

**IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION**

JANE DOE et al.,

Plaintiffs,

v.

JOSEPH A. LADAPO et al.,

Defendants.

Civil No. 4:23-cv-00114-RH-MAF

PLAINTIFFS' NOTICE OF FILING TRIAL EXHIBITS

Pursuant to the Court's October 31, 2023 Order Confirming the Deadline to File Exhibits and the Pretrial Stipulation (Dkt. 174), Plaintiffs hereby submit this Notice of Filing Trial Exhibits¹, with copies of each exhibit Plaintiffs expect to or may offer at trial listed on the Exhibit List below and appended hereto.² Plaintiffs reserve the right to use additional documents for purposes of impeachment, and to offer any exhibit identified by Defendants.

¹ Due to the extensive number of documents, Plaintiffs are filing multiple, identical copies of this Notice on the case docket, each attaching a separate set of the below listed exhibits.

² Sealed versions of Plaintiffs' medical records (Doe Pls' Trial Exs. 80-86) have been filed at Dkt. 147.

Plaintiffs' Exhibit List

Trial Ex. No.	Bates No.	Exhibit Description	Will Use	May Use	Stipulated/ Defendants' Objections
<i>Dekker Exhibits</i>		Any exhibit that was entered into evidence in the <i>Dekker</i> trial		X	
Doe Pls' Trial Ex. 1	PL000566 - 000579	Defendants' Response to Pls' First Set of Interrogatories		X	
Doe Pls' Trial Ex. 2	PL000580 - 000625	Expert Report of Dr. Aaron Janssen, M.D. (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 3	PL000626- 000683	Expert Report of Dr. Brittany Bruggeman, M.D. (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 4	PL000684- 000735	Expert Report of Dr. Dan H. Karasic, M.D. (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 5	PL000736 – 000816	Expert Report of Dr. Daniel Shumer, M.D. (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 6	PL000817 – 000886	Expert Report of Dr. Loren Schechter, M.D. (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 7	PL000887 - 000910	Expert Report of Dr. Vernon Langford, DNP, APRN-CNP, FNP-C (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 8	PL000911 - 000929	Expert Report of Dr. Kenneth W. Goodman, PhD, FACMI, FACE (8.16.2023)		X	Hearsay
Doe Pls' Trial Ex. 9	PL000930 - 000938	Expert Rebuttal Report of Dr. Aaron Janssen, M.D. (9.5.2023)		X	Hearsay

Doe Pls' Trial Ex. 10	PL000939 - 000946	Expert Rebuttal Report of Dr. Dan H. Karasic (9.5.2023)		X	Hearsay
Doe Pls' Trial Ex. 11	PL000947	Florida Admin. Code R. 64B8-9.019, <i>Standards of Practice for the Treatment of Gender Dysphoria in Minors</i> (effective 3.16.2023)	X		
Doe Pls' Trial Ex. 12	PL000948	Florida Admin. Code R. 64B15-14.014, <i>Standards of Practice for the Treatment of Gender Dysphoria in Minors</i> (effective 3.28.2023)	X		
Doe Pls' Trial Ex. 13	PL000949	Notice of Change, Fla Admin Code R. 64B15-14.014 (filed 2.10.2023)		X	
Doe Pls' Trial Ex. 14	PL000950	Florida Department of Health Guidance, <i>Treatment of Gender Dysphoria for Children and Adolescents</i> (4.20.22)	X		
Doe Pls' Trial Ex. 15	PL000951	Surgeon General Ladapo Letter to Florida Boards of Medicine (6.2.22)	X		
Doe Pls' Trial Ex. 16	PL000952 - 000959	Florida Department of Health Petition to Initiate Rulemaking Setting the Standard of Care for the Treatment of Gender Dysphoria (7.28.22)	X		
Doe Pls' Trial Ex. 17	PL000960 – 000969	Florida Senate Bill 254 (2023)	X		
Doe Pls' Trial Ex. 18	PL000970 - 000979	Florida House Bill 1421 (2023)	X		

Doe Pls’ Trial Ex. 19	PL000980 - 000981	Section 456.001(1)(8) – (9), Florida Statutes (2023)		X	
Doe Pls’ Trial Ex. 20	PL000982 - 000983	Section 456.52, Florida Statutes (2023)		X	
Doe Pls’ Trial Ex. 21	PL000984 - 001462	Rulemaking Record (Produced by Defendants)	X		
Doe Pls’ Trial Ex. 22	PL001463 - 008066	Public Book for 02.10.2023 Joint Hearing (Produced by Defendants)	X		
Doe Pls’ Trial Ex. 23	Med Def_001485 - 001622; PL012003 – PL012012	Transcript of Florida Board of Medicine Meeting 08.05.2022	X		
Doe Pls’ Trial Ex. 24	Med Def_001058 – 001349	Transcript of Florida Boards’ Joint Rule Workshop 10.28.2022	X		
Doe Pls’ Trial Ex. 25	Med Def_000876 - 001016	Transcript of Florida Boards’ Joint Meeting 11.04.2022	X		
Doe Pls’ Trial Ex. 26	Med Def_001017 – 001043; PL012013 - PL012137	Transcript of Florida Boards’ Joint Public Hearing 02.10.2023 (*Incomplete at present)	X		
Doe Pls’ Trial Ex. 27	Med Def_001350 – 001484	Transcript of Florida House HHS Committee Meeting 02.21.2023	X		
Doe Pls’ Trial Ex. 28	Med Def_002232 - 002234	Excerpt from Speech of Governor Ron DeSantis – Joint Session 03.07.2023		X	

