphoria?

6 MR. HASKEL: Objection to the form.

7 A. So gender dysphoria -- well, first of all,
8 there are a couple gender dysphorias. There is the
9 gender dysphoria, the symptom. You might say small
10 letter "G," small letter "D."

11 There is also gender dysphoria, capital "G,"
12 capital "D," the DSM-5 diagnosis. If for gender
13 dysphoria the symptom, it is distress about the
14 difference between one's identified or lived gender
15 and one's assigned gender.

16 BY MR. KNEPPER:

17 Q. Okay. And then what is the diagnosis of
18 gender dysphoria?

19 A. So the diagnosis of gender dysphoria is a
20 diagnosis that the American Psychiatric Association
21 has put in DSM-5. That includes the presence of
22 persistent gender dysphoria along with -- well, it
23 lists various manifestations of that, but it also --
24 as potential symptoms and also has that the symptoms
25 cause social or occupational -- impairment of social

1 occupational functioning or clinically significant
2 distress.

3 Q. Is it clinically significant distress?

4 A. Distress.

5 Q. And how is that distinguished from the
6 distress identified as a symptom? You described it
7 as little-G-little-D dysphoria.

8 MR. HASKEL: Object to form.

9 A. So the gender dysphoria as a symptom was --
10 or has been something that has been described in
11 people long before there was -- the DSM-5 came out
12 in 2013, but for example, WPATH Standards of Care 7
13 refers to gender dysphoria, not capitalized, and not
14 as -- not as an APA diagnosis, but as this symptom
15 of distress.

16 BY MR. KNEPPER:

17 Q. So what -- let me just -- if an
18 individual -- and this is what I'm trying to
19 understand: If an individual suffers from gender
20 dysphoria, little-G-little-D, does that mean that
21 they suffer from gender dysphoria, the psychiatric
22 diagnosis?

23 MR. HASKEL: Objection to form, foundation.
24 You can answer.

25 A. Not necessarily. I would say very often

1 clinician-given scales as well as self-report
2 scales.

3 BY MR. KNEPPER:

4 Q. Sure. So did the Carmichael report find a
5 measurable improvement on physician administered
6 scales for individuals receiving puberty blockers?

7 MR. HASKEL: Objection; form.

8 A. So my recollection was or my question when I
9 had seen this report was that the people getting
10 puberty blockers in some ways were perhaps kind of
11 frozen in place, that their gender dysphoria and
12 associated mental health measures were not being
13 treated necessarily by other puberty blockers, but
14 the puberty blockers may have prevented a worsening
15 that people coming into the study presumably, you
16 know, had some worsening of gender dysphoria as they
17 entered puberty, and then they are brought to the
18 study and started on puberty blockers and that
19 really kind of addressing that dysphoria, you know,
20 could happen at a later point, but it was kind of
21 preventing further changes from puberty that might
22 exacerbate their dysphoria and distress.

23 That was just the impression, again, from my
24 recollection of seeing the study.

25

Exhibit 27(a)

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

DALE FOLWELL, *et al.*,

Defendants.

No. 1:19-cv-00272-LCB-LPA

EXPERT REBUTTAL REPORT OF DR. DAN H. KARASIC, M.D.

1. My name is Dan H. Karasic. I have been retained by counsel for plaintiffs Maxwell Kadel, Jason Fleck, Connor Thonen-Fleck, Julia McKeown, Michael D. Bunting, Jr., C.B., Sam Silvaine, and Dana Caraway (collectively, “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 gender identity, the treatment and diagnosis of gender dysphoria, particularly as it pertains to children and adolescents, and to respond to, rebut, and provide my expert opinion regarding the reports by Drs. Stephen R. Levine, Paul R. McHugh, Paul W. Hruz, and Patrick W. Lappert in this case.

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 Professor Emeritus of Psychiatry at the UCSF Weill Institute for Neurosciences. I have been on faculty at the University of California San Francisco since 1991. I have also had a telepsychiatry private practice since 2020.

**Exhibit
0002**

5. I received my Doctor of Medicine (M.D.) degree from the Yale Medical School in 1987. In 1991, I completed my residency in psychiatry at the University of California Los Angeles Neuropsychiatric Institute, and from 1990 to 1991, I was a postdoctoral fellow in a training program in mental health services for persons living with AIDS at UCLA.

6. For over thirty years, I have worked with transgender patients and worked on issues related to transgender health care. I am a Distinguished Fellow of the American Psychiatric Association and currently the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, as well as the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

7. Over the past 30 years, I have provided care for thousands of transgender patients.

8. I previously sat on the Board of Directors of the World Professional Association for Transgender Health (WPATH) and am a co-author of the *WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, Version 7, which are the internationally accepted guidelines designed to promote the health and welfare of transgender, transsexual, and gender variant persons. For the upcoming WPATH Standards of Care, Version 8, I am the lead author on the Mental Health chapter.

9. As a member of the WPATH Global Education Initiative, I helped develop a specialty certification program in transgender health and helped train over 1,000 health providers. At UCSF, I developed protocols and outcome measures for the Transgender Surgery Program at the UCSF Medical Center. I also served on the Medical Advisory Board for the UCSF Center of Excellence for Transgender Care, and co-wrote the mental health section of the original *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* and the revision in 2016.

10. I have also worked with the San Francisco Department of Public Health, having developed and implemented their training program for the care of transgender patients and for mental health assessments for gender-affirming surgery. I served on the City and County of San Francisco Human Rights Commission's LGBT Advisory Committee, and I have been an expert consultant for California state agencies and on multiple occasions for the United Nations Development Programme on international issues in transgender care.

11. I have held numerous clinical positions concurrent to my clinical professorship at UCSF. Among these, I served as an attending psychiatrist for San Francisco General Hospital's consultation-liaison service for AIDS care, as an outpatient psychiatrist for HIV-AIDS patients at UCSF, as a psychiatrist for the Transgender Life Care Program and Dimensions Clinic of the Castro Mission Health Center, and the founder and co-lead of the UCSF Alliance Health Project's Transgender Team. In these clinical roles, I specialized in the evaluation and treatment of transgender, gender dysphoric, and HIV-positive patients. I also regularly provide consultation on challenging cases to psychologists and other psychotherapists working with transgender and gender dysphoric patients. I have been a consultant in transgender care to the California Department of State Hospitals and am currently a consultant for the California Department of Corrections and Rehabilitation on the care of incarcerated transgender people.

12. In addition to this work, I have done research on the treatment of depression. I have authored many articles and book chapters, and edited the book *Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation*.

13. In preparing this report, I have relied on my training and years of research and clinical experience, as set out in my curriculum vitae, and on the materials listed therein. 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.

14. I have also reviewed the materials listed in the attached bibliography (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 report.

15. In addition, I have reviewed the Amended Complaint in this case, the reports by Dr. Levine, Dr. McHugh, Dr. Hruz, and Dr. Lappert, and the reports by Dr. George Brown and Dr. Loren S. Schechter. I may rely on these documents, as well as those cited in curriculum vitae and the attached bibliography, as additional support for my opinions.

16. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

Prior Testimony

17. In the last four years, I have not testified as an expert at trial or by deposition.

Compensation

18. I am being compensated for my work on this matter at a rate of \$400.00 per hour for preparation of declarations and expert reports. I will be compensated \$3,200.00 per day for any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

II. EXPERT OPINIONS

A. Gender Identity

19. Sex assigned at birth refers to the sex assigned to a person at the time of their birth, typically based on the appearance of external genitals. While male and female sex are sometimes used in reference to genitals, chromosomes, and hormones, the reality is that sex is complicated and multifactorial. Aside from the appearance of external genitals, chromosomes, and endogenous hormones, other factors related to sex include gonads, exposure to exogenous hormones during fetal development, and variations in brain structure and function. Because each of these factors may not always be in perfect alignment, “the terms biological sex and biological male or female are imprecise and should be avoided.” (Hembree, et al., 2017).

20. Indeed, sex assigned at birth does not always align with XX or XY chromosomes. For example, children with Androgen Insensitivity Syndrome have XY chromosomes and are exposed to androgens in utero, but commonly are assigned female at birth.

21. “Gender” refers to attitudes, feelings, identity, and expression associated culturally with male, female, nonbinary, or another gender.

22. Gender identity is “a person’s deep felt, inherent sense of being a girl, woman, or female; a man, or male; a blend of male or female; [or another] gender” (American Psychological Association, 2015, p. 862). Gender identity and lived gender roles do not always align with sex assigned at birth or other markers. Gender identity has biological bases and is highly resistant to change. As documented by multiple leading medical authorities, efforts to change a person’s gender identity are ineffective, can cause harm, and are unethical. (American Psychological Association, 2021; Byne, et al., 2018; Coleman, et al., 2012).

B. Gender Dysphoria and its Treatment

23. Gender dysphoria is distress related to the incongruence between one's gender identity and attributes related to one's sex assigned at birth.

24. "Gender Dysphoria in Children" is a diagnosis applied only to pre-pubertal children, in the Diagnostic and Statistical Manual Fifth Edition (DSM-5), released in 2013. The criteria include "A: A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration." The diagnosis also requires the presence of criterion A1, which is "A strong desire to be of the other gender or insistence that one is the other gender (or some alternative gender different from one's assigned gender." The prior version of the diagnosis, Gender Identity Disorder of Children, in DSM IV, did not require this A1 criterion of gender identity, and could be applied solely on the basis of gender atypical behavior. Most research on persistence and desistance of gender identity in pre-pubertal children was conducted in the era of DSM-IV and earlier versions, and applied a broader diagnosis that could be based only on gender atypical behavior alone, without necessarily a transgender identity.

25. The DSM-5 diagnosis of "Gender Dysphoria in Adolescents and Adults" includes at least 6 months of distress or impairment with "A marked incongruence between one's experienced/expressed gender and assigned gender," and at least 2 of 6 other symptoms. The name change from DSM-IV's Gender Identity Disorder in Adolescents and Adults emphasized that the distress, or dysphoria, was the disorder, and not transgender identity. (DSM-5, 2013).

26. The World Professional Association for Transgender Health (formerly the Harry Benjamin Gender Dysphoria Association) has issued *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* since 1979. The current version is WPATH SOC 7, with WPATH SOC 8 due out later this year. WPATH SOC 7 provides guidelines

for multidisciplinary care of transgender and gender diverse individuals, and describes criteria for the treatment of gender dysphoria, including hormone treatment and surgery. WPATH SOC 7 also states, “Treatment aimed at trying to change a person’s gender identity and expression ... is no longer considered ethical.”

27. The WPATH Standards of Care are endorsed and cited as authoritative by many professional medical associations including the American Medical Association, the American Psychiatric Association, the American Psychological Association, the Endocrine Society, the Pediatric Endocrine Society, the American College of Obstetrics and Gynecology, the American College of Physicians, and the World Medical Association, among others.

28. Guidelines from other organizations, including UCSF and the Endocrine Society of North America, also list similar protocols for the medically necessary treatment of gender dysphoria.

29. In accordance with the WPATH SOC 7, addressing gender dysphoria and gender transition may include aspects of social transition, treatment with hormones, and treatment with surgery.

30. The World Professional Association of Transgender Health Medical Necessity Statement (WPATH, 2016) also lists gender-confirming surgeries among the medically necessary for the treatments of gender dysphoria.

31. No medical or surgical treatment for gender dysphoria is provided to pre-pubertal children. Adolescents may be treated with medications to delay the onset of puberty, which are also used in children without gender dysphoria, but with early onset of puberty. After ongoing work with mental health professionals, adolescents may start treatment with hormones. Adults

may start hormones after work with a therapist, or after assessment by a primary care provider or endocrinologist.

32. Mental health professionals, primary care providers, endocrinologists, and surgeons often work collaboratively, whether in multidisciplinary teams, or with communication between individual professional practices.

33. Affirming care for transgender children does not mean steering children in any particular direction, but rather supporting them through their period of exploration of gender expression and increasing self-awareness of their identity (Coleman, et al., 2012). For pre-pubescent children, no medical or surgical intervention is involved. Instead, interventions are directed at supporting the child with family, peers, and school.

34. Puberty blockers may be indicated at Tanner Stage 2 of puberty if the onset of physical changes of puberty is causing distress. Puberty blockers allow the child time to better understand their gender identity under the care of a mental health professional, while delaying distress from the progression of the development of secondary sex characteristics.

35. Given that prior longitudinal studies included gender nonconforming children who were not transgender due to the broad criteria for the since-abandoned “gender identity disorder in children” diagnosis, these studies shed little light into questions of persistence and desistance of gender dysphoria in pre-pubertal children. However, longitudinal studies show that gender dysphoria in adolescence usually persists (DeVries, et al., 2011). Additionally, no medical treatment, let alone irreversible medical and surgical interventions, is used prior to puberty, so the persistence and desistance statistics of pre-pubertal children do not inform the decision whether or not to initiate these treatments.

36. Data from the Dutch experience with evaluation and care by a multidisciplinary team, using puberty blockers, followed by hormones and surgery when indicated, show that this approach appears to result in high satisfaction, a lack of regret, and mental health outcomes similar to those of a control group that was not transgender. (DeVries, et al., 2014).

37. In a United States study, treatment with gender affirming hormones in transgender youth was associated with a substantial reduction in body dissatisfaction, and well as improvement on mental health measures (Kuper, et al., 2020).

C. Harms of Denying Gender-Affirming Care

38. The overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self. The denial of medically indicated care to transgender people not only results in the prolonging of their gender dysphoria, but causes additional distress and poses other health risks, such as depression, posttraumatic stress disorder, and suicidality. The prevalence of these mental health conditions is widely thought to be a consequence of minority stress, the chronic stress from coping with societal stigma and discrimination because of one's identity, including gender identity and gender expression. (American Medical Association, 2019). In other words, lack of access to gender-affirming care directly contributes to poorer mental health outcomes for transgender people. (Owen-Smith, et al., 2018).

39. Accordingly, major medical organizations, such as the American Medical Association, American Psychiatric Association, and American College of Obstetricians and Gynecologists, oppose the denial of this medically necessary care and support public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician. (American Medical Association, 2019).

40. Denial of this appropriate care for transgender youth is also opposed by mainstream organizations responsible for the care of youth, including the American Academy of Pediatrics, the Academy of Child and Adolescent Psychiatry, and the Pediatric Endocrine Society.

41. Parental support and other social support have been associated with dramatically less suicidal ideation in transgender people, as has treatment with hormones and completing medical transition. (Bauer, et al., 2015). Provision of puberty blockers for transgender youth likewise decreases suicidality (Turban, et al., 2020). The American Academy of Child and Adolescent Psychiatry states, “Research consistently demonstrates that gender diverse youth who are supported to live and/or explore the gender role that is consistent with their gender identity have better mental health outcomes than those who are not.” (AACAP, 2019).

42. In the past 10 years, there has been a reversal in longstanding policies that had excluded reimbursement for transgender people, including youth. There are many more clinics providing care to transgender youth and adults in academic medical centers than a decade ago, because funding is now available. This change is allowing clinical researchers to expand the body of research in the United States, as well as increasing access to care.

D. Specific Critiques

43. The critiques below apply to more than one expert. The experts for the defense are outside the mainstream of transgender health. Instead, they are better known for their political efforts to deny care to transgender people and to oppose LGBTQ rights, rather than for providing care for or clinical research regarding transgender people. Their views are outside the mainstream of experts in transgender health and mainstream medical organizations.

44. The use of the terms “transgender treatment industry” and “gender transition industry” are particularly inappropriate to reference the dedicated health professionals and

researchers who have worked to provide medically necessary care for their transgender patients, as they do for other patients, despite the fact that for many years care for transgender patients was specifically denied government funding and insurance reimbursement, in part due to the efforts of political opponents, such as Paul McHugh.

45. Health professionals across disciplines attempting to provide good and medically necessary care for transgender people, as they do for their other patients, do not constitute a “transgender treatment industry.”

Dr. Levine’s Report

46. Stephen Levine, MD, was an editor of Standards of Care 5 (“SOC 5”) of the Harry Benjamin Gender Dysphoria Association (the precursor to WPATH), which were released in 1998. After widespread criticism of the SOC 5, it was replaced by the SOC 6 in just three years. By contrast, the SOC 6 (published in 2001) and SOC 7 (published in 2012) have each been used for approximately 10 years. Dr. Levine was critical of the changes in transgender care since 1998, and has been a critic of modern transgender care since. His involvement in transgender health in recent years has centered on the denial of care to transgender people through his role providing testimony with respect to prison systems. Dr. Levine’s bias was noted in *Norsworthy v. Beard*, in which U.S. District Judge Jon Tigar stated: “The Court gives very little weight to the opinions of Levine, whose report misrepresents the Standards of Care; overwhelmingly relies on generalizations about gender dysphoric prisoners, rather than an individualized assessment of Norsworthy; contains illogical inferences; and admittedly includes references to a fabricated anecdote.”

47. Regarding Dr. Levine’s criticism of the DSM-5 (Levine Decl. ¶ 13), Dr. Insel was emphasizing the need to research the biological conditions underlying mental illness, rather than the focus on categorization of the illnesses. These critiques are about categorization of mental

illness as a whole, not specifically a criticism of the diagnosis of or criteria for Gender Dysphoria contained in the DSM-5.

48. In addition, Dr. Levine’s criticism, particularly with regard to desistance, is based on studies relying on the now obsolete and overly broad categorizations contained in the DSM III-R and DSM IV for “Gender Identity Disorder in Children.” None of the studies cited by Dr. Levine use the current DSM-5 gender dysphoria diagnosis. As noted above, a child could meet criteria for the DSM III-R or DSM-IV diagnosis of gender identity disorder without identifying as transgender because the diagnostic criteria did not require identification with a gender other than the one assigned to the person at birth. This problem with the diagnosis was remedied with the new DSM-5 diagnosis of “Gender Dysphoria in Children,” which requires a child to have “a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender).” It is therefore not surprising that children discussed in the studies cited by Dr. Levine did not identify as transgender at follow-up as these children did not necessarily identify as transgender to begin with.

49. In addition, the studies cited by Dr. Levine all examined *pre-pubertal* children. There is broad consensus that once youth reach the earliest stages of puberty (i.e., Tanner 2) and identify as transgender, desistance is rare. The notion of desistance therefore is not generally applied to transgender people once they reach the Tanner 2 stage of puberty. Even the researchers who published the dataset about desistance that Dr. Levine cites are clear that once a child reaches puberty, it is not medically appropriate to withhold affirming treatment.

50. In any event, aside from the DSM, there is only one other comprehensive, widely accepted listing of disorders, the World Health Organization’s International Classification of Diseases, now in its eleventh version, ICD-11. Reflecting the medical nature of the diagnosis, ICD-

11's diagnosis of Gender Incongruence is not listed with the mental disorders, and is not focused on distress and impairment, but otherwise is similar to Gender Dysphoria in DSM-5. Mainstream health providers rely on categorization in DSM and ICD to diagnose each patient, and this is true for the use of Gender Dysphoria and Gender Incongruence as well.

51. Dr. Levine uses his prior experience with WPATH over two decades ago to burnish his credentials as an expert in transgender health, but otherwise dismisses WPATH as an "activist," rather than a professional organization. WPATH restricts its full membership to professional clinicians and health academics. That more clinicians and health academics are transgender themselves than in Dr. Levine's long-ago tenure with the organization does not diminish their expertise as clinicians and researchers.

52. Dr. Levine's beliefs in the early malleability of gender identity in youth, whether by parental support or "social contagion," are in contrast to the actual experience of transgender youth, who express their identity despite the overwhelming disapproval of society to transgressing gender norms. The etiology or "pathways" to any particular gender identity remain the subject of debate and research, though research to date indicates that gender identity has biological bases. However, any debate surrounding the etiology of any particular gender identity does not diminish the necessity of treatment of those suffering from the distress of gender dysphoria, especially since treatments endorsed by mainstream medicine have been shown to improve quality of life, decrease distress, and decrease suicidality.

53. Dr. Levine's assertions that successful transition for transgender individuals "is not biologically attainable" due to lack of reproductive capacity are untrue. Transgender individuals may find other ways to build families, but so do other individuals who need medical assistance with reproduction or choose to adopt. Reproductive capacity is not what makes a person a man or

a woman, and we do not describe others as less of a man or woman for needing assistance with family building or choosing not to raise children.

54. As a clinician who, unlike Dr. Levine, actively works with a multitude of clinicians providing care to transgender youth and adults, I reject Dr. Levine's false claim that these clinicians simply see their roles as pushing youth towards a transgender identity. First, transgender youth identity and dysphoria is not a product of external influence and not subject to voluntary change. Second, dedicated professionals who provide care to transgender people, like the care they provide to others, undertake a serious endeavor in trying to provide the best care for their patients according to prevailing standards of care, not the pushing of a political agenda or being "fashionable." The alternative proposed by Dr. Levine, "conversion therapy," has been opposed by mainstream health organizations as ineffective and harmful.

55. Dr. Levine describes "confirmation bias" as "the methodologically defective tendency to process information by only looking for, and interpreting, evidence consistent with existing beliefs, favorite theories, and pre-conceived notions." Dr. Levine believes this applies to the thousands of clinicians actually providing care for transgender patients, and to the academics researching transgender care, but seems unable to apply the concept of confirmation bias to examine his own views. Dr. Levine's confirmation bias leads him to propound at length his own theories of etiology and treatment of gender dysphoria (which are unsupported by scientific peer-reviewed literature), while dismissing the approaches of modern mainstream medicine and pediatrics, as put forward in academic journals like *The Lancet*, the *American Journal of Psychiatry*, the *Journal of the American Medical Association*, and the *New England Journal of Medicine*, as well as by organizations including the American Medical Association, the American Psychiatric Association, and American Academy of Pediatrics, the American Psychological

Association. Dr. Levine’s theories should be understood in the context of his own confirmation bias that seemingly places him as the lone truth-teller in a deluded world.

56. Dr. Levine states that mainstream transgender care, including gender confirming surgery, “is *not supported by credible, reliable-valid scientific research*, not accepted by the relevant scientific community, and has no known error rates, and no careful systematic follow-up using agreed upon criteria to even assess multifaceted failure rates.” In fact, transgender care, including gender confirming surgery, has been studied extensively, with much evidence of the effectiveness of such treatment, and of low regret rates. (Cornell “What We Know” systematic review; *see also, e.g.*, Marano, et al., 2021; Colton-Meier, et al., 2011; Murad, et al., 2010; Smith, et al., 2005; Pfafflin & Junge, 1998).

57. Dr. Levine refers to purportedly high rates of regret, and also refers to data on the Swedish experience with surgery as treatment for transgender patients’ dysphoria. From 1960-2010, the regret rate in those who received surgery in Sweden was 2%. The regret rate went down over the 50 years covered in the study of Swedes having transgender surgery, and in the last decade of the Swedish study, 2001-2010, the regret rate was 0.3%. These regret rates are low, including in comparison to rates of regret for a number of surgical procedures that cisgender people undergo. For example, one study of women who had mastectomy for breast cancer, followed by breast reconstructive surgery, reported a 47% regret rate for having breast reconstruction (Sheehan, et al., 2008).

58. Dr. Levine also implies that allowing a child to socially transition makes them identify more strongly as transgender and thus more likely to “persist” in their transgender identity. A recently published study, which Dr. Levine fails to cite, has found this not to be true. The study

authors found that gender identification did not meaningfully differ before and after social transition. (Rae, et al., 2019).

59. Additionally, research shows that transgender youth supported by their families in socially transitioning have been shown to have measures of depression and self-worth similar to their non-transgender siblings. (Durwood, et al., 2017).

60. Mainstream medicine, transgender health advocates, and Dr. Levine all agree on the centrality of informed consent in the provision of healthcare. Dr. Levine’s version of informed consent includes his confirmation bias on the futility of care for transgender people. Informed consent should encapsulate the risks and benefits of the given treatment as best known through the perspective of scientific evidence and modern health practice.

61. There are limits on the capacity of children to consent, which is why parents consent for healthcare, including for transgender youth.

Dr. McHugh’s Report

62. Dr. McHugh was central to the cutoff of funding of transgender healthcare in the late 1970’s and early 1980’s, including the closure of the transgender surgery program at Johns Hopkins in 1979, leading to the federal restriction of funding for transgender health in 1981. He became active again opposing transgender health funding when the 1981 decision was reversed in 2014. In the interim, he was best known for making public his views outside the medical mainstream on broad range of issues, from the use of stem cells in medical research to the alleged “dangers” of marriage by same-sex couples. Dr. McHugh is indeed a vociferous opponent of LGBTQ rights, as he considers homosexuality an “erroneous desire” and has advocated against any medical treatment for gender dysphoria. He has submitted multiple amicus briefs to the U.S. Supreme Court opposing marriage for same-sex couples and regarding which restrooms

transgender youth should use. Yet, Dr. McHugh is not currently a provider of transgender care nor a researcher of transgender health, and his direct experience in the field in the past has been limited.

63. Dr. McHugh states: “There are no long-term, peer-reviewed published, reliable and valid, research studies documenting the reliability and validity of *assessing* gender identity by relying solely upon the unverified statements of a patient.” As a psychiatrist, Dr. McHugh must know that most DSM-5 psychiatric diagnoses are made via the psychiatric interview of the patient. The diagnosis of Gender Dysphoria under the DSM-5 is made the same way as other DSM diagnoses, through an interview in which the health professional determines if DSM-5 diagnostic criteria are met. Mental health professionals are well-trained to conduct such interviews. The validity and reliability of DSM-5 diagnoses were assessed and determined in the process of creating the DSM-5. Clinicians do not simply defer to the reported experiences of the patient, but instead rely on the application of professional experience and expertise to assess whether the patient meets the relevant diagnostic criteria. Similarly, the ICD-11 diagnosis of Gender Incongruence is made by interview of the patient. The World Health Organization conducted field studies internationally on the reliability and validity of the Gender Incongruence diagnosis of ICD-11.

64. Dr. McHugh cites a survey by Lisa Littman of participants on discussion websites for parents who opposed their children’s gender transition and derived a theory that adolescents develop gender dysphoria via social contagion. This survey has been contradicted by the World Professional Association for Transgender Health. The survey was of parents’ perception after learning of their children’s transgender identity, rather than of the children themselves, and conflicts with the experience of those who work with the children themselves. No conclusions can be drawn from the Littman survey other than the fact that some anonymous people recruited from

internet sites who opposed transition care for youth speculate that transgender identity is due to social contagion. This speculation from anonymous people online does not constitute a reliable source, and does not establish a true phenomenon. No study to date has demonstrated that the determinant of gender identity is psychosocial.

65. Furthermore, noting the serious flaws with the Littman survey, a correction to the article was later published, which noted that, “Rapid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis at this time” and that the “report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon.” The correction goes on to say that “the term should not be used in any way to imply that it explains the experiences of all gender dysphoric youth.”

66. Dr. McHugh states that medical and surgical care for transgender people are experimental and unproven. Transgender care has been studied for over half a century, and there is substantial evidence that it improves quality of life and measures of mental health. (Cornell, “What We Know” review).

67. Dr. McHugh states that some transgender children do not persist with their cross-gender identification into adolescence. However, puberty blockers, hormones, and surgery are not provided to pre-pubertal children, and the desistance of gender dysphoria to which Dr. McHugh refers, to the extent it happens, occurs *before* puberty. It is also important to keep in mind that the studies on which Dr. McHugh relies pertain to gender nonconforming children diagnosed with “Gender Identity Disorder in Children” under the DSM III-R and DSM-IV, which included children who are not transgender. One could meet criteria for the DSM III-R or DSM-IV diagnosis of Gender Identity Disorder without identifying as transgender because the diagnostic criteria did not require identification with a gender other than the one assigned to the person at birth, as is

required under the DSM-5 for “Gender Dysphoria in Children.” Moreover, research shows that Gender Dysphoria is unlikely to desist in adolescence and adulthood, and that is when treatment begins. Hence all of the debate about desistance of gender dysphoria in pre-pubescent children is irrelevant to the debate over medical and surgical treatment.

68. Dr. McHugh states: “Medical treatments may differ significantly by sex according to chromosomal assessment but not by gender identity.” People born with complete androgen insensitivity syndrome have XY chromosomes but are assigned female at birth and usually identify as female. Chromosomal sex is not the basis of treatment for transgender people, but rather the presence or absence of gender dysphoria.

Dr. Hruz’s Report

69. Dr. Hruz is not a psychiatrist or psychologist and his use of the DSM in his ordinary work as a pediatrician is therefore limited.