Doe Pls' Trial Ex. 29	Med Def_000087 - 000250	Transcript of Florida Senate Health Policy Committee Meeting 03.13.2023		X	
Doe Pls' Trial Ex. 30	Med Def_002235 - 002335	Transcript of Florida House Healthcare Regulation Subcommittee Meeting 03.22.2023		X	
Doe Pls' Trial Ex. 31	Med Def_001913 - 002001	Transcript of Florida Senate Fiscal Policy Committee Meeting 03.23.2023		X	
Doe Pls' Trial Ex. 32	Med Def_002336 - 002461	Transcript of Florida House HHS Committee Meeting 03.27.2023		X	
Doe Pls' Trial Ex. 33	Med Def_002462 - 002571	Transcript of Florida Senate General Session 04.03.2023		X	
Doe Pls' Trial Ex. 34	Med Def_002002 - 002028	Transcript of Florida Senate General Session 04.04.2023		X	
Doe Pls' Trial Ex. 35	Med Def_002029 - 002144	Transcript of Florida House General Session 04.18.2023		X	
Doe Pls' Trial Ex. 36	Med Def_002145	Transcript of Florida House General Session 04.19.2023		X	
Doe Pls' Trial Ex. 37	Med Def_002215 - 002231	Transcript of Florida Senate General Session 05.04.2023		X	
Doe Pls' Trial Ex. 38	Med Def_002193 - 002214	Transcript of Florida House General Session 05.04.2023		X	
Doe Pls' Trial Ex. 39	Med Def_001623 - 001912	Transcript of Florida Boards' Joint Meeting 06.23.2023		X	

Doe Pls' Trial Ex. 40	Med Def_000251 - 000454	Transcript of Florida Boards' Joint Public Meeting 06.30.2023		X	
Doe Pls' Trial Ex. 41	Med Def_000001 - 000086	Transcript of Florida Boards' Joint Meeting 08.03.2023		X	
Doe Pls' Trial Ex. 42	FDOH_000 0 44095- 000044100; 000044010- 000044014; 000042401- 000043407; 000044022- 000044026; 000044081- 000044086; 000042389- 000042398.	Composite Exhibit - Emails between Board of Osteopathic Medicine Executive Director Danielle Terrell and Vernadette Broyles (Oct. 25-28, 2022)	X		
Doe Pls' Trial Ex. 43	FDOH_000 065015- 000065016	Emails from Board of Osteopathic Medicine Executive Director Terrell (11.07.22)		X	
Doe Pls' Trial Ex. 44	FDOH_000 058615- 000058616	Gender Dysphoria Roundtable (7.8.22)		X	Foundation Hearsay
Doe Pls' Trial Ex. 45	FDOH_002 874150- 002874157	Governor Talking Points		X	Foundation Hearsay
Doe Pls' Trial Ex. 46	FDOH_000 065735- 000065778	Request for Hearing to Board of Medicine		X	Foundation Hearsay

Doe Pls' Trial Ex. 47	FDOH_000 038015- 000038019	Open Letter to the Florida Board of Medicine (9.23.22)	X		Foundation Hearsay
Doe Pls' Trial Ex. 48	EOG_0051 21- 005156	FDOH Updates (4.8.22)		X	Hearsay, as to draft material
Doe Pls' Trial Ex. 49	FDOH_000 064667- 000064671	Emails between Board of Medicine Executive Director Paul Vazquez and Dr. Laidlaw (10.14.22-10.25.22)		X	Foundation Hearsay Objection as to highlights
Doe Pls' Trial Ex. 50	EOG_0008 49-000864	Governor Talking Points (5.13.22)		X	Foundation Hearsay Objection as to highlights
Doe Pls' Trial Ex. 51	FDOH_000 039058	Emails between Board of Medicine Paul Vazquez and Dr. Patrick Hunter (10.16.22)		X	
Doe Pls' Trial Ex. 52	FDOH_001 9000113	Emails between Dr. Van Mol Dr. Patrick Hunter (9.14.22)		X	Foundation Hearsay Objection as to highlights
Doe Pls' Trial Ex. 53	FDOH_000 030412	Email between Vazquez and Hunter (9.14.22)		X	
Doe Pls' Trial Ex. 54	FDOH_000 030376- 000030377	Emails between Vazquez and Hunter (9.13.22)		X	
Doe Pls' Trial Ex. 55	FDOH_000 030366- 30369	Email between Hunter and Vazquez (9.12.22)		X	
Doe Pls' Trial Ex. 56	EOG_0005 19-000520	Gender Affirming Guidance Event		X	
Doe Pls' Trial Ex. 57	EOG_0006 67-000682	Governor DeSantis Interview Transcript (4.28.22)		X	

Doe Pls' Trial Ex. 58	Def_000286 709	AHCA Invoice for Dr. Van Meter attendance at Board of Medicine Meeting (8.11.22)	X		
Doe Pls' Trial Ex. 59	EOG_0081 28-008235	Memo on Gender Dysphoria Legislation	X		Foundation Hearsay
Doe Pls' Trial Ex. 60	EOG_0081 25-008127	Email from Maureen Furino with attachments (1.06.23)		X	Hearsay
Doe Pls' Trial Ex. 61	EOG_0052 82- 005284	Email from Savanah Kelly Jefferson with attachment (6.29.22)		X	Foundation Hearsay Objection as to drafts
Doe Pls' Trial Ex. 62	EOG_0051 57 - 005250	Alliance Defending Freedom Binder		X	Foundation Hearsay
Doe Pls' Trial Ex. 63	EOG_ 004414, 004636- 004640, 004487- 004492	Briefers – Safeguarding Kids from Gender Surgeries and Drugs		X	
Doe Pls' Trial Ex. 64	FDOH_000 035598	Email from Board of Osteopathic Medicine Executive Director Danielle Terrell to Bettye Strickland (10.19.22)		X	
Doe Pls' Trial Ex. 65	FDOH_000 040582 – 000040599	Email from Patrick Hunter to Paul Vazquez (10.23.22)		X	
Doe Pls' Trial Ex. 66	FDOH_000 045008 - 000045010	Appearance Request Form (11.02.22)		X	
Doe Pls' Trial Ex. 67	FDOH_000 034212 – 000034214,	Email from Vazquez to Strickland (9.27.22)		X	