70. Dr. Hruz says that “[t]he reliability and validity of the term ‘gender identity’ is controversial and not accepted by the relevant scientific community.” The term “gender identity” is credited to Dr. Robert Stoller, a professor of psychiatry at UCLA. Dr. Stoller started the Gender Identity Clinic in 1963. The use of the term has been well established in the intervening years since 1963. It is used in research and medicine, and by every major medical organization in the United States.

71. Dr. Hruz repeats the assertion that the diagnosis of Gender Dysphoria lacks validity and reliability. Validity and reliability of each diagnosis in DSM-5 were field tested prior to inclusion.

72. Dr. Hruz dismisses the reliability of psychiatrists and psychologists to make the DSM diagnosis of Gender Dysphoria. Psychiatrists and psychologists have many years of training

to make diagnoses, which are made primary by the clinical interview with the patient. This process is similar to that of diagnosing other DSM diagnoses, to determine treatment for other disorders. The process of taking a history of symptoms from a patient is not only used to determine most psychiatric treatment, but also many medical and pediatric treatments. It is surprising to hear any medical professional dismiss the importance of taking a good history from a patient. Even medical disorders that rely on blood tests and imaging for a definitive diagnosis rely first on taking a history to know which tests to order.

73. Mental health professionals have years in training in determining diagnoses. In my clinical experience, we have not seen people play-acting being transgender at the behest of YouTube influencers as Dr. Hruz contends, but we are confident we would recognize this if it were to happen.

74. Dr. Hruz correctly states that Cognitive Behavioral Therapy (CBT) is effective for depressive and anxiety disorders, and questions why CBT is not used to change gender identity. The answer is simple: CBT has been demonstrated effective to treat depression and anxiety but not to change gender identity. However, CBT is commonly used in transgender patients who have depression and anxiety to help alleviate these symptoms, as it is used in patients who are not transgender.

75. Dr. Hruz discusses the “watchful waiting” of pre-pubescent children. Note that the debate over desistance in pre-pubertal children and of watchful waiting versus affirming approaches is for the period of life before medical and surgical interventions are warranted. “Watchful waiting” was coined by the same Dutch researchers who pioneered the use of puberty blockers once the same children reached puberty, and found that puberty blockers, hormones, and later surgery successfully treated gender dysphoria in the same youth once they were of

developmental stage for puberty blockers. The result was that mental health outcomes significantly improved in the youth who received transition care in the study. (de Vries, et al., 2014). Other studies have also shown improvement in mental health measures in trans youth with gender-affirming medical treatment. (van der Miesen, et al., 2020; Kuper, et al., 2020). It is important to emphasize that in the Dutch research, the youth who were going to desist from the gender identity disorder diagnosis were not treated with medications and surgery, and desistance occurred before puberty. The youth whose gender dysphoria persisted to puberty, and who were therefore treated, did not have a reversion to the gender identity congruent with sex assigned at birth, nor did any research participants who transitioned experience regret at doing so.

76. Dr. Hruz mentions ratings of quality of evidence for transgender care. Randomized, controlled, blinded trials of whether a child or adult is allowed to transition are not possible. Often evidence is derived from lesser-graded evidence, not only for transgender care, but for many treatments for which randomized, controlled, blinded trials are not possible.

77. Dr. Hruz states in paragraph 57 of his report (all caps are his): “INTERVENTIONS (‘TREATMENTS’) OF CHILDREN WITH POTENTIALLY HARMFUL HORMONES TO INTERVENE IN THE LIFE OF A CHILD WHO IS HIGHLY LIKELY (80%+) TO RESOLVE THE GENDER DYSPHOTIA [sic] ISSUE NATURALLY IS RISKY, UNSCIENTIFIC and UNETHICAL. IATROGENIC DAMAGES TO PATIENTS.” This shows Dr. Hruz’s misunderstanding of the care of transgender children. The data on children who desist are on pre-pubertal children who were diagnosed with “gender identity disorder in children.” When children persist with gender dysphoria, it is persistent into adolescence. By that phase of the child’s life, the child is unlikely to desist. In early adolescence, the child may be treated with puberty blockers, which delay the onset of puberty but are reversible as an intervention by simply stopping the

medication. Puberty blockers are also used in children who are not transgender but experience puberty early, so that they can go through puberty with their peers. It is not until later in adolescence, when it is clear to the adolescent's care providers that the gender identity is stable and persistent, that cross-sex hormones are started. At that point, the patient is better able to understand the risks and benefits of treatment, and the parents also must consent. Note that this informed consent includes a discussion of options for the preservation of reproductive capacity.

78. The continued discussion in the ensuing paragraphs of Dr. Hruz's report reflects a misunderstanding of the point in the child's life at which irreversible interventions are employed. The pre-pubertal child is not treated with medications. After the start of puberty, a youth experiencing the onset of puberty may be treated with puberty blockers, but these treatments are reversible, and if stopped the youth will undergo a normal puberty. Later in adolescence, when the adolescent and parents, in consultation with mental health professionals and pediatricians, have had time to ensure that change in gender identity is unlikely, the adolescent may start cross-sex hormones, with the consent of parents and agreement of mental health and medical professionals.

79. Outcomes of gender affirming care have been observed for over 60 years, with a study of 50 years of the experience of gender clinics in Sweden showing that regret is rare (Dhejne, et al., 2014).

Dr. Lappert's Report

80. Dr. Lappert is a cosmetic plastic surgeon who, per his "Lappert Skin Care" practice website, provides his patients with botox treatment, Juvederm fillers, treatment of age spots, and tattoo removal. Dr. Lappert reports that he has taken care of transgender patients when they have appeared in his office with skin issues. But his background is not in transgender health, nor does he have experience in mental health and making diagnoses using the DSM-5.

81. Dr. Lappert has a misunderstanding of how DSM-5 diagnoses are made. Psychiatrists, psychologists, and other mental health professionals take histories from patients and use their years of training to make diagnoses. DSM-5 diagnoses are the basis of the medical treatment of depression, anxiety, schizophrenia, and other mental disorders, and well as for psychotherapy treatments. Gender Incongruence is a diagnosis in the ICD-11. The ICD is used to make medical as well as mental health diagnoses.

82. Dr. Lappert states that children who may desist from gender dysphoria are treated with irreversible interventions. Again, this is based on studies looking at children using the more expansive “gender identity disorder in children” diagnosis contained in the DSM III-R and DSM IV, and not on the “gender dysphoria in children” diagnosis contained in the DSM-5. In any event, any desistance happens *before* puberty, and no irreversible interventions are considered until well into adolescence, *after* puberty.

83. Dr. Lappert discusses regret by those who have received transition care. Over 50 years of experience in Swedish gender clinics, the regret rate was 2%. By contrast, in Dr. Lappert’s field of cosmetic plastic surgery, one poll shows that the regret rate among those having cosmetic plastic surgery was 65%. (<https://www.medicalaccidentgroup.co.uk/news/two-thirds-brits-regret-cosmetic-surgery/>). There have been few randomized, blinded clinical trials of the efficacy of many cosmetic plastic surgery interventions, or much study of how to help heal those who regret cosmetic plastic surgery interventions. Regret rates for transgender surgery thankfully are far lower. A pooled review of 7,928 patients receiving gender affirming surgery showed a regret rate of 1%. (Bustos, et al., 2021). Informed consent lets patients know the risks and benefits of the surgical interventions they plan to have, including the risk of regret.

84. Dr. Lappert states, “A large percentage of children (over 80% in some studies) ... will, if left alone, develop an acceptance of their natal (biological) sex.” This statement misconstrues earlier studies and is inaccurate for the reasons explained above.

III. CONCLUSION

85. Drs. McHugh, Levine, Hruz, and Lappert present a perspective on transgender health that is far from the mainstream medicine and mental health practices. The practice of transgender health and the medical necessity of the provision of health care to treat gender dysphoria is well established. Transgender patients benefit from gender affirming healthcare and regret rates are very low.

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

Executed this 30th day of May, 2021.



Dan H. Karasic, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on June 1, 2021, I caused a copy of the foregoing document and all attachments to be served upon the following parties via email:

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Exhibit 27(b)

Exhibit A

Curriculum vitae

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CURRICULUM VITAE**

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EDUCATION

1978 - 1982	Occidental College, Los Angeles	A.B.; Summa Cum Laude	Biology
1982 - 1987	Yale University School of Medicine	M.D.	Medicine
1987 - 1988	University of California, Los Angeles	Intern	Medicine, Psychiatry, and Neurology
1988 - 1991	University of California, Los Angeles; Neuropsychiatric Institute	Resident	Psychiatry
1990 - 1991	University of California, Los Angeles; Department of Sociology	Postdoctoral Fellow	Training Program in Mental Health Services for Persons with AIDS

LICENSES, CERTIFICATION

1990 Medical Licensure, California, License Number G65105

1990 Drug Enforcement Administration Registration Number BK1765354

1993 American Board of Psychiatry and Neurology, Board Certified in Psychiatry

PRINCIPAL POSITIONS HELD

1991 - 1993	University of California, San Francisco	Health Sciences Psychiatry Clinical Instructor
1993 - 1999	University of California, San Francisco	Health Sciences Psychiatry Assistant Clinical

		Professor
1999 - 2005	University of California, San Francisco	Health Sciences Psychiatry Associate Clinical Professor
2005 - present	University of California, San Francisco	Health Sciences Psychiatry Clinical Professor

OTHER POSITIONS HELD CONCURRENTLY

1980 - 1980	Associated Western Universities / U.S. Department of Energy	Honors Undergraduate Research Fellow	UCLA Medicine
1981 - 1981	University of California, Los Angeles; Medicine American Heart Association, California Affiliate	Summer Student Research Fellow	UCLA
1986 - 1987	Yale University School of Medicine; American Heart Association, Connecticut Affiliate	Medical Student Research Fellow	Psychiatry
1990 - 1991	University of California, Los Angeles	Postdoctoral	Sociology Fellow
1991 - 2001	SFGH Consultation-Liaison Service; Attending AIDS Care	Psychiatry Psychiatrist	
1991 - 2001	AIDS Consultation-Liaison Medical Student Elective	Course Director	Psychiatry
1991 - present	UCSF Positive Health Program at San General Hospital (Ward 86)	HIV/AIDS Outpatient Psychiatrist	Psychiatry Francisco
1991 - present	UCSF AHP (AIDS Health Project/Alliance Health Project)	HIV/AIDS Outpatient Psychiatrist	Psychiatry
1994 - 2002	St. Mary's Medical Center CARE Unit. The CARE Unit specializes in the care of patients with AIDS dementia.	Consultant	Psychiatry
2001 - 2010	Depression and Antiretroviral Adherence Study (The H.O.M.E. study: Health Outcomes of Mood Enhancement)	Clinical Director	Psychiatry and Medicine
2003 - present	Transgender Life Care Program and Dimensions Clinic, Castro Mission Health Center	Psychiatrist Clinic	Dimensions
2013 - present	UCSF Alliance Health Project, Co-lead, Transgender Team	Co-Lead and Psychiatrist	Psychiatry

HONORS AND AWARDS

1981	Phi Beta Kappa Honor Society	Phi Beta Kappa
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1990	NIMH Postdoctoral Fellowship in Mental Health Services for People with AIDS (1990-1991)	National Institute of Mental Health
2001	Lesbian Gay Bisexual Transgender Leadership Award, LGBT Task Force of the Cultural Competence and Diversity Program	SFGH Department of Psychiatry
2006	Distinguished Fellow	American Psychiatric Association
2012	Chancellor's Award for Leadership in LGBT Health	UCSF

KEYWORDS/AREAS OF INTEREST

Psychiatry, HIV/AIDS, consultation-liaison, medication adherence, gay/lesbian, transgender, gender dysphoria, sexuality, homeless/marginally housed, mood disorders, teaching/supervision

CLINICAL ACTIVITIES SUMMARY

As psychiatrist for the Positive Health Practice at Ward 86, I evaluate and treat patients with psychiatric illness and HIV. I provide consultation to internists, fellows, and nurse practitioners on managing psychiatric illness in their patients. Clinical work includes attention to the needs of special populations, including working with a multidisciplinary team in a drop-in clinic for HIV-positive women, and addressing issues emerging in HIV and Hepatitis C co-infection. As psychiatrist at the UCSF Alliance Health Project, I evaluate and treat patients and I am co-chair of the Gender Team, which provides assessment and care for transgender patients. As psychiatrist for the Transgender Life Care program and Dimensions Clinic, I evaluate and treat transgender patients, working with a multidisciplinary team at Castro Mission Health Center. In my faculty practice, I treat transgender, gender dysphoric, and HIV-positive patients referred from providers across Northern California, and I provide consultation on challenging cases to psychologists and other psychotherapists working with transgender and gender dysphoric patients.

MEMBERSHIPS

- 1990 - present Association of Gay and Lesbian Psychiatrists
- 1992 - present Northern California Psychiatric Society
- 1992 - present American Psychiatric Association
- 2000 - present Bay Area Gender Associates (an organization of psychotherapists working with transgendered clients)
- 2001 - present World Professional Association for Transgender Health

SERVICE TO PROFESSIONAL ORGANIZATIONS

1981 - 1982	The Occidental	News Editor
1984 - 1985	Yale University School of Medicine	Class President
1989 - 1991	Kaposi's Sarcoma Group, AIDS Project Los Angeles	Volunteer Facilitator

1992 - 1996	Early Career Psychiatrist Committee, Association of Gay and Lesbian Psychiatrists	Chair and
1992 - 1996	Board of Directors, Association of Gay and Lesbian Psychiatrists	Member
1993 - 1993	Local Arrangements Committee, Association of Gay and Psychiatrists	Chair Lesbian
1994 - 1995	Educational Program, Association of Gay and Lesbian	Director Psychiatrists,
	1995 Annual Meeting	
1994 - 1998	Board of Directors, BAY Positives	Member
1994 - present	Committee on Lesbian, Gay, Bisexual and Transgender Issues, Northern California Psychiatric Society	Member
1995 - 1997	Board of Directors, Bay Area Young Positives. BAY Positives is the nation's first community-based organization providing psychosocial and recreational services to HIV-positive youth	President
1995 - 1997	Executive Committee, Bay Area Young Positives.	Chair
1996 - 2004	Committee on Lesbian, Gay, Bisexual and Transgender Issues, Northern California Psychiatric Society	Chair
1998 - 2002	City of San Francisco Human Rights Commission, Lesbian, Gay Bisexual Transgender Advisory Committee	Member
2000 - 2004	Association of Gay and Lesbian Psychiatrists. Vice President Responsible for the organization's educational programs	
2004 - 2005	Association of Gay and Lesbian Psychiatrists	President-elect
2005 - 2007	Caucus of Lesbian, Gay, and Bisexual Psychiatrists of the American Psychiatric Association	Chair
2005 - 2007	Association of Gay and Lesbian Psychiatrists	President
2007 - 2009	Association of Gay and Lesbian Psychiatrists	Immediate Past President
2009 - 2010	Consensus Committee for Revision of the Sexual and Gender Identity Disorders for DSM-V, GID of Adults subcommittee. (Wrote WPATH recommendations as advisory body to the APA DSM V Committee for the Sexual and Gender Identity Disorders chapter revision.)	Member
2010 - 2011	Scientific Committee, 2011 WPATH Biennial Symposium, Member Atlanta	
2010 - present	World Professional Association for Transgender Care Standards of Care Workgroup and Committee (writing next revision of the WPATH Standards of Care, which is used internationally for transgender care.)	Member
2010 - 2018	ICD 11 Advisory Committee, World Professional Association for Transgender Health	Member

2012 - 2014	Psychiatry and Diagnosis Track Co-chair, Scientific 2014 WPATH Biennial Symposium, Bangkok	Member Committee,
2014 - 2016	Scientific Committee, 2016 WPATH Biennial Symposium, Member	Amsterdam
2014 - 2018	Board of Directors (elected to 4 year term), World Professional Association for Transgender Health	Member
2014 - 2018	Public Policy Committee, World Professional Association Chair for Transgender Health	
2014 - 2018	WPATH Global Education Initiative: Training providers and specialty certification in transgender health	Trainer and and Steering Committee Member
2014 - 2016	American Psychiatric Association Workgroup on Gender	Member Dysphoria
2016 - present	American Psychiatric Association Workgroup on Gender	Chair Dysphoria
2016	USPATH: Inaugural WPATH U.S. Conference, Los Angeles, 2017	Conference Chair

SERVICE TO PROFESSIONAL PUBLICATIONS

- 2011 - present Journal of Sexual Medicine, reviewer
- 2014 - present International Journal of Transgenderism, reviewer
- 2016 - present LGBT Health, reviewer

INVITED PRESENTATIONS - INTERNATIONAL

2009	World Professional Association for Transgender Health, Oslo, Norway	Plenary Session Speaker
2009	World Professional Association for Transgender Health, Oslo, Norway	Symposium Speaker
2009	Karolinska Institutet, Stockholm Sweden	Invited Lecturer
2012	Cuban National Center for Sex Education (CENESEX), Havana, Cuba	Invited Speaker
2013	Swedish Gender Clinics Annual Meeting, Stockholm, Sweden	Keynote Speaker
2013	Conference on International Issues in Transgender care, United Nations Development Programme - The Lancet, Beijing, China	Expert Consultant
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Track Chair
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker

2015	European Professional Association for Transgender Health, Ghent, Belgium	Invited Speaker
2015	European Professional Association for Transgender Health, Ghent, Belgium	Symposium Chair
2015	Israeli Center for Human Sexuality and Gender Identity, Aviv	Invited Speaker Tel Aviv
2016	World Professional Association for Transgender Health, Amsterdam	Symposium Chair
2016	World Professional Association for Transgender Health, Amsterdam	Invited Speaker
2016	World Professional Association for Transgender Health, Amsterdam	Invited Speaker
2018	Brazil Professional Association for Transgender Health, Paulo	Sao
2018	World Professional Association for Transgender Health, Buenos Aires	Invited Speaker

INVITED PRESENTATIONS - NATIONAL

1990	Being Alive Medical Update, Century Cable Television	Televised Lecturer
1992	Institute on Hospital and Community Psychiatry, Toronto	Symposium Speaker
1992	Academy of Psychosomatic Medicine Annual Meeting, San Diego	Symposium Speaker
1994	American Psychiatric Association 150th Annual Meeting, Philadelphia	Workshop Chair
1994	American Psychiatric Association 150th Annual Meeting, Philadelphia	Workshop Speaker
1994	American Psychiatric Association 150th Annual Meeting, Philadelphia	Paper Session Co-chair
1995	Spring Meeting of the Association of Gay and Lesbian Psychiatrists, Miami Beach	Symposium Chair
1996	American Psychiatric Association 152nd Annual Meeting, New York	Workshop Speaker
1997	American Psychiatric Association Annual Meeting, San Diego	Workshop Speaker
1997	Gay and Lesbian Medical Association Annual	Invited Speaker Symposium
1998	American Psychiatric Association Annual Meeting, Toronto	Workshop Chair
1998	American Psychiatric Association Annual Meeting, Toronto	Workshop Chair

1998	American Psychiatric Association Annual Meeting, Toronto	Media Session Chair
1998	American Psychiatric Association Annual Meeting, Toronto	Media Session Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Presenter
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Workshop Chair
2000	American Psychiatric Association Annual Meeting, Chicago	Workshop Chair
2000	National Youth Leadership Forum On Medicine, University of California, Berkeley	Invited Speaker
2001	American Psychiatric Association Annual Meeting, New Orleans	Workshop Chair
2001	American Psychiatric Association Annual Meeting, New Orleans	Media Program Chair
2001	Association of Gay and Lesbian Psychiatrists Symposium, New Orleans	Chair
2001	Harry Benjamin International Gender Dysphoria Association Biennial Meeting, Galveston, Texas	Invited Speaker
2002	American Psychiatric Association Annual Meeting, Philadelphia	Media Program Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2003	Association of Gay and Lesbian Psychiatrists CME	Chair Conference
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Co-Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Workshop Chair
2003	American Public Health Association Annual Meeting, San Francisco	Invited Speaker
2004	Mission Mental Health Clinic Clinical Conference	Invited Speaker
2004	Association of Gay and Lesbian Psychiatrists	Co-Chair

	Conference, New York	
2004	Mental Health Care Provider Education Program: Los Angeles. Sponsored by the American Psychiatric Association Office of HIV Psychiatry	Invited Speaker
2005	American Psychiatric Association Annual Meeting, Atlanta	Workshop Speaker
2005	Association of Gay and Lesbian Psychiatrists Saturday Symposium	Invited Speaker
2008	Society for the Study of Psychiatry and Culture, San Francisco	Invited Speaker
2009	American Psychiatric Association Annual Meeting, San Francisco	Symposium Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Chair
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Speaker
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	Invited Speaker
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	Invited Speaker

Invited Speaker

2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	
2011	Institute on Psychiatric Services, San Francisco	Invited Speaker
2012	Gay and Lesbian Medical Association Annual Meeting	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	American Psychiatric Association Annual Meeting, San Francisco	Invited Speaker
2013	Gay and Lesbian Medical Association, Denver, CO	Invited Speaker
2014	American Psychiatric Association Annual Meeting, New York	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Moderator
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Workshop Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Course Faculty
2016	American Psychiatric Association Annual Meeting	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Atlanta	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Springfield, MO	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Fort Lauderdale, FL	Course Faculty
2017	World Professional Association for Transgender Health, GEI, Los Angeles	Course Faculty
	World Professional Association for Transgender Health	

Surgeon's Training, Irvine, CA Course Faculty

- 2017 American Urological Association Annual Meeting, San Francisco CA
Invited Speaker
- 2018 World Professional Association for Transgender Health GEI, Portland OR,
Course Faculty
- 2018 World Professional Association for Transgender Health GEI, Palm Springs,
Course Faculty
- 2018 American Society for Adolescent Psychiatry Annual Meeting, San Francisco,
Speaker
- 2018 American Psychiatric Association Annual Meeting, San Francisco, Session
Chair

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

- 1990 Advanced Group Therapy Seminar, UCLA Invited Lecturer
Neuropsychiatric Institute
- 1991 Joint Project of the Southern California AIDS Interfaith Symposium
Council and UCLA School of Medicine Speaker
- 1991 Joint Project of the Southern California AIDS Interfaith Workshop Panelist
Council and UCLA School of Medicine
- 1992 Advanced Group Therapy Seminar, UCLA Invited Lecturer
Neuropsychiatric Institute
- 1993 UCSF School of Nursing Invited Lecturer
- 1995 UCSF/SFGH Department of Medicine Clinical Care Invited Speaker
Conference
- 1996 UCSF School of Nursing Invited Speaker
- 1996 Psychopharmacology for the Primary Care AIDS/Clinician, Invited Lecturer
series of four lectures, UCSF Department of Medicine
- 1996 UCSF AIDS Health Project Psychotherapy Internship
Training Program
- 1996 UCSF/SFGH Department of Medicine AIDS Quarterly Invited Speaker
Update
- 1996 San Francisco General Hospital, Division of Addiction Invited Speaker
Medicine

1996	UCSF Langley Porter Psychiatric Hospital and Clinics Rounds	Invited Speaker Invited Speaker Grand
1997	UCSF School of Nursing	Invited Speaker
1997	UCSF Department of Medicine AIDS Program	Invited Speaker
1997	Northern California Psychiatric Society Annual Meeting, Monterey	Workshop Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	Northern California Psychiatric Society LGBT Committee Chair Fall Symposium	
1997	Progress Foundation, San Francisco	Invited Speaker
1998	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1999	Northern California Psychiatric Society Annual Meeting, Santa Rosa	Invited Speaker
1999	Northern California Psychiatric Society Annual Meeting, Santa Rosa	Invited Speaker
1999	University of California, Davis, Department of Psychiatry Grand Rounds	Invited Speaker Grand
1999	California Pacific Medical Center Department of Grand Rounds	Invited Speaker Psychiatry
1999	San Francisco General Hospital Department of Psychiatry Departmental Case Conference	Discussant
2000	Langley Porter Psychiatric Hospital and Clinics Consultation Liaison Seminar	Invited Speaker
2000	San Francisco General Hospital, Psychopharmacology Seminar	Invited Speaker
2000	UCSF Transgender Health Conference, Laurel Heights Conference Center	Invited Speaker
2000	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2000	Community Consortium Treatment Update Symposium, California Pacific Medical Center, Davies Campus	Invited Speaker
2000	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker

2001	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2003	Tom Waddell Health Center Inservice	Invited Speaker
2003	San Francisco Veterans Affairs Outpatient Clinic	Invited Speaker
2004	San Francisco General Hospital Psychiatric Emergency Service Clinical Conference	Invited Speaker
2004	South of Market Mental Health Clinic, San Francisco	Invited Speaker
2005	Northern Psychiatric Society Annual Meeting	Invited Speaker
2005	Equality and Parity: A Statewide Action for Transgender Prevention and Care, San Francisco	Invited Speaker HIV
2005	San Francisco General Hospital Department of Psychiatry Grand Rounds.	Invited Speaker
2006	SFGH/UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2007	UCSF Department of Medicine, HIV/AIDS Grand Rounds, Positive Health Program	Invited Speaker
2007	California Pacific Medical Center LGBT Health, San Francisco LGBT Community Center	Invited Speaker Symposium,
2007	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2008	UCSF Department of Medicine, Positive Health Program, HIV/AIDS Grand Rounds	Invited Speaker
2008	San Francisco General Hospital Psychiatry Grand Rounds	Invited Speaker
2008	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2010	Northern California Psychiatric Society Annual Meeting, Monterey, CA	Invited Speaker
2011	Transgender Mental Health Care Across the Life Span, Stanford University	Invited Speaker
2011	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
2012	UCSF AIDS Health Project Veterans Affairs Medical Center.	Invited Speaker 2012 San Francisco
2013	Association of Family and Conciliation Courts Conference, Los Angeles, CA	Invited Speaker
2014	UCSF Transgender Health elective	Invited Speaker
2014	UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2014	California Pacific Medical Center Department of Psychiatry Grand Rounds	Invited Speaker

2014	UCLA Semel Institute Department of Psychiatry Grand Rounds	Invited Speaker Invited Speaker
2015	UCSF Transgender Health elective	Invited Speaker
2015	Fenway Health Center Boston, MA (webinar)	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Co-Chair
2015	Santa Clara Valley Medical Center Grand Rounds	Invited Speaker
2016	UCSF School of Medicine Transgender Health elective	Invited Speaker
2016	Langley Porter Psychiatric Institute APC Case Conference	Invited Speaker (2 session series)
2016	Zuckerberg San Francisco General Department of Psychiatry Grand Rounds	Invited Speaker
2016	UCSF Mini-Medical School Lectures to the Public	Invited Speaker

CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT ACTIVITIES

2005	Northern California Psychiatric Society
2005	Northern California Psychiatric Society Annual Meeting, Napa
2005	Association of Gay and Lesbian Psychiatrist Annual Conference
2006	Annual Meeting, American Psychiatric Association, Atlanta
2006	Annual Meeting, American Psychiatric Association, Toronto
2006	Institute on Psychiatric Services, New York
2007	Association of Gay and Lesbian Psychiatrists Annual Conference
2007	American Psychiatric Association Annual Meeting, San Diego
2007	The Medical Management of HIV/AIDS, a UCSF CME Conference
2008	Society for the Study of Psychiatry and Culture, San Francisco
2009	American Psychiatric Association, San Francisco
2009	World Professional Association for Transgender Health, Oslo, Norway
2010	Annual Meeting of the Northern California Psychiatric Society, Monterey, CA
2011	Transgender Mental Health Care Across the Life Span, Stanford University
2011	National Transgender Health Summit, San Francisco
2011	American Psychiatric Association Annual Meeting, Honolulu, HI
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA

2011	Institute on Psychiatric Services, San Francisco
2012	Gay and Lesbian Medical Association Annual Meeting, San Francisco
2013	National Transgender Health Summit, Oakland, CA
2013	American Psychiatric Association Annual Meeting, San Francisco
2013	Gay and Lesbian Medical Association, Denver, CO
2014	American Psychiatric Association Annual Meeting, New York
2014	Institute on Psychiatric Services, San Francisco
2015	European Professional Association for Transgender Health, Ghent, Belgium
2015	National Transgender Health Summit, Oakland
2015	American Psychiatric Association Annual Meeting, Toronto
2016	American Psychiatric Association Annual Meeting, Atlanta
2016	World Professional Association for Transgender Health, Amsterdam

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

1998 - 2002 City and County of San Francisco Human Rights Member Commission LGBT Advisory Committee

SERVICE ACTIVITIES SUMMARY

My current service work focuses on developing transgender care at UCSF, nationally, and internationally.