	Att. FDOH_000 034022 - 000034111				
Doe Pls' Trial Ex. 68	FDOH_000 069398 – 000061417	Phillip Penna comment (9.19.22)		X	
Doe Pls' Trial Ex. 69	FDOH_000 017897- 000017908	Email from Jeremy Redford (7.10.22)		X	
Doe Pls' Trial Ex. 70	PL008067 - 010525	Public Book for 8.3.23 Joint Meeting (Produced by Defendants)	X		
Doe Pls' Trial Ex. 71	FDOH_000 040530 - 000040542	Email from Hunter to Vazquez (10.22.22)		X	
Doe Pls' Trial Ex. 72	FDOH_000 039931 – 000039932	Email from Vazquez to Strickland (10.18.22)		X	
Doe Pls' Trial Ex. 73	FDOH_000 037928	September 30, 2022 Rule Workshop Agenda (9.30.22)		X	
Doe Pls' Trial Ex. 74	FDOH_000 040020	Original October 28, 2022 Workshop Agenda (10.28.22)		X	
Doe Pls' Trial Ex. 75	FDOH_000 035446 – 000035448	Email from Vazquez to Diamond (10.14.22)		X	
Doe Pls' Trial Ex. 76	FDOH_000 028162 – 000028163; FDOH_000 064956; and FDOH_000 065030	Emails from Senate Committee on Health Policy (Composite)		X	

Doe Pls' Trial Ex. 77	FDOH_000039513 - 000039516	Emails between Dr. Dayton and Paul Vazquez (10.18.22)		X	
Doe Pls' Trial Ex. 78	FDOH_000035604- 000035604	Email from Board of Osteopathic Medicine Danielle Terrell (10.19.22)		X	Completeness
Doe Pls' Trial Ex. 79	FDOH_000039521 - 000039522	Email from Paul Vazquez to Danielle Terrell (10.18.22)		X	
Doe Pls' Trial Ex. 80	PL000022- 000048	Plaintiff Susan Doe Medical Records (SEALED)	X		
Doe Pls' Trial Ex. 81	PL000001 - 000015	Plaintiff Gavin Goe Medical Records (SEALED)	X		
Doe Pls' Trial Ex. 82	PL000366- 408; 000509-565	Plaintiff Lucien Hamel Medical Records (SEALED)		X	
Doe Pls' Trial Ex. 83	PL000418 - 000483	Plaintiff Olivia Noel Medical Records (SEALED)		X	
Doe Pls' Trial Ex. 84	PL000016 - 000021	Plaintiff Lisa Loe Medical Records (SEALED)		X	
Doe Pls' Trial Ex. 85	PL000409- 417; 000484-508	Plaintiff Kai Pope Medical Records (SEALED)		X	
Doe Pls' Trial Ex. 86	PL000049 - 000365	Plaintiff Rebeca Cruz Evia Medical Records (SEALED)		X	
Doe Pls' Trial Ex. 87	FDOH_000035423 - 000035428	Emails between Hunter, Diamond, and Vazquez (10.04.22)		X	

Doe Pls’ Trial Ex. 88	FDOH_000 062034 - 000062035	Emails between Hunter and Vazquez (9.23.22)		X	
Doe Pls’ Trial Ex. 89	FDOH_000 061277 - 000061279	Emails between Hunter, Vazquez and Biggs (9.19.22)		X	
Doe Pls’ Trial Ex. 90	FDOH_000 030412	Email from Hunter to Vazquez (9.14.22)		X	
Doe Pls’ Trial Ex. 91	PL010526 – 010528	Governor Ron DeSantis Appoints Four to the Board of Medicine (6.17.22)		X	
Doe Pls’ Trial Ex. 92	PL010529- 010530	Dr. Hunter article “Political Issues Surrounding Gender- Affirming Care for Transgender Youth” (JAMA Pediatr., December 20, 2021, doi:10.1001/jamapediatrics.2 021.5348)		X	Hearsay
Doe Pls’ Trial Ex. 93	PL010531- 011801	<i>Eknes-Tucker v. Ivey</i> , 2:22- cv-00184, ECF 69-6 (5.02.22)		X	Relevance Foundation Hearsay
Doe Pls’ Trial Ex. 94	PL011802- 011804	Catholic Medical Association Resolutions 8-7 through 8-14		X	Authentication Foundation Hearsay
Doe Pls’ Trial Ex. 95	PL011805 - 001806	Catholic Medical Association 92 nd Annual Education Conference (9.18.23)		X	Authentication Foundation Hearsay
Doe Pls’ Trial Ex. 96	EOG_0081 25 - 008127	Email from Furino with texts attached (1.06.23)		X	Foundation Hearsay
Doe Pls’ Trial Ex. 97	PL011807 - 011811	AAP Resolution # 27		X	Authentication Foundation Hearsay

Doe Pls’ Trial Ex. 98	PL011812 - 011817	WSJ article “Youth Gender Transition Is Pushed Without Evidence” by Hunter, Roman, Kaltiala, Malone, etc. (7.13.23)		X	Hearsay
Doe Pls’ Trial Ex. 99	PL011818 - 011819	U.S. EO 12866 Meeting 0945-AA17 (4.25.22)		X	Foundation Hearsay
Doe Pls’ Trial Ex. 100	PL011820 – PL011825	SEGM “About Us” Page		X	Foundation Hearsay
Doe Pls’ Trial Ex. 101	PL011826 - 011827	“Challenges in Timing Puberty Suppression for Gender-Nonconforming Adolescents” (de Vries, 7.14.20)			Hearsay
Doe Pls’ Trial Ex. 102	PL011828 - 011830	Governor Ron DeSantis Appoints Three to the Board of Osteopathic Medicine (12.06.22)			
Doe Pls’ Trial Ex. 103	PL011831 - 011833	Governor Ron DeSantis Appoints Two to the Board of Medicine (12.28.22)			
Doe Pls’ Trial Ex. 104	PL011834 - 011857	NYT Article, Dr. Benson quoted (11.14.22)		X	Hearsay
Doe Pls’ Trial Ex. 105	PL011858 - 011866	Smalley, et al., <i>Improving Global Access to Transgender Health Care</i> , Transgender Health, Vol. 7, No. 2 (2022)		X	Hearsay
Doe Pls’ Trial Ex. 106	PL011867	Fla. Admin R. 64B8-30.008		X	

Doe Pls' Trial Ex. 107	PL011868	Fla. Admin. R. 64B8-30.012		X	
Doe Pls' Trial Ex. 108	PL011869 - 011871	Fla. Stat. 464.0123		X	
Doe Pls' Trial Ex. 109	PL011872 - 011874	Fla. Stat. 464.012		X	
Doe Pls' Trial Ex. 110	PL011875 - 011880	Fla. Stat. 458.347		X	
Doe Pls' Trial Ex. 111	PL011881	20 CFR 10.310		X	
Doe Pls' Trial Ex. 112	PL011882 - 011888	A Letter to Christian Physicians_CMDA Today		X	Hearsay
Doe Pls' Trial Ex. 113	PL011889 - 0011890	Composite Exhibit (Jonathan Clemens Tweets)		X	Hearsay
Doe Pls' Trial Ex. 114	PL011891 - 011938	FSU Student Handbook 2022-2023		X	Hearsay
Doe Pls' Trial Ex. 115	PL011939 - 011948	Detransitioners in Your Church Doorway		X	Hearsay
Doe Pls' Trial Ex. 116	PL011949 - 011973	Composite Exhibit – Tweets from Defendants and Lawmakers		X	Foundation Relevance Hearsay
Doe Pls' Trial Ex. 117	PL01974 - 011975	SB 254 Amendment (350064 - Failed)		X	

Doe Pls' Trial Ex. 118	PL011976 – 011977	SB 254 Amendment (299002 – Failed)		X	
Doe Pls' Trial Ex. 119	PL011978 - 011979	SB 254 Amendment (212692 - Failed)		X	
Doe Pls' Trial Ex. 120	PL011980 - 011981	SB 254 Amendment (374289 - Failed)		X	
Doe Pls' Trial Ex. 121	PL011982 - 011996	SB 254 Amendment (256341) (and Failed Amndts to Amndt)		X	
Doe Pls' Trial Ex. 122	PL011997	SB 254 Amendment (388571 - Failed)		X	
Doe Pls' Trial Ex. 123	PL011998 - 012000	Dr. Hunter Letter to the Editor, JACCP, DOI: 10.1002/jac5.1691 (6.06.22)		X	Hearsay
Doe Pls' Trial Ex. 124	Def_000177 905 - 000177906	Email from Jeremy Redfern re: Surgeon General Ladapo Meeting (7.10.22)		X	
Doe Pls' Trial Ex. 125	PL012001 - 012002	ALEC Legislative Membership List		X	Authentication Foundation Relevance Hearsay
Doe Pls' Trial Ex. 126	PL012138 – PL012143	Notice of Emergency Rules 64B8ER23-11 and 64B15ER23-12	X		

Dated: November 6, 2023

LOWENSTEIN SANDLER LLP

By: /s/ Thomas Redburn, Jr.

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CERTIFICATE OF SERVICE

I hereby certify that, on November 6, 2023, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system.

By: /s/ Thomas Redburn, Jr.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

JANE DOE, individually and on
behalf of her minor daughter,
SUSAN DOE, et al.,

Plaintiffs,

v.

Case No. 4:23-cv-000114-RH-MAF

JOSEPH A. LADAPO, in his
official capacity as Florida's
Surgeon General of the Florida
Department of Health, et al.,

Defendants.

/

**DEFENDANTS' RESPONSES TO PLAINTIFFS' FIRST SET OF
INTERROGATORIES**

Surgeon General Ladapo, the Florida Board of Medicine, the Florida Board
of Osteopathic Medicine, and State Attorney Gladson ("Defendants") respond to
Plaintiffs' first set of interrogatories.

PRELIMINARY STATEMENT

Defendants reserve the right to supplement, clarify, or otherwise amend their
responses to these interrogatories.

Interrogatory No. 1:

Describe in detail each governmental interest that any Defendant contends is
furthered by the Transgender Medical Restrictions, including the factual bas(es) for

that contention, and how the Transgender Medical Restrictions further each of these governmental interest(s).

Response:

Defendants object to the phrase “Transgender Medical Restrictions”; SB 254 and the at-issue board rules are reasonable medical regulations.

Collectively, the challenged health and welfare laws further the governmental interest in ensuring safe, effective, and quality medical care. They ensure that patients are adequately informed of potential benefits and risks of medical treatments, and ensure that patients can be adequately evaluated by and receive treatment from competent, qualified medical professionals.

When and as applied to minors, the challenged health and welfare laws additionally further the governmental interest of protecting children, and specifically protecting children from experimental medical treatments that could lead to negative, permanent health consequences, including sterility, cognitive decline, and cancer.

The factual bases and means-ends tailoring are provided in the responses to interrogatories 2, 3, and 4.

Interrogatory No. 2:

State each and every fact which provided or provides the basis for the Florida Legislature and Boards’ decisions to, through the Physician Requirement, ban APRN-NPs from prescribing Hormones to transgender persons or administer Procedures to transgender adults. As part of your response, identify all Documents that support or undermine these facts, all individuals who were responsible for or assisted with this decision and each such person’s respective role and authority, as well as any reports, studies, or reviews considered in the development and adoption of the Physician Requirements.