I worked with urologist Maurice Garcia, MD on developing protocols as well as outcome measures for the UCSF Transgender Surgery Program at UCSF Medical Center. I am on the Medical Advisory Board of the UCSF Center of Excellence for Transgender Care, and have cowritten the mental health section of the original Primary Care Protocols and the new revision. I have chaired the Mental Health Track of UCSF's National Transgender Health Summit since its inception in 2011. I am a founder and co-chair of the Gender Team at the UCSF Alliance Health Project. I helped develop, and participated as a trainer, in the San Francisco

Department of Public Health provider training program for care of transgender patients and for mental health assessments for surgery, and have worked in program development for the SFDPH Transgender Health Services surgery program.

I am the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, which developed a CME course for the 2015 and 2016 APA Annual Meetings, and is now embarking on a larger educational mission to train American psychiatrists to better care for transgender patients. I have been leading education efforts in transgender health at APA meetings since 1998. On the APA Workgroup on Gender Dysphoria, I am a co-author of a paper of transgender issues that has been approved by the American Psychiatric Association as a resource document and is in press for the American Journal of Psychiatry. I am also the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

I am active internationally in transgender health through my work as a member of the Board of Directors of the World Professional Association for Transgender Health. I am an author of the WPATH Standards of Care, Version 7, and am Chapter Lead for the Mental Health Chapter of SOC 8. I chaired the WPATH Public Policy Committee and was a member of the Global Education Initiative, which developed a specialty certification program in transgender health. I helped plan the 2016 WPATH Amsterdam conference, and was on the scientific committee for the last four biennial international conferences. I was on the founding committee of USPATH, the national affiliate of WPATH, and I chaired the inaugural USPATH conference, in Los Angeles in 2017. As a member of the steering committee of the WPATH Global Educational Initiative, I helped train over 1000 health providers in transgender health, and helped develop a board certification program and examination in transgender health.

UNIVERSITY SERVICE UC SYSTEM AND MULTI-CAMPUS SERVICE

1991 - present	HIV/AIDS Task Force	Member
1992 - 1993	HIV Research Group	Member
1992 - 1997	Space Committee	Member
1992 - present	Gay, Lesbian and Bisexual Issues Task Force	Member
1994 - 1997	SFGH Residency Training Committee	Member
1996 - 1997	Domestic Partners Benefits Subcommittee.	Chair
1996 - 2000	Chancellor's Advisory Committee on Gay, Lesbian, and Transgender Issues.	Member Bisexual
1996 - 2003	HIV/AIDS Task Force	Co-Chair
1996 - 2003	Cultural Competence and Diversity Program	Member
2009 - present	Medical Advisory Board, UCSF Center of Excellence for Transgender Health	Member
2010 - present	Steering Committee, Child Adolescent Gender Center	Member
2011 - present	Mental Health Track, National Transgender Health Summit	Chair

DEPARTMENTAL SERVICE

1991 - present San Francisco General Hospital, Department of Psychiatry, Member HIV/AIDS Task Force

- 1992 - 1993 San Francisco General Hospital, Department of Psychiatry, Member HIV Research Group
- 1992 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Space Committee
- 1992 - 2003 San Francisco General Hospital, Department of Psychiatry, Member GLBT Issues Task Force
- 1994 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Residency Training Committee
- 1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Member Cultural Competence and Diversity Program
- 1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Co-Chair HIV/AIDS Task Force
- 2012 - present San Francisco Department of Public Health Gender Competence Trainings Committee Member
- 2013 - present San Francisco Department of Public Health Transgender Health Implementation Task Force Member
- 2014 - present San Francisco General Hospital, Department of Psychiatry, Member Transgender Surgery Planning Workgroup

PEER REVIEWED PUBLICATIONS

1. Berliner JA, Frank HJL, **Karasic D**, Capdeville M. Lipoprotein-induced insulin resistance in aortic endothelium. *Diabetes*. 1984; 33:1039-44.
2. Bradberry CW, **Karasic DH**, Deutch AY, Roth RH. Regionally-specific alterations in mesotelencephalic dopamine synthesis in diabetic rats: association with precursor tyrosine. *Journal of Neural Transmission. General Section*, 1989; 78:221-9.
3. Targ EF, **Karasic DH**, Bystritsky A, Diefenbach PN, Anderson DA, Fawzy FI. Structured group therapy and fluoxetine to treat depression in HIV-positive persons. *Psychosomatics*. 1994; 35:132-7.
4. Karasic DH. Homophobia and self-destructive behaviors. *The Northern California Psychiatric Physician*. 1996; 37 Nov.-Dec. Reprinted by the Washington State Psychiatric Society and the Southern California Psychiatric Society newsletters.
5. Karasic D. Anxiety and anxiety disorders. *Focus*. 1996 Nov; 11(12):5-6. PMID: 12206111
6. Polansky JS, **Karasic DH**, Speier PL, Hastik KL, Haller E. Homophobia: Therapeutic and training considerations for psychiatry. *Journal of the Gay and Lesbian Medical Association*. 1997 1(1) 41-47.
7. Karasic DH. Progress in health care for transgendered people. Editorial. *Journal of the Gay and Lesbian Medical Association*, 4(4) 2000 157-8.
8. Perry S, **Karasic D**. Depression, adherence to HAART, and survival. *Focus: A Guide to AIDS Research and Counseling*. 2002 17(9) 5-6.

9. Fraser L, **Karasic DH**, Meyer WJ, Wylie, K. Recommendations for Revision of the DSM Diagnosis of Gender Identity Disorder in Adults. *International Journal of Transgenderism*. Volume 12, Issue 2. 2010, Pages 80-85.
10. Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., **Karasic D** and 22 others. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version. *International Journal of Transgenderism*, 13:165-232, 2011
11. Tsai AC, **Karasic DH**, et al. Directly Observed Antidepressant Medication Treatment and HIV Outcomes Among Homeless and Marginally Housed HIV-Positive Adults: A Randomized Controlled Trial. *American Journal of Public Health*. February 2013, Vol. 103, No. 2, pp. 308-315.
12. Tsai AC, Mimmiaga MJ, Dilley JW, Hammer GP, **Karasic DH**, Charlebois ED, Sorenson JL, Safren SA, Bangsberg DR. Does Effective Depression Treatment Alone Reduce Secondary HIV Transmission Risk? Equivocal Findings from a Randomized Controlled Trial. *AIDS and Behavior*, October 2013, Volume 17, Issue 8, pp 2765-2772.
13. **Karasic DH**. Protecting Transgender Rights Promotes Transgender Health. *LGBT Health*. 2016 Aug; 3(4):245-7. PMID: 27458863
14. Winter S, Diamond M, Green J, **Karasic D**, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. *Lancet*. 2016 Jul 23;388(10042):390-400. doi: 10.1016/S0140-6736(16)00683-8. Review./> PMID: 27323925
15. Grelotti DJ, Hammer GP, Dilley JW, **Karasic DH**, Sorensen JL, Bangsberg DR, Tsai AC. Does substance use compromise depression treatment in persons with HIV? Findings from a randomized controlled trial. *AIDS Care*. 2016 Sep 2:1-7. [Epub ahead of print]/> PMID: 27590273
16. Strang JF, Meagher H, Kenworthy L, de Vries AL, Menvielle E, Leibowitz S, Janssen A, Cohen-Kettenis P, Shumer DE, Edwards-Leeper L, Pleak RR, Spack N, **Karasic DH**, Schreier H, Balleur A, Tishelman A, Ehrensaft D, Rodnan L, Kushner ES, Mandel F, Caretto A, Lewis HC, Anthony LG. Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. *J Clin Child Adolesc Psychol*. 2016 Oct 24:1-11. [Epub ahead of print]/> PMID: 27775428
17. Milrod C, **Karasic DH**. Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States. *J Sex Med* 2017;14:624–634.
18. **Karasic, DH** & Fraser, L. Multidisciplinary Care and the Standards of Care for Transgender and Gender Non-conforming Individuals. Schechter, L & Safa, B. (Eds.) *Gender Confirmation Surgery, Clinics in Plastic Surgery Special Issue*, Vol 45, Issue 3, pp 295-299. 2018 Elsevier, Philadelphia. <https://doi.org/10.1016/j.cps.2018.03.016>
19. Milrod C, Monto M, **Karasic DH**. Recommending or Rejecting "the Dimple": WPATH-Affiliated Medical Professionals' Experiences and Attitudes Toward Gender-Confirming Vulvoplasty in Transgender Women. [J Sex Med](#). 2019 Apr;16(4):586-595. doi: 10.1016/j.jsxm.2019.01.316. Epub 2019 Mar 2.

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1. **Karasic DH**, Dilley JW. Anxiety and depression: Mood and HIV disease. In: The UCSF AIDS Health Project Guide to Counseling: Perspectives on Psychotherapy, Prevention, and Therapeutic Practice. Dilley JW and Marks R, eds. Jossey-Bass. San Francisco, 1998, pp.227-248.
2. **Karasic DH**, Dilley JW. Human immunodeficiency-associated psychiatric disorders. In: The AIDS Knowledge Base, Third Edition. Cohen PT, Sande MA, Volberding PA, eds. Lippincott-Williams &Wilkins, Philadelphia, 1999, pp. 577-584.
3. **Karasic DH** and Drescher J. eds. Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation. 2005. Haworth Press, Binghamton, NY. (Book Co-Editor)
4. **Karasic DH**. Transgender and Gender Nonconforming Patients. In: Clinical Manual of Cultural Psychiatry, Second Edition. Lim RF ed. pp 397-410. American Psychiatric Publishing, Arlington VA. 2015.
5. **Karasic DH**. Mental Health Care of the Transgender Patient. In: Comprehensive Care of the Transgender Patient, Ferrando CA ed. pp. 8-11. Elsevier, 2019.
6. **Karasic DH**. The Mental Health Assessment for Surgery. In: Gender Confirmation Surgery – Principles and Techniques for an Emerging Field. Schechter L ed. Springer Nature, in press 2019.

OTHER PUBLICATIONS

1. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Treatment issues. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base. Waltham, MA: The Medical Publishing Group/ Massachusetts Medical Society. 1994. pp. 5.31-1-5.
2. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Clinical syndromes and diagnosis. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base, Second Edition. Waltham, MA: The Medical Publishing Group/Massachusetts Medical Society. 1994 pp. 5.30-1-5.
3. **Karasic DH**. A primer on transgender care. In: Gender and sexuality. The Carlat Report Psychiatry. April 2012. Vol 10, Issue 4.
4. **Karasic D and Ehrensaft D**. We must put an end to gender conversion therapy for kids. Wired. 7/6/15.

EXPERT WITNESS AND CONSULTATION ON TRANSGENDER CARE AND RIGHTS

2008 Consultant, California Department of State Hospitals

2012 Dugan v. Lake, Logan UT

2012 XY v. Ontario <http://www.canlii.org/en/on/onhrt/doc/2012/2012hrto726/2012hrto726.html>

2014 Cabading v California Baptist University

2014 CF v. Alberta

<http://www.canlii.org/en/ab/abqb/doc/2014/2014abqb237/2014abqb237.html>

2017 United Nations Development Programme consultant, transgender health care and legal rights in the Republic of Vietnam; Hanoi.

2017- Forsberg v Saskatchewan; Saskatchewan Human Rights v Saskatchewan

2018 <https://canliiconnects.org/en/summaries/54130>

<https://canliiconnects.org/en/cases/2018skqb159>

2018 United Nations Development Programme consultant, transgender legal rights in Southeast Asia; Bangkok.

2018 Consultant, California Department of State Hospitals

2019, 2021 Consultant/Expert, Disability Rights Washington

2019, 2021 Consultant/Expert, ACLU Washington

2021 Consultant, California Department of Corrections and Rehabilitation

Exhibit 27(c)

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Exhibit 28



Deposition of:
Patrick Lappert, M.D.

September 30, 2021

In the Matter of:
Kadel, et al vs. Folwell

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1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

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7 CIVIL ACTION NO.: 1:19-cv-272-LCB-LPA

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9 MAXWELL KADEL, et al.

10 Plaintiffs

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12 v.

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14 DALE FOLWELL, et al.