Response:

Defendants object to this interrogatory, because the interrogatory is unduly burdensome. The interrogatory asks Defendants to cull through legislative proceedings and records of the Florida House, legislative proceedings and records of the Florida Senate, administrative hearings and records of the Florida Board of Medicine, and administrative hearings and records of the Florida Board of Osteopathic Medicine, read countless pages of records and

listen to countless hours of proceedings, and provide “each and every fact” and “all Documents” that support and reference a specific requirement, all within fourteen days of being served their interrogatories.

Federal Rule of Civil Procedure 33(d) applies:

If the answer to an interrogatory may be determined by examining . . . [and] compiling . . . [Defendants’] records (including electronically stored information), and if the burden of deriving or ascertaining the answer will be substantially the same for either party, [Defendants] may answer by:

- (1) specifying the records that must be reviewed, in sufficient detail to enable the interrogating party to locate and identify them as readily as the responding party could; and
- (2) giving the interrogating party a reasonable opportunity to examine and audit the records and to make copies, compilations, abstracts, or summaries.

Fed. R. Civ. P. 33(d).

Consistent with Rule 33(d), Defendants will provide Plaintiffs with (1) transcripts of relevant legislative and administration proceedings, which are already available to Plaintiffs through the Florida Channel, the Florida Legislature’s websites, and the boards’ websites,¹ and (2) the boards’ administrative record for each hearing. Legislative documentation can be found on the Florida Senate website: <https://www.flsenate.gov/Session/Bill/2023/254>; <https://www.flsenate.gov/Session/Bill/2023/1421>.

The burden of answering the interrogatory is the same for both parties; answering it would require an examination of the proceedings and records.

The deadlines for providing these documents have been provided by the court: August 24 for records and September 10 for transcripts. Doc.130. This is also consistent with the parties’ 26(f) report, which states that “fact discovery will be limited to . . . the legislative and administrative records underlying SB254 and the challenged regulations – specifically, obtaining transcripts of the

¹ Defendants provided Plaintiffs with links to legislative and administrative hearings on Friday, August 11, 2023.

legislative and administrative hearings concerning SB254 and the challenged regulations, as well as any other documents that are part of the legislative or administrative records.” Doc.113 at 7.

Interrogatory No. 3:

State each and every fact which provided or provides the basis for the Florida Legislature decision to impose, and the Boards’ adoption of, the Informed Consent Requirements, including details pertaining to the process undertaken to draft the Informed Consent Requirements, the individuals involved and each person’s respective role and authority. As part of your response, identify all Documents that support or undermine these facts, including any drafts of any of the Informed Consent Requirements (whether they were adopted or not), as well as any reports, studies, or reviews considered in the development and adoption of the Informed Consent Requirements.

Response:

Please refer to the response to interrogatory 2.

Interrogatory No. 4:

State each and every fact which provided or provides the basis for the Florida Legislature and Boards’ decisions banning or restricting access to Hormone and Procedures for transgender minors. As part of your response, identify all Documents that support or undermine these facts, all individuals who were responsible for or assisted with this decision and each such person’s respective role and authority, as well as any reports, studies, or reviews considered in the development and adoption of the Transgender Medical Restrictions that apply only to transgender minors.

Response:

Please refer to the response in interrogatory 2.

Interrogatory No. 5:

Describe any defenses to Plaintiffs’ claims or justifications for the Transgender Medical Restrictions that Defendants plan to present at trial and explain the factual basis for any such defense or justification.

Response:

Defendants object to the phrase “Transgender Medical Restrictions.” SB 254 and the at-issue board rules are reasonable medical regulations.

The interrogatory seeks work-product-privileged information. However, the defenses to Plaintiffs’ claims and the justifications for the at-issue laws are contained within: (1) the *Dekker* trial record, particularly the parties’ expert-witness testimony and the individual plaintiffs’ quality of medical care; (2) the expert reports that Defendants will serve in this case; (3) the legislative and administrative records detailed above; and (4) the arguments contained in Defendants’ two responses to Plaintiffs’ two preliminary-injunction motions. Doc.55, Doc.126.

VERIFICATION

By: _____

Printed Name: Scot Ackerman

As Its: Chairman
Board of Medicine

STATE OF Florida

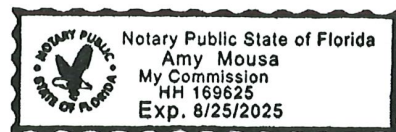
COUNTY OF Duval

The foregoing instrument was acknowledged before me this 16th day of August 2023, by Scot Ackerman, who is personally known to me or has produced _____ as identification, and who swears that the foregoing answers to the First Set of Interrogatories, as to Interrogatories 1 and 5, are true and correct.

Amy Mousa
Notary Public, Signature

(NOTARY SEAL)

Amy Mousa
Notary, Print or Type



Commission No. HH 169625
My Commission Expires 8/25/25



Doe v. Ladapo_Response to First Roggs.pdf

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E-Signature 1: Paul A. Vazquez (PAV)

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 paul.vazquez@flhealth.gov (Principal) (ID Verified)

E-Signature Notary: Amanda Fischer (Man)

August 16, 2023 13:03:59 -8:00 [F79E4A31521E] [142.190.45.174]
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I, Amanda Fischer, did witness the participants named above electronically sign this document.



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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

JANE DOE, individually and on
behalf of her minor daughter,
SUSAN DOE, et al.,

Plaintiffs,

v.

Case No. 4:23-cv-000114-RH-MAF

JOSEPH A. LADAPO, in his
official capacity as Florida's
Surgeon General of the Florida
Department of Health, et al.,

Defendants.

**DEFENDANTS' RESPONSES TO PLAINTIFFS' FIRST SET OF
INTERROGATORIES**

Surgeon General Ladapo, the Florida Board of Medicine, the Florida Board
of Osteopathic Medicine, and State Attorney Gladson ("Defendants") respond to
Plaintiffs' first set of interrogatories.

PRELIMINARY STATEMENT

Defendants reserve the right to supplement, clarify, or otherwise amend their
responses to these interrogatories.

Interrogatory No. 1:

Describe in detail each governmental interest that any Defendant contends is
furthered by the Transgender Medical Restrictions, including the factual bas(es) for



that contention, and how the Transgender Medical Restrictions further each of these governmental interest(s).

Response:

Defendants object to the phrase “Transgender Medical Restrictions”; SB 254 and the at-issue board rules are reasonable medical regulations.

Collectively, the challenged health and welfare laws further the governmental interest in ensuring safe, effective, and quality medical care. They ensure that patients are adequately informed of potential benefits and risks of medical treatments, and ensure that patients can be adequately evaluated by and receive treatment from competent, qualified medical professionals.

When and as applied to minors, the challenged health and welfare laws additionally further the governmental interest of protecting children, and specifically protecting children from experimental medical treatments that could lead to negative, permanent health consequences, including sterility, cognitive decline, and cancer.

The factual bases and means-ends tailoring are provided in the responses to interrogatories 2, 3, and 4.

Interrogatory No. 2:

State each and every fact which provided or provides the basis for the Florida Legislature and Boards’ decisions to, through the Physician Requirement, ban APRN-NPs from prescribing Hormones to transgender persons or administer Procedures to transgender adults. As part of your response, identify all Documents that support or undermine these facts, all individuals who were responsible for or assisted with this decision and each such person’s respective role and authority, as well as any reports, studies, or reviews considered in the development and adoption of the Physician Requirements.

Response:

Defendants object to this interrogatory, because the interrogatory is unduly burdensome. The interrogatory asks Defendants to cull through legislative proceedings and records of the Florida House, legislative proceedings and records of the Florida Senate, administrative hearings and records of the Florida Board of Medicine, and administrative hearings and records of the Florida Board of Osteopathic Medicine, read countless pages of records and

listen to countless hours of proceedings, and provide “each and every fact” and “all Documents” that support and reference a specific requirement, all within fourteen days of being served their interrogatories.

Federal Rule of Civil Procedure 33(d) applies:

If the answer to an interrogatory may be determined by examining . . . [and] compiling . . . [Defendants’] records (including electronically stored information), and if the burden of deriving or ascertaining the answer will be substantially the same for either party, [Defendants] may answer by:

- (1) specifying the records that must be reviewed, in sufficient detail to enable the interrogating party to locate and identify them as readily as the responding party could; and
- (2) giving the interrogating party a reasonable opportunity to examine and audit the records and to make copies, compilations, abstracts, or summaries.

Fed. R. Civ. P. 33(d).

Consistent with Rule 33(d), Defendants will provide Plaintiffs with (1) transcripts of relevant legislative and administration proceedings, which are already available to Plaintiffs through the Florida Channel, the Florida Legislature’s websites, and the boards’ websites,¹ and (2) the boards’ administrative record for each hearing. Legislative documentation can be found on the Florida Senate website: <https://www.flsenate.gov/Session/Bill/2023/254>; <https://www.flsenate.gov/Session/Bill/2023/1421>.

The burden of answering the interrogatory is the same for both parties; answering it would require an examination of the proceedings and records.

The deadlines for providing these documents have been provided by the court: August 24 for records and September 10 for transcripts. Doc.130. This is also consistent with the parties’ 26(f) report, which states that “fact discovery will be limited to . . . the legislative and administrative records underlying SB254 and the challenged regulations – specifically, obtaining transcripts of the

¹ Defendants provided Plaintiffs with links to legislative and administrative hearings on Friday, August 11, 2023.



legislative and administrative hearings concerning SB254 and the challenged regulations, as well as any other documents that are part of the legislative or administrative records.” Doc.113 at 7.

Interrogatory No. 3:

State each and every fact which provided or provides the basis for the Florida Legislature decision to impose, and the Boards’ adoption of, the Informed Consent Requirements, including details pertaining to the process undertaken to draft the Informed Consent Requirements, the individuals involved and each person’s respective role and authority. As part of your response, identify all Documents that support or undermine these facts, including any drafts of any of the Informed Consent Requirements (whether they were adopted or not), as well as any reports, studies, or reviews considered in the development and adoption of the Informed Consent Requirements.

Response:

Please refer to the response to interrogatory 2.

Interrogatory No. 4:

State each and every fact which provided or provides the basis for the Florida Legislature and Boards’ decisions banning or restricting access to Hormone and Procedures for transgender minors. As part of your response, identify all Documents that support or undermine these facts, all individuals who were responsible for or assisted with this decision and each such person’s respective role and authority, as well as any reports, studies, or reviews considered in the development and adoption of the Transgender Medical Restrictions that apply only to transgender minors.

Response:

Please refer to the response in interrogatory 2.

Interrogatory No. 5:

Describe any defenses to Plaintiffs’ claims or justifications for the Transgender Medical Restrictions that Defendants plan to present at trial and explain the factual basis for any such defense or justification.



Response:

Defendants object to the phrase “Transgender Medical Restrictions.” SB 254 and the at-issue board rules are reasonable medical regulations.

The interrogatory seeks work-product-privileged information. However, the defenses to Plaintiffs’ claims and the justifications for the at-issue laws are contained within: (1) the *Dekker* trial record, particularly the parties’ expert-witness testimony and the individual plaintiffs’ quality of medical care; (2) the expert reports that Defendants will serve in this case; (3) the legislative and administrative records detailed above; and (4) the arguments contained in Defendants’ two responses to Plaintiffs’ two preliminary-injunction motions. Doc.55, Doc.126.



VERIFICATION

By:  Paul A. Vazquez
Signed on 2023/08/16 13:03:59 -8:00

Printed Name: Paul A. Vazquez

As Its: _____

STATE OF FLORIDA

COUNTY OF LEON

The foregoing instrument was acknowledged before me this ____ day of _____ 2023, by _____, who is personally known to me or has produced _____ as identification, and who swears that the foregoing answers to the First Set of Interrogatories, as to Interrogatories 2, 3, and 4, are true and correct.