15 Defendants

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18 REMOTE VIDEOTAPED VIDEOCONFERENCE

19 DEPOSITION TESTIMONY OF:

20 PATRICK LAPPERT, M.D.

21 September 30, 2021

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I N D E X

EXAMINATION BY:	PAGE
Mr. Tishyevich	11
Mr. Knepper	472
REEXAMINATION BY:	
Mr. Tishyevich	489

E X H I B I T S

FOR THE PLAINTIFFS:	MARKED
Exhibit 1 Lappert Expert Report	12
Exhibit 2 ABPlasticSurgery.org	27
Exhibit 3 Brandt - Lappert Declaration	34
Exhibit 4 Brandt - Supplemental Order, 08/02/2021	37
Exhibit 5 Utah Legislature - Answers for Joint Interim Committee	55
Exhibit 6 "Alabama bill that would criminalize treatment for transgender minors headed to full Alabama Senate,"	62

1	rocketcitynow.com		
2	Exhibit 7	ASPS - "State Focus on	108
3		Gender Affirmation	
4		Intensifies"	
5	Exhibit 8	ASPS - 2021 State Policy	116
6		Priorities	
7	Exhibit 9	Lappert Resumé	127
8	Exhibit 10	Code of Ethics of the	171
9		American Society of Plastic	
10		Surgeons	
11	Exhibit 11	Federal Register, Vol, 59,	223
12		No. 22 - November 18, 1994	
13	Exhibit 12	FDA, Understanding	230
14		Unapproved Use of Approved	
15		Drugs "Off Label"	
16	Exhibit 13	FDA, "Off-Label" and	232
17		Investigational Use of	
18		Marketed Drugs, Biologics,	
19		and Medical Devices	
20	Exhibit 14	American Academy of	239
21		Pediatrics Policy Statement,	
22		Off-Label Use of Drugs in	
23		Children	

1	Exhibit 15	Yackey, Off-label Medication	256
2		Prescribing Patterns in	
3		Pediatrics: An Update	
4	Exhibit 16	FDA Botox Cosmetic	263
5		2017-10-02 Approval Letter	
6	Exhibit 17	Sugrue 2019, Levels of	299
7		Evidence in Plastic and	
8		Reconstructive Surgery	
9		Research: Have We Improved	
10		Over the Past 10 Years?	
11	Exhibit 18	Reversal Surgery in	326
12		Regretful Male-to-Female	
13		Transsexuals After Sex	
14		Reassignment Surgery	
15		(Djordjevic)	
16	Exhibit 19	(Exhibit number not used)	---
17	Exhibit 20	Wiepjes 2018, The Amsterdam	339
18		Cohort of Gender Dysphoria	
19		Study (1972-2015)	
20	Exhibit 21	Wilson 2017, Regret In	355
21		Surgical Decision Making: A	
22		Systematic Review of Patient	
23		and Physician Perspectives	

1	Exhibit 22	Exposito-Campos, A Typology	361
2		of Gender Detransition and	
3		Its Implications for	
4		Healthcare Providers	
5	Exhibit 23	BCBS NC - Corporate Medical	375
6		Policy, update July 2021	
7	Exhibit 24	Dhejne, Long-Term Follow-Up	388
8		of Transsexual Persons	
9		Undergoing Sex Reassignment	
10		Surgery: Cohort Study in	
11		Sweden	
12	Exhibit 25	Finnish Guidelines 2020	394
13		Minors, Unofficial	
14		Translation	
15	Exhibit 26	WPATH Standards of Care,	396
16		Version 7	
17	Exhibit 27	Carmichael, Short-term	411
18		outcomes of pubertal	
19		suppression in a selected	
20		cohort of 12 to 15 year old	
21		young people with persistent	
22		gender dysphoria in the UK	
23	Exhibit 28	2020 Cochrane Database of	414

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23

Systematic Reviews

Exhibit 29	Tradition 70/30 PPO Plan Benefits Booklet, 2017	419
Exhibit 30	Aetna, Gender Affirming Surgery Policy	427
Exhibit 31	Cigna Medical Coverage Policy, Treatment of Gender Dysphoria	430
Exhibit 32	United Healthcare Medical Policy, Gender Dysphoria Treatment	434
Exhibit 33	Lappert Denver Conference Presentation	451
Exhibit 34	Plastic surgeon: Sex-change operation 'utterly unacceptable' and a form of 'child abuse', LifeSiteNews.com	463

(Exhibits attached to transcript.)

1 risk but also the potential benefits.
2 And the potential benefits have to be
3 very high. The higher the risk is, the
4 higher the benefit has to be. And that's
5 kind of a general principle of the
6 medical care. You know, before all else,
7 do no harm. That's what informs all
8 medical care, and I would hope that's
9 what informs the FDA policy, whatever
10 that may be.

11 Q. Okay. Well, let's look at the
12 policy.

13 A. Okay.

14 Q. I'm going to introduce another
15 exhibit. Okay. This is going to be
16 Exhibit 11. Let me know when you have
17 it.

18 (Exhibit 11 was marked for identification
19 and is attached.)

20 A. Okay.

21 Q. Have you ever seen this document
22 before?

23 A. I have not.

1 Q. Do you know what the Federal
2 Register is?

3 A. It's a -- it's a federal list of
4 regulations pertaining to things like
5 this.

6 Q. Yeah. It's the
7 official publication --

8 A. Federal code.

9 Q. -- of federal rules, proposed
10 rules, and notices for federal agencies;
11 right?

12 A. Yeah. Right.

13 Q. I see this is dated at the top
14 November 18, 1994. See that?

15 A. Yes.

16 Q. Page 1, middle column, see it
17 says, "Agency: Food and Drug
18 Administration, HHS"?

19 A. Let's see. "Agency: Food and
20 Drug Administration, HHS." Yes.

21 Q. It says, "Action." It says,
22 "Notice; request for comments." Do you
23 see that?

1 A. Yes.

2 Q. All right. Go to page 2.

3 A. Okay.

4 Q. In the column all the way to the
5 right, you see there's a section II, and
6 it's titled, "FDA Policy on Promotion of
7 Unapproved Uses." Do you see that?

8 A. I do.

9 Q. All right. The first paragraph
10 says, "Over a decade ago, the FDA Drug
11 Bulletin informed the medical community
12 that 'once a [drug] product had been
13 approved for marketing, a physician may
14 prescribe it for uses or in treatment
15 regimens of patient populations that are
16 not included in approved labeling.'" Do
17 you see that?

18 A. I do.

19 Q. What do you understand that to
20 mean?

21 A. That --

22 MR. KNEPPER: Objection.

23 A. I apply that to mean that --

1 that the -- that the FDA does not -- does
2 not intend to weigh in on off-label use,
3 you know, without restriction, I guess.
4 The sense I get of it is that they're --
5 they're declining to prohibit the
6 off-label use in -- in other patients at
7 this time, I would -- I would guess. I
8 suppose that if they started to see
9 complications, they might weigh in. This
10 has been the history, for example, with
11 nausea medicines and things like that
12 that created problems after use.

13 Q. At that time at least, the FDA
14 was telling the medical community that
15 doctors may prescribe drugs for uses
16 outside of FDA-approved indications;
17 correct?

18 A. Yes. I would say that --

19 MR. KNEPPER: Objection, form.

20 A. -- in 1994, the FDA declined to
21 -- to -- I don't know what they've done
22 subsequently. I -- but -- but in 1994,
23 they -- they -- off-label use was not

1 prohibited.

2 Q. Well, actually --

3 A. They finally --

4 Q. Sorry, finish.

5 A. No, go ahead.

6 Q. Well, you see this actually
7 says, "The publication further stated,"
8 and then there's a quote. And after the
9 quote, there's a Footnote 4.

10 Before we get to that, do you
11 see it says -- it cites to the FDA Drug
12 Bulletin from 1982.

13 A. Right.

14 Q. Right?

15 A. Right.

16 Q. So that original guidance came
17 from a 1982 FDA position; right?

18 A. Right.

19 MR. KNEPPER: Objection, form.

20 Q. And you say that you read this
21 and you don't think that the FDA has
22 taken a position, but let's see what else
23 that quote says. You see the quoted

1 language starting with "The publication
2 further stated"? Do you see that?

3 A. That starts with the word
4 "unapproved"?

5 Q. Yeah. It says, "'unapproved'
6 or, more precisely, 'unlabeled' uses may
7 be appropriate and rational in certain
8 circumstances, and may, in fact reflect
9 approaches to drug therapy that have been
10 extensively reported in medical
11 literature." Do you see that?

12 A. I do.

13 Q. You understand what that means;
14 right?

15 MR. KNEPPER: Objection to form.

16 A. Yes. Yes.

17 Q. Off-label use -- strike that.

18 The FDA has recognized as early
19 as 1982 that off-label use may be based
20 on medical literature, not published
21 indications; right?

22 A. Right.

23 Q. And then it says, "Valid new

1 uses for drugs already on the market are
2 often first discovered through
3 serendipitous observations and
4 therapeutic innovations, subsequently
5 confirmed by well-planned and executed
6 clinical investigations." Right?

7 A. Yeah. That's -- that's kind of
8 a -- just a restating of what I related
9 to you about, for example, the use of
10 Botox and hyperhidrosis, as I have done.
11 Yeah, I would totally agree with that.

12 Q. And then it says, "The agency
13 and its representatives have restated
14 this policy on numerous occasions." Do
15 you see that?

16 A. I do.

17 Q. Do you understand that for
18 decades, for three decades at least, the
19 FDA has taken the position that
20 physicians are allowed to prescribe drugs
21 on an off-label basis?

22 MR. KNEPPER: Objection, form.

23 A. Yes.

1 Q. Your report doesn't acknowledge
2 this longstanding position from the FDA,
3 does it?

4 A. My report does not -- no, it
5 does not.

6 Q. And I mean, I know I just heard
7 you say, well, maybe this is from the
8 '80s. Let me show you what the FDA says
9 today.

10 A. Okay.

11 Q. I'm going to introduce another
12 exhibit. This is Exhibit 12. Let me
13 know when you get it.

14 (Exhibit 12 was marked for identification
15 and is attached.)

16 A. Okay. All right. I've got it.

17 Q. All right. You see that this is
18 a printout from fda.gov, the official
19 website of the FDA; right?

20 A. Right.

21 Q. The title is "Understanding
22 Unapproved Use of Approved Drugs 'Off
23 Label.'" Right?

1 A. Right.

2 Q. Go to page 2.

3 A. Okay.

4 Q. Toward the bottom, it says in
5 bold, "Why might an approved drug be used
6 for an unapproved use?" Do you see that?

7 A. I do.

8 Q. Then it says, "From the FDA
9 perspective, once the FDA approves a
10 drug, healthcare providers generally may
11 prescribe the drug for an unapproved use
12 when they judge that it is medically
13 appropriate for their patient." Do you
14 see that?

15 A. I do.

16 Q. And then skipping one sentence,
17 it says, "One reason is that there"
18 may -- "might not be an approved drug to
19 treat your disease or medical condition."
20 Right?

21 A. Right.

22 Q. So the FDA -- the position that
23 the FDA takes is off-label use may be

1 medically appropriate for patients;
2 right?

3 A. Right.

4 Q. That's a position they've taken
5 for thirty years plus; right?

6 A. Right.

7 MR. KNEPPER: Objection, form.

8 Q. All right. And we talked
9 earlier about, you know, is off-label use
10 experimental or investigational. Before
11 forming those opinions, did you look to
12 see what the FDA says on that point?

13 A. How the FDA classifies
14 experimental or investigational?

15 Q. Do you know what position the
16 FDA takes on whether off-label use is
17 considered investigational?

18 A. I don't know what their official
19 position is, no.

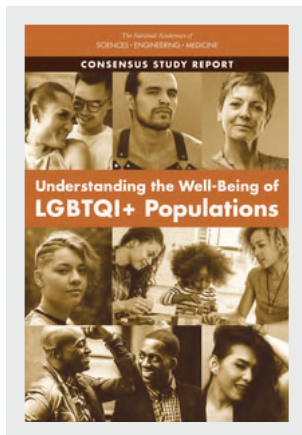
20 Q. All right. Let's look at that.
21 All right. This is going to be Exhibit
22 13. Let me know when you have it.

23 (Exhibit 13 was marked for identification

Exhibit 29

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Understanding the Well-Being of LGBTQI+ Populations (2020)

DETAILS

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Understanding the Well-Being of LGBTQI+ Populations

Committee on Understanding the Well-Being of Sexual and
Gender Diverse Populations

Charlotte J. Patterson, Martín-José Sepúlveda, and Jordyn White, *Editors*

Committee on Population

Division of Behavioral and Social Sciences and Education

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Guidelines and Policies Related to Gender Affirmation

Clinicians who provide gender-affirming psychosocial and medical services in the United States are informed by expert evidence-based guidelines. In 2012, the World Professional Association for Transgender Health (WPATH) published version 7 of the *Standards of Care for the Health of Transgender, Transsexual, and Gender-Nonconforming People*, which have been continuously maintained since 1979, and revisions for version 8 are currently underway (Coleman et al., 2012). Two newer guidelines have also been published by the Endocrine Society (Hembree et al., 2017) and the Center of Excellence for Transgender Health (UCSF Transgender Care, 2016). Each set of guidelines is informed by the best available data and is intended to be flexible and holistic in application to individual people. All of the guidelines recommend psychosocial support in tandem with physical interventions and suggest timing interventions to optimize an individual's ability to give informed consent. Mental and physical health problems need not be resolved before a person can begin a process of medical gender affirmation, but they should be managed sufficiently such that they do not interfere with treatment.

A major success of these guidelines has been identifying evidence and establishing expert consensus that gender-affirming care is medically necessary and, further, that withholding this care is not a neutral option (World Professional Association for Transgender Health, 2016). A number of professional medical organizations have joined WPATH in recognizing that gender-affirming care is medically necessary for transgender people because it reduces distress and promotes well-being, while withholding care increases distress and decreases well-being (AMA, 2008; American Psychiatric Association, 2018; American Psychological Association (APA), 2008, 2015; American Academy of Family Physicians, 2012; American Academy of Pediatrics, 2018; American College of Nurse-Midwives, 2012; American College of Obstetricians and Gynecologists, 2011; Endocrine Society, 2017). Accordingly, public and private insurers have expanded access to gender-affirming care; some have done so proactively, while others have been required by state and federal nondiscrimination laws to remove coverage exclusions (Baker, 2017).

Coverage requirements for gender-affirming care typically rely on an overarching principle of parity between medically necessary services for transgender and cisgender people. Treatments that are gender-affirming for transgender patients are covered by public and private insurers for intersex and cisgender people for a variety of conditions, including genital difference, endocrine disorders, cancer prevention or treatment, and reconstructive surgeries following an injury. Examples of these services include testosterone or estrogen replacement therapy after surgery or menopause, vaginoplasty after pelvic surgery or for women with vaginal agenesis in the context of an intersex condition, and phalloplasty for cisgender male service members injured in war (Spade et al., 2009; Baker et al., 2012; Balzano and Hudak, 2018).

As this report goes to press, 24 states and the District of Columbia have enacted laws or made administrative changes prohibiting transgender-specific insurance exclusions in private coverage (Movement Advancement Project, 2020a). However, Medicaid programs in 10 states continue to explicitly exclude gender-affirming care for transgender individuals, and many states do not address the issue of this coverage in Medicaid (Mallory and Tentindo, 2019). At the federal level, the Medicare program removed its exclusion for "transsexual surgery" in 2014 (U.S. Department of Health and Human Services, 2014), though coverage decisions related to gender-affirming surgeries are still made on a case-by-case basis (CMS, 2016). As discussed

Exhibit 30

From: Lotta Crabtree <Lotta.Crabtree@nctreasurer.com>
Sent: Fri, 27 May 2016 16:36:52 -0400
To: "Gillihan, Ashley" <Ashley.Gillihan@alston.com>
Subject: RE: time to talk on Tuesday?

Thanks – I look forward to chatting about this fascinating topic!

From: Gillihan, Ashley [mailto:Ashley.Gillihan@alston.com]
Sent: Friday, May 27, 2016 4:22 PM
To: Lotta Crabtree
Subject: RE: time to talk on Tuesday?

Yes. I will send an invite.