08/16/2023

Notary Public, Signature

Notary, Print or Type

Commission No. _____
My Commission Expires _____

(NOTARY SEAL)



Notarial act performed by audio-visual communication



Dated: August 16, 2023

As to Objections,

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*Counsel for the Surgeon General, the
Department of Health, the Boards of
Medicine, and the individual Board
Members*

CERTIFICATE OF SERVICE

I hereby certify that on August 16, 2023, I emailed this document to counsel
of record.

/s/ Mohammad O. Jazil
Mohammad O. Jazil

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE et al.,

Plaintiffs,

Civil No. 4:23-cv-00114-RH-MAF

v.

JOSEPH A. LADAPO et al.,

Defendants.

**EXPERT REPORT OF ARON JANSSEN, M.D.
ON BEHALF OF PLAINTIFFS**

August 16, 2023

Prepared by
Aron Janssen, M.D.

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PL000580

TABLE OF CONTENTS

	Page
I. INTRODUCTION AND SUMMARY OF OPINIONS	1
A. Qualifications.....	1
B. Compensation	5
C. Prior Testimony.....	5
D. Bases for Opinions.....	5
II. EXPERT OPINIONS	6
A. Gender Identity Development and Gender Dysphoria in Children and Adolescents.....	6
B. Standard of Care for Treatment of Gender Dysphoria in Youth	8
C. Safe and Effective Treatments for Gender Dysphoria.....	10
D. The Role of Mental Health Providers in Assessing Necessity of Medical Treatments for Gender Dysphoria.....	12
E. Assessing Co-Occurring Conditions & Necessity of Medical Treatment for Gender Dysphoria.....	15
F. The Florida Boards’ Informed Consent Forms for Transgender Minors Contain Many False and Misleading Statements that Undermine Rather than Enhance Informed Consent and Impose Unnecessary Mental Health Requirements	19

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I. INTRODUCTION AND SUMMARY OF OPINIONS

1. My name is Aron Janssen, M.D. I am a board-certified child and adolescent psychiatrist. I specialize in the treatment of gender dysphoria in children and adolescents. I have been retained by counsel for Plaintiffs in the above-captioned lawsuit to provide an expert opinion on the standards of care for treating individuals diagnosed with gender dysphoria.

2. Gender dysphoria is a serious medical condition that is highly treatable. There is a well-established standard of care for the treatment of gender dysphoria, including for treatment of gender dysphoria in transgender youth with puberty blockers and hormone therapy. Medical treatment for gender dysphoria in transgender youth provides considerable positive psychological benefits. On my understanding, the rules challenged in this case will prevent Florida's transgender youth and adults who are diagnosed with gender dysphoria from accessing essential medical care. In my professional opinion, transgender youth and adults who cannot obtain the medical care that they need, including puberty blockers and hormone therapy, will suffer and their mental health will deteriorate.

A. *Qualifications*

3. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae. A true and correct copy of my CV is attached as **Exhibit A**.

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4. I received my medical degree from the University of Colorado School of Medicine. I completed my residency in psychiatry and a fellowship in child and adolescent psychiatry at New York University Langone Medical Center.

5. In 2011, I founded the Gender and Sexuality Service at New York University, a clinical service dedicated to treating children and adolescents with gender dysphoria. In my last five years at NYU, that clinic served over 200 families, with 2-3 new referrals each week.

6. I am currently the Vice Chair of the Pritzker Department of Psychiatry and Behavioral Health and Chief Psychiatrist for the Gender Development Program at Ann and Robert H. Lurie Children's Hospital of Chicago. I am also a Clinical Associate Professor of Child and Adolescent Psychiatry at Northwestern University Feinberg School of Medicine. I maintain a clinical practice in Illinois where I treat patients from Illinois and the surrounding states.

7. I have been treating children and adolescents with gender dysphoria for over 10 years. I have treated over 300 children and adolescents with gender dysphoria during my medical career. Currently, approximately 90 percent of the patients in my clinical practice are transgender children and adolescents.

8. I am a contributing author to the Child and Adult Mental Health chapters of the Eighth Version of the World Professional Association for

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Transgender Health's (WPATH) *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* (hereafter, "WPATH SOC").

9. The WPATH SOC provides clinical guidance for health professionals based on the best available science and expert professional consensus. The purpose of the WPATH SOC is to assist health providers in delivering necessary and appropriate medical care to transgender and gender diverse people, in order to maximize their patients' overall health, psychological well-being, and self-fulfillment. The WPATH SOC has been recognized and adopted as the prevailing standard of care by the major professional associations medical and mental health providers in the United States, including the American Medical Association, American Academy of Pediatrics, American Psychiatric Association, American Psychological Association, and Pediatric Endocrine Society, among others.

10. In addition, I have written a number of peer-reviewed journal articles and chapters in professional textbooks about treatment of gender dysphoria in children and adolescents. In 2018, I co-edited *Affirmative Mental Health Care for Transgender and Gender Diverse Youth: A Clinical Casebook*, which is the first published clinical casebook on mental health treatment for children and adolescents with gender dysphoria. A full and complete list of my publications is included in my CV.

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11. I am an Associate Editor for the journal *Transgender Health*, and an Ad Hoc Reviewer for the journal *LGBT Health*. Each of these publications is a peer-reviewed medical journal.

12. I am actively involved in training other medical and mental health providers in the treatment of children and adolescents with gender dysphoria. I have conducted trainings for over 1,000 medical and mental health providers and have given dozens of public addresses, seminars, and lectures on the treatment of gender dysphoria in children and adolescents. 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.

13. I am a member of the following professional organizations: American Psychiatric Association, American Academy of Child and Adolescent Psychiatry (AACAP), and World Professional Association for Transgender Health (WPATH). I am also a co-chair of the Sexual Orientation and Gender Identity Committee of AACAP and have participated in the Gender Dysphoria Working Group of the American Psychiatric Association, and the Transgender Health Committee of the Association of Gay and Lesbian Psychiatrists.