From: Lotta Crabtree [mailto:Lotta.Crabtree@nctreasurer.com]
Sent: Friday, May 27, 2016 4:06 PM
To: Gillihan, Ashley <Ashley.Gillihan@alston.com>
Subject: RE: time to talk on Tuesday?

Yes! Will 1:30 work for you?

From: Gillihan, Ashley [mailto:Ashley.Gillihan@alston.com]
Sent: Friday, May 27, 2016 3:03 PM
To: Lotta Crabtree
Subject: time to talk on Tuesday?

About the new 1557 rules? I am available until 3:00 EST with the exception of 10:30-11:00

Ash

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Exhibit 31

From: Lotta Crabtree
Sent: Tue, 05 Jul 2016 20:21:42 +0000
To: Mark Collins
Subject: Coverage for gender dysphoria

Mark - We would like for Segal to look at the cost of coverage for gender dysphoria. The Plan believes that we will need to cover treatment and services for gender dysphoria beginning with Plan year 2017. We have not nailed down the medical policy yet but expect that it will cover the cost of sex reassignment surgery, hormone therapy, etc. To the extent something is purely cosmetic (shaving of the Adam's apple, electrolysis for hair removal, etc. we probably won't cover.) Breast enlargement for male to female would not be considered cosmetic and some breast reduction for female to male may also be covered.

Let me know, if they can give us an estimate of annual cost for coverage without any more information than what I have included above.

Thanks!

Lotta Crabtree
Deputy Executive Administrator & Legal Counsel
State Health Plan
Phone: (919) 814-4414



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Exhibit 32

Message

From: Lotta Crabtree [/O=NCDST/OU=ALBEMARLE1/CN=RECIPIENTS/CN=LOTTA.CRABTREE]
Sent: 7/14/2016 11:22:55 AM
To: Chris Almberg [chris.almberg@nctreasurer.com]
CC: Lauren Wides [Lauren.Wides@nctreasurer.com]
Subject: FW: 1557
Attachments: rtf-body.rtf; Final Rule Section 1557.pdf; APA GD.pdf; Aetna policy GD.pdf; Action required to meet 1557.pdf; GD fact sheet APA.pdf; Groom review of final rule 1557.pdf; Summary_Final Rule Implementing Section 1557 of the Affordable Care Act.pdf; UHC policy gender_identity_disorder_dysphoria_treatment.pdf; SOC WPATH v 7.pdf; image001.jpg; image002.png; image003.png; image004.png

Attached is some information on the requirements for the Plan regarding compliance with Section 1557 of the ACA. Basically, we need to ensure that members for whom English is a second language have resources available to them to understand their benefits and we need to ensure coverage under our benefits do not discriminate on the basis of age, race, religion, ethnicity, or sex. Sex includes gender identity and so we are trying to determine what we need to cover for individuals diagnosed with gender dysphoria.

The regulation requires us to have a policy in place for processing alleged discrimination, including a contact person designated to take those complaints. Please review the requirements around this particular requirement and draft a policy for the Plan. In the meeting this morning, Melissa indicated that a policy template had been provided by OCR that we can use.

Let me know if you have any questions.

Thank you!

Lotta

From: Lotta Crabtree
Sent: Monday, July 11, 2016 1:11 PM
To: Blake Thomas
Subject: 1557

Attached is various information on 1557 regulations and gender dysphoria. Thanks.

Lotta Crabtree
Deputy Executive Administrator & Legal Counsel
State Health Plan
Phone: (919) 814-4414

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<<https://shp.nctreasurer.com/AboutSHP/connect/Pages/Sign-Up-for-Member-Focus.aspx>>

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Exhibit 33

DST POLICIES AND PROCEDURES

DST Reference:	SHP-PRO-1005-SHP
Title:	Section 1557 Grievance Procedure
Cross Reference:	
Chapter:	Healthcare Compliance
Current Effective Date:	7/15/2016
Revision History:	
Original Effective Date:	7/15/2016

Applies to: NC Department of State Treasurer – SHP

Keywords: 1557, Grievance Procedure, Discrimination, Race, Color, National Origin, Sex, Gender, Age, Disability, Investigation,

Background

The North Carolina State Health Plan for Teachers and State Employees (SHP) is committed to complying with all applicable laws and regulations and adhering to the highest ethical standards in its undertaking to provide health benefits to its eligible population. The SHP receives funding from the Department of Health and Human Services through the Retiree Drug Subsidy Program. Therefore, SHP is subject to Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Part 92 requires SHP to designate a responsible employee and a grievance procedure to resolve grievances alleging any action that would be prohibited by Section 1557 or Part 92.

Purpose

The purpose of this procedure is to designate a responsible employee and establish a Grievance Procedure to reduce risk, foster a culture of inclusion and compliance, and meet federal requirements.

Related Statutes, Rules, and Policies

1. 42 U.S.C. 18116
2. 45 CFR 92

DST Reference:	SHP-PRO-1005-SHP	Page 1 of 6
Title:	Section 1557 Grievance Procedure	
Cross reference		
Chapter:	Healthcare Compliance	
Current Effective Date:	7/15/2016	

DST POLICIES AND PROCEDURES

Procedure

SHP shall designate a responsible employee and establish and maintain a grievance procedure so that any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age, or disability may file a grievance under this procedure. It is against the law for SHP to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of SHP relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Executive Administrator within 15 days of receiving the Section 1557 Coordinator's decision. The Executive Administrator shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age, or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

DST Reference:	SHP-PRO-1005-SHP	Page 2 of 6
Title:	Section 1557 Grievance Procedure	
Cross reference		
Chapter:	Healthcare Compliance	
Current Effective Date:	7/15/2016	

DST POLICIES AND PROCEDURES

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination.

SHP will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes (or other electronic means) of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Nature of the Procedure

The Policy serves as a nonbinding interpretative statement, within the delegated authority of the Department of State Treasurer that defines, interprets, or explains the meaning of the laws and/or regulations listed above. Those laws or regulations, not this Policy, shall take priority if they conflict in any way.

This Policy sets forth criteria or guidelines to be used by Department of State Treasurer staff in performing audits, investigations, or inspections.

Implementation

SHP shall disseminate the attached external-facing procedure (Attachment A) to its members, shall maintain an employee designated as Section 1557 Coordinator, and shall adopt and execute this internal grievance procedure for providing prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services.

Enforcement

The Executive Administrator/Deputy Treasurer (EA/DT) shall have authority to interpret and apply this policy and procedure. This policy and procedure may be modified or amended at any time as approved by the EA/DT. Failure to comply with this policy could result in disciplinary action up to and including dismissal. The Compliance Officer will work with Human Resources, Legal, and Senior Management to assess the situation and recommend appropriate disciplinary action.

DST Reference:	SHP-PRO-1005-SHP	Page 3 of 6
Title:	Section 1557 Grievance Procedure	
Cross reference		
Chapter:	Healthcare Compliance	
Current Effective Date:	7/15/2016	

DST POLICIES AND PROCEDURES

Revision History

This section is required. Outline the version history, approval date(s), and provide a brief description of changes in table format.

Version/Revision	Date Approved	Description of Changes
V1.0	7/15/2016	New

For questions or clarification on any of the information contained in this policy, please contact the policy owner or designated contact point: Chris Alberg, chris.alberg@nctreasurer.com. For general questions about department-wide policies and procedures, contact the DST Policy Coordinator.

DST Reference:	SHP-PRO-1005-SHP	Page 4 of 6
Title:	Section 1557 Grievance Procedure	
Cross reference		
Chapter:	Healthcare Compliance	
Current Effective Date:	7/15/2016	

DST POLICIES AND PROCEDURES

ATTACHMENT A

SECTION 1557 GRIEVANCE PROCEDURE

It is the policy of the North Carolina State Health Plan for Teachers and State Employees (SHP) not to discriminate on the basis of race, color, national origin, sex, age, or disability. SHP has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Chris Almborg, (Section 1557 Coordinator, 3200 Atlantic Avenue, Raleigh, NC 27604, (919) 814-4428, TTY number—711, Fax - 919-855-5815, email - Chris.Almborg@nctreasurer.com), who has been designated to coordinate the efforts of SHP to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age, or disability may file a grievance under this procedure. It is against the law for SHP to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of SHP relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Executive Administrator within 15 days of receiving the Section 1557 Coordinator's decision. The Executive Administrator shall issue a written decision in response to the appeal no later than 30 days after its filing.

DST Reference:	SHP-PRO-1005-SHP	Page 5 of 6
Title:	Section 1557 Grievance Procedure	
Cross reference		
Chapter:	Healthcare Compliance	
Current Effective Date:	7/15/2016	

DST POLICIES AND PROCEDURES

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age, or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201. Show citation box

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination.

SHP will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

DST Reference:	SHP-PRO-1005-SHP	Page 6 of 6
Title:	Section 1557 Grievance Procedure	
Cross reference		
Chapter:	Healthcare Compliance	
Current Effective Date:	7/15/2016	

Exhibit 34

Message

From: Lotta Crabtree [/O=NCDST/OU=ALBEMARLE1/CN=RECIPIENTS/CN=LOTTA.CRABTREE]
Sent: 7/27/2016 11:40:41 AM
To: Mona Moon [Mona.Moon@nctreasurer.com]
Subject: RE: Bullet points for the BOT
Attachments: rtf-body.rtf; Information for the BOT.docx; image001.jpg; image002.png; image003.png; image004.png

See highlights for the information I have added to address your points. Thanks.

From: Mona Moon
Sent: Monday, July 25, 2016 9:48 AM
To: Lotta Crabtree
Subject: FW: Bullet points for the BOT

Looks good - and one page! I think it might be helpful to add a point or two noting the requirements we are moving forward with (grievance policy, taglines) and what requires Board approval (elimination of the categorical exclusions).

Let me know what you hear from Blake. Thanks!

From: Lotta Crabtree
Sent: Friday, July 22, 2016 4:56 PM
To: Mona Moon <Mona.Moon@nctreasurer.com <mailto:Mona.Moon@nctreasurer.com> >; Blake Thomas <Blake.Thomas@nctreasurer.com <mailto:Blake.Thomas@nctreasurer.com> >
Subject: Bullet points for the BOT

Attached are the bullet points I have pulled together...this seems like a lot of words...let me know if you think we need a different format. Thanks.

Lotta Crabtree
Deputy Executive Administrator & Legal Counsel
State Health Plan
Phone: (919) 814-4414

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Affordable Care Act – Section 1557 Final Rule

The Rule

- The final rule on Section 1557 of the ACA was issued May 18, 2016.
- Section 1557 prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities.
- The rule applies to any health program or activity, any part of which receives funding from the Department of Health and Human Services (DHHS).
- The rule applies to the State Health Plan (Plan) which receives a retiree drug subsidy from DHHS for its Medicare Retirees covered under the Traditional 70/30 plan. The Plan received \$19.5 million last year.
- Individuals participating in the Plan may file a grievance with the Plan, the Office of Civil Rights (OCR), and have a private right of action to sue for violations of the rule.
- If OCR finds noncompliance it may require remedial action and has the ability to reduce or eliminate any financial assistance, and refer the matter to the Department of Justice for litigation.
- The rule requires covered entities to take reasonable steps to provide meaningful access to each individual with limited English proficiency to be served or likely to be encountered in their health programs and activities.
- The rule requires covered entities to make all programs and activities provided through electronic and information technology accessible; ensure physical accessibility of newly constructed or altered facilities; and to provide appropriate auxiliary aids and services for individuals with disabilities.
- The rule requires that women be treated equally in the health care they receive and also prohibits the denial of health care or health coverage based on an individual's sex, including discrimination based on pregnancy, gender identity, and sex stereotyping. Must treat individuals consistent with their gender identity.
- To the extent the rules require changes to health plan benefit design, such provisions have an applicability date of the first day of the first plan year beginning on or after January 1, 2017.

Implications for the State Health Plan

- Must have a grievance procedure and a compliance coordinator to intake and review complaints of discrimination. This has been completed and posted to the Plan's website. Chris Almberg, the Plan's compliance officer will also serve as the compliance coordinator.
- Must post notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services. Required notices will be included in all future printed materials.
- Cannot deny health coverage solely on the basis of gender identity.
- Cannot categorically exclude all health services related to gender identity.
- Cannot categorically exclude all health services related to gender transition. The Plan's benefits currently contain the following categorical exclusions:
 - Treatment or studies leading to or in connection with sex changes or modifications and related care
 - Psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation
- Removal of the above categorical exclusions will be a benefit change and will require BOT approval.
- Cannot deny or limit coverage based solely on the fact that the person identifies as belonging to a gender different from the sex assigned at birth.
- Must ensure that the Plan is administered with respect to services or treatments related to gender identity consistent with the generally applicable and neutral terms of the Plan.

Exhibit 35

November 1, 2016

Mr. Stuart Wohl
The Segal Company
1920 N Street N.W., Suite 400
Washington, D.C., 20036-1659

Subject: Letter of Agreement (LOA) for Assistance Related to Compliance with Section 1557 of the ACA.

Dear Stuart:

The State Health Plan for Teachers and State Employees (Plan) wishes to engage The Segal Company (Segal) to provide support regarding the Plan's compliance with Section 1557 of the Patient Protection and Affordable Care Act (ACA) pursuant to Section V.B.3.4.3 of the Actuarial and Analytical and Health Benefits Consulting Services Contract (Contract).

Section 1557 of the ACA prohibits discrimination on the basis of disability, race, color, national origin, language, age, sex, sexual identity (transgender), and sexual orientation in health programs and activities. No later than October 17, 2016, Section 1557 Covered Entities must assure that protected individuals have equal access to benefits under this law. The purpose of this LOA is to state the terms to which Segal will provide assistance to the Plan related to the Plan's compliance with Section 1557. The total cost of this engagement will not exceed \$36,744.00.

The Parties agree as follows:

A. Term

This LOA is effective upon execution and will terminate upon the Plan's acceptance of the final audit report and the final draft vendor questionnaire, unless otherwise terminated by the Plan.

B. Obligations of Segal:

1. Provide the services described in the 1557 Compliance Assistance Letter (Letter) dated October 31, 2016, labeled and attached as Exhibit One. All services, deliverables, terms and conditions described in the Letter, unless modified by this LOA, are incorporated into this LOA as though originally a part thereof.
2. Invoice the Plan for the services provided under this LOA as provided in the Contract under Section VII of the Contract and the Letter. Each invoice shall reflect actual billable hours incurred at the rates established in the Contract.

C. Obligations of the Plan:

The Plan will reimburse for approved services performed by the Segal team proposed in the attached Exhibit One, up to a maximum of thirty-six thousand, seven hundred forty-four dollars (\$36,744.00) based on actual hours incurred by skill level/title at the hourly rates established in the Contract and the subcontractor fee quoted in the Letter.

D. General Terms and Obligations

1. The Parties may modify or establish additional agreed upon due dates for any service or deliverable provided under this LOA as required by the Plan.
2. The Plan must approve, in writing, any revision in fees or changes in scope of work, deliverables, or key personnel for this project prior to the services being rendered. Key personnel includes only those individuals specifically named in the Letter; however, Segal may invoice the Plan for other staff or skill levels assisting in the development of material, assembly of information, or providing required services without prior notice to the Plan, provided the total cost of services performed by Segal personnel and approved subcontractors does not exceed the amount specified in Section C of this LOA.
3. The Letter notes that due to the specialized nature of this engagement Segal proposes using Federal Compliance Consulting, LLC as a subcontractor for this project. Pursuant to Section IV.OO of the Contract, the Plan approves the use of Federal Compliance Consulting, LLC as a subcontractor for this project.
4. Revisions to the due dates for submission of deliverables, as specified in the Letter, may be communicated and approved via email between the Plan's Deputy Executive Administrator and Legal Counsel, Lotta Crabtree, and Segal's Senior Vice President (SVP) and Account Manager, Stuart Wohl. Any other revisions must be approved by the Plan's Executive Administrator.
5. Except as otherwise provided in this LOA, all of the other terms and conditions of the Contract shall apply.

The remainder of this page is intentionally left blank. See following page.)

Stuart Wohl
November 1, 2016
Page 3 of 3

Please indicate your acknowledgment and acceptance to the above terms by signing below.

Sincerely,



Mona M. Moon
Executive Administrator
North Carolina State Health Plan for Teachers and State Employees

Acceptance:



Stuart Wohl
Senior Vice President
The Segal Company, Inc.

11/14/2016

Date

Exhibit 36

MEMORANDUM

To: Mona Moon

From: Kirsten R. Schatten, ASA, MAAA
Kenneth C. Vieira, FSA, MAAA

Date: November 29, 2016

Re: Transgender Cost Estimate

Section 1557 of the ACA prohibits discrimination in health programs on the basis of age, race, sex, national origin, color, or disability. We have attached Segal's publication in June 2016 that provides additional details and supporting documentation. It is likely that you are subject to the law ("covered entities"), because the State has a Medicaid program that receives federal funding from the Department of HHS and you also receive federal HHS funding from the RDS program. Plans must provide coverage for transgender health care no later than plan years beginning on or after 1-1-17. This includes removing exclusions for gender identity treatment.

This brief memo is focused on the calculation of potential cost impact to the North Carolina State Health Plan. Please note that there is a lack of information and data to provide specific information on estimated cost to the Plan. Therefore, we have provided a range of estimates based on potential utilization information gathered from research and treatment cost estimates from BCBSNC. Please also note there are wide variations in some of these studies, and past experience from various counties that have provided coverage long enough to have data to review have shown the prior estimates to be overstated.

Key Assumptions

Three key assumptions drive our cost estimates: prevalence of transgender members, percentage of those who seek benefits (including surgery) and the cost of the various treatment options.

Prevalence – According to the Centers for Disease Control and Prevention (CDC) 2015 Behavioral Risk Factor Surveillance System (BRFSS), approximately 0.58% of adults in the United States self-identify as transgender. This has increased slightly from 2014 & 2013.

The Williams Institute in June of 2016 published a paper entitled "How Many Adults Identify as Transgender in the United States?" which goes a little further by drilling down on prevalence by state and also providing ranges. This paper estimated a prevalence range of 0.35% to 1.03% for North Carolina.

Percentage Who Seek Benefits – Those seeking benefits is difficult to predict since a new benefit may alter past patterns. One study was published by Olyslager, F. & Conway, L. (September 2007) entitled "On the Calculation of the Prevalence of Transsexualism." This paper was presented at the WPATH 20th International Symposium, Chicago, Illinois. This study from 2007 estimates that, of those who identify as transgender, between 0.1% and 0.5% have taken some steps to transition from one gender to another.

NCSHP membership from age 18 to 64 is approximately 472,000. Applying the prevalence and utilization assumptions above, we would expect 8 to 24 members to use transgender benefits.

For those who seek benefits, the vast majority of cost comes from members choosing to have gender reassignment surgery. There are a couple of sources we found (Mohammed A. Memon, MD; February 22, 2016; "Gender Dysphoria and Transgenderism: Epidemiology" Medscape, as well as HealthResearchFunding.Org) that site prevalence rates for adults seeking reassignment surgery of 1 in 30,000 for males and 1 in 100,000 for females. Using these statistics, we would expect 6 males and 3 females in our expected scenario, and we have applied a range of +/- 50% to get a range of 6-13 adults in total.

Cost of Treatment – Information was provided at a very high level from BCBSNC. Their pricing analysis was based entirely on external studies and sources, so they caution that this may differ from what Dr. McCauley or others may say—

- For male to female surgery they assumed roughly \$28K, with \$3,600 in hormonal therapy
- For female to male surgery they assumed about \$56K, with \$7,200 in hormonal therapy

They also noted that there would be fairly substantial counseling costs associated with the surgery—roughly \$10K in a given year.

No other cost estimates were provided.

Financial Impact

Using the above, we have estimated the annual cost to range from \$350,000 to \$850,000. The costs are highly variable based on the assumptions described above. Below is brief summary;

		Prevalence		Estimated Cost	Cost Estimate	
		Low	High		Low	High
Surgical Benefits	Male	3.89	8.76	\$ 41,600	\$ 161,918	\$ 364,316
Surgical Benefits	Female	1.98	4.46	\$ 73,200	\$ 145,195	\$ 326,688
Surgical Benefits	Total	5.88	13.22	\$ 52,267	\$ 307,113	\$ 691,004
Non-Surgical Benefits	Male/Female	2.40	11.12	\$ 15,400	\$ 36,900	\$ 171,288
Total Using Benefits	Male/Female	8.27	24.34		\$ 344,013	\$ 862,292
Adult Members					472,682	
Total PMPM					\$ 0.06	\$ 0.15

There are a few other sources we found and reviewed that provide similar information and would bring us to a similar range of cost estimates. Based on approximately \$3.2 billion of premiums, the cost for NCSHP is estimated to be 0.011% to 0.027% of premium.

Exhibit 37

From: Schorr Johnson <Schorr.Johnson@nctreasurer.com>
Sent: Tue, 29 Nov 2016 09:05:01 -0500
To: Lotta Crabtree <Lotta.Crabtree@nctreasurer.com>
CC: Blake Thomas <Blake.Thomas@nctreasurer.com>, Mona Moon <Mona.Moon@nctreasurer.com>, Brad Young <Brad.Young@nctreasurer.com>
Subject: Re: 1557 draft statement

I like version 2 and think we need to have the outside counsel reference since we know the incoming Treasurer opposes this and will likely speak out.

Thanks,

Schorr

On Nov 29, 2016, at 8:44 AM, Lotta Crabtree <Lotta.Crabtree@nctreasurer.com> wrote:

I am not sure why we reference outside counsel since the rule is clear about action as it relates to benefit changes. Otherwise, I am good with either version. Thanks.

From: Blake Thomas
Sent: Tuesday, November 29, 2016 7:38 AM
To: Schorr Johnson; Mona Moon; Lotta Crabtree; Brad Young
Subject: RE: 1557 draft statement

Two versions of the message below for your consideration. The first version is just a small tweak. The second version adds a sentence noting that several states with conservative governance have already taken the action that the Plan is considering on Friday. I prefer the second version of the message, but would be fine with either.

Version 1 (small tweak)

"The State Health Plan Board of Trustees will be voting on complying with the federal Department of Health and Human Services final rule interpreting section 1557 of the Affordable Care Act. **The Plan's outside legal counsel determined this rule requires action by the Plan on or before January 1, 2017. If the Plan does not take action to comply,** the Plan risks losing millions of dollars in federal funding and could face discrimination lawsuits for non-compliance."

Version 2 (notes what other states are doing)



PLAN DEF0016424

"The State Health Plan Board of Trustees will be voting on complying with the federal Department of Health and Human Services final rule interpreting section 1557 of the Affordable Care Act. The Plan's outside legal counsel determined this rule requires action by the Plan on or before January 1, 2017. **States such as Indiana, Wyoming, Wisconsin, and Kentucky have already taken this compliance action.** If the Plan does not take action to comply, the Plan risks losing millions of dollars in federal funding and could face discrimination lawsuits for non-compliance."

--Blake

From: Schorr Johnson
Sent: Monday, November 28, 2016 4:15 PM
To: Mona Moon; Lotta Crabtree; Blake Thomas; Brad Young
Subject: RE: 1557 draft statement

I'm good with that. Blake?

"The State Health Plan Board of Trustees will be voting on complying with the federal Department of Health and Human Services final rule interpreting section 1557 of the Affordable Care Act, which the Plan's outside legal counsel determined must take effect before January 1, 2017. The Plan risks losing millions of dollars in federal funding **and could face discrimination lawsuits for non-compliance.**"

From: Mona Moon
Sent: Monday, November 28, 2016 2:47 PM
To: Schorr Johnson; Lotta Crabtree; Blake Thomas; Brad Young
Subject: RE: 1557 draft statement

Schorr, we also risk being sued by members who think our coverage is discriminatory. Should that be noted as well?

From: Schorr Johnson
Sent: Monday, November 28, 2016 2:27 PM
To: Mona Moon <Mona.Moon@nctreasurer.com>; Lotta Crabtree

PLAN DEF0016425

<Lotta.Crabtree@nctreasurer.com>; Blake Thomas <Blake.Thomas@nctreasurer.com>;
Brad Young <Brad.Young@nctreasurer.com>
Subject: 1557 draft statement

DRAFT STATEMENT (if we get press questions prior to Friday's meeting)—edit at will.
Separately, we will draft a statement from Treasurer Cowell for after the vote.

"The State Health Plan Board of Trustees will be voting on complying with the federal Department of Health and Human Services final rule interpreting section 1557 of the Affordable Care Act, which the Plan's outside legal counsel determined must take effect before January 1, 2017. The Plan risks losing millions of dollars in federal funding for non-compliance."

Background:

<http://www.hhs.gov/about/news/2016/05/13/hhs-finalizes-rule-to-improve-health-equity-under-affordable-care-act.html>

From DHHS:

"Under the final rule, categorical coverage exclusions or limitations for all health services related to gender transition are discriminatory. Also, a covered entity cannot deny or limit coverage, deny or limit a claim, or impose additional cost sharing or other limitations or restrictions, for any specific health services related to gender transition if such denial, limitation or restriction results in discrimination against a transgender individual."
[<http://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html>]

PLAN DEF0016426

Exhibit 38

From: Mona Moon <Mona.Moon@nctreasurer.com>
Sent: Thu, 01 Dec 2016 11:30:05 -0500
To: Beth Horner <Beth.Horner@nctreasurer.com>, Lotta Crabtree <Lotta.Crabtree@nctreasurer.com>
Subject: RE: Inclusion of Sex Change Surgery on Plan?

My edit. Lotta may have others...

I think it's fine to send the response and copy the BOT members DST addresses.

From: Beth Horner
Sent: Thursday, December 01, 2016 11:04 AM
To: Lotta Crabtree <Lotta.Crabtree@nctreasurer.com>; Mona Moon <Mona.Moon@nctreasurer.com>
Subject: FW: Inclusion of Sex Change Surgery on Plan?

We received this inquiry in our PPO box. I'm sure it's not the last. I drafted the response below, see if you think it's appropriate and if you in fact want us to forward to board members.

Thank you for contacting the State Health Plan. Your concerns and feedback will be shared with the Plan's Board of Trustees. Currently, the Plan does not cover treatment of gender dysphoria which includes treatment or studies leading to or in connection with sex changes or modifications and related care or the psychological assessment and psychotherapy treatment in conjunction with proposed gender transformation.

However, the Plan's Board of Trustees will be voting this Friday, December 2, on removing these exclusions and offering this coverage effective January 1, 2017, **as required by Federal law and to preserve federal Retiree Drug Subsidy funds received by the Plan**. If the Board votes to remove these exclusions, utilization management policies will apply to transition surgery and the Plan will follow Blue Cross and Blue Shield of North Carolina's medical policy. Board materials are available on the Plan's [website](#) for review if you're interested in reviewing the proposed benefit changes regarding this coverage.

Thank you—

From: Jane Schairer

Sent: Thursday, December 01, 2016 9:19 AM
To: Beth Horner <Beth.Horner@nctreasurer.com>
Cc: PPO Inquiries (SHPNC) <PPO.Inquiries@nctreasurer.com>
Subject: FW: Inclusion of Sex Change Surgery on Plan?

Please see the inquiry below.....can you please provide some language for us to use regarding inquiries from members who are unhappy with the proposed benefit change.

Thanks!

Jane

From: PPO Inquiries (SHPNC)
Sent: Thursday, December 01, 2016 9:14 AM
To: Jane Schairer <Jane.Schairer@nctreasurer.com>
Subject: FW: Inclusion of Sex Change Surgery on Plan?

From: wjames2711 [<mailto:wjames2711@bellsouth.net>]
Sent: Thursday, December 01, 2016 9:05 AM
To: PPO Inquiries (SHPNC) <PPO.Inquiries@nctreasurer.com>
Subject: Inclusion of Sex Change Surgery on Plan?

Sirs:

I understand that there is a rumor afoot that the state authorities are recommending that sex change surgery be part of the coverage included in the State Employees Health Plan. If this rumor is correct, I can think of no more frivolous, wasteful, or absurd use of taxpayers' money! As a retiree who pays for his spouse's coverage, I see nothing but higher premiums for participants and heavier burdens for the taxpayer if the plan is expanded to include such nonsense.

There is serious medical and psychiatric opinion against the practice of sex change surgery. I call sex-changing just plain insane. Were we to live in a sane age, there would be no question of such a judgment.

Sincerely,

W. E. James

Reidsville