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B. Compensation

14. I am being compensated at an hourly rate of \$400/hour plus expenses for my time spent in connection with this case. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

C. Prior Testimony

15. In the previous four years, I have provided expert testimony by deposition or at trial in *Dekker v. Weida*, No. 4:22-cv-00325-RH-MAF (N.D. Fla.), *B.P.J. v. West Virginia State Board of Education et al.*, No. 2:21-cv-00316 (S.D.W.V.), *L.E. v. Lee et al*, No. 3:21-cv-00835 (M.D. Tenn.), and *Loe v. Texas*, No. D-1-GN-23-003616 (District Court of Texas, Travis County).

D. Bases for Opinions

16. My opinions contained in this report are based on: (1) my clinical experience as a psychiatrist treating transgender patients, including adolescents and young adults; (2) my knowledge of the peer-reviewed research, including my own, regarding the treatment of gender dysphoria, which reflects the clinical advancements in the field of transgender health; (3) my work as a contributing author of the WPATH SOC; and (4) my review of the law challenged in this case. In preparing this report, I have also reviewed the materials listed in the attached bibliography, **Exhibit B**. The sources cited therein are authoritative, scientific peer-reviewed publications. These are the same types of materials that experts in my field

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of study regularly rely upon when formulating 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.

17. Additionally, I have reviewed the text of Florida Senate Bill 254, and the text of the emergency rules adopted by the Florida Boards of Medicine and Osteopathic Medicine entitled “Sex-reassignment Standards of Practice in Minors” (64B8ER23-7, 64B15ER23-9) and “Mandatory Standardized Informed Consent for Sex-reassignment Prescriptions or Procedures in Adults” (664B8ER23-8, 4B15ER23-10), along with the informed consent forms that each rule adopts.

II. EXPERT OPINIONS

A. *Gender Identity Development and Gender Dysphoria in Children and Adolescents*

18. At birth, infants are assigned a sex, either male or female, based on the appearance of their external genitalia. For most people, their sex assigned at birth, or assigned sex, matches that person’s gender identity. For transgender people, their assigned sex does not align with their gender identity.

19. Gender identity is a person’s innate sense of their gender. It is a core and universal component of human identity.

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20. It is essential to a person's mental health and well-being to be able to live consistent with their gender identity. This is true for transgender and non-transgender people.

21. Gender identity has a biological basis and cannot be altered through medical or psychological interventions.

22. The evidence demonstrating that gender identity cannot be altered, either for transgender or for non-transgender individuals, underscores the innate nature of gender identity. Past attempts to "cure" transgender individuals by using talk therapy, and even aversive therapy, to change their gender identity to match their birth-assigned sex were ineffective and caused harm. The major associations of medical and mental health providers, such as the American Medical Association, the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, the American Psychological Association, and WPATH's standards of care, consider such efforts harmful and unethical.

23. Gender dysphoria is the medical diagnosis for the severe and unrelenting psychological distress resulting from the incongruity between a transgender person's assigned sex and their gender identity. That distress can be alleviated when a transgender person is able to live consistent with their gender identity.

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24. It is a serious medical condition and is listed in the Diagnostic and Statistical Manual, Version 5 (DSM-5), the diagnostic and coding compendium for mental health professionals.

B. *Standard of Care for Treatment of Gender Dysphoria in Youth*

25. Like all children, transgender children can thrive, grow into healthy adults, and have the same capacity for happiness, achievement, and contribution to society as others. For this group of young people, that means supporting their need to live in a manner consistent with their gender identity in all aspects of their lives.

26. Accordingly, the goal of treatment for gender dysphoria is to reduce distress and improve functioning which often occurs through the process of enabling the individual to live consistent with their gender identity. The process of undergoing those treatments is often referred to as gender transition. The stages that make up a transgender person's gender transition will depend on that individual's medical and mental health needs. The purpose of transition is to allow a transgender person to live congruently with their gender identity, including in many cases undergoing medical treatments to align the person's body with who they are.

27. Typically, transgender people start their transition with a series of steps that are commonly referred to as a "social transition." Those steps include, but are not limited to, changing their name, using different pronouns, wearing clothing and adopting grooming habits typically associated with their gender identity. Making

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those changes enable a transgender person to begin living their life consistent with their gender identity and helps ensure that they are treated as such by family, peers, and others in the community. It is important to note that there are no medical interventions for pre-pubertal transgender and gender-diverse children. For some children, social transition is an appropriate intervention, while for others, treatment for gender dysphoria may involve but not be limited to building family and social support or building resilience.

28. After the onset of puberty, transgender young people may also start taking puberty-delaying medication to prevent the development of unwanted and psychologically distressing secondary-sex characteristics that conflict with the person's identity.

29. Gender affirming hormone therapy is medically necessary for some transgender young people regardless of whether they have taken puberty-delaying medication. That treatment causes their bodies to develop the secondary-sex characteristics more aligned with their gender identity, such as facial and body hair for boys who are transgender and female breast development in girls who are transgender.

30. Delaying any of these treatments, including puberty blockers or hormone therapy, when determined to be medically necessary will not only exacerbate a transgender young person's gender dysphoria, but also could lead to

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the development of other co-occurring mental health conditions, including depression, anxiety, and disordered eating. Those co-occurring mental health conditions may be accompanied by unhealthy coping behaviors such as self-harm, substance misuse, and suicide attempts.

C. Safe and Effective Treatments for Gender Dysphoria

31. Research and clinical experience repeatedly reaffirm that gender transition significantly improves the mental and physical health of transgender young people and is the only treatment that has been demonstrably effective for gender dysphoria.

32. This is true of each stage of a transgender young person's gender transition. Transgender young people who underwent a social transition in childhood demonstrated better mental health profiles than prior studies of gender nonconforming children. *See* Lily Durwood, et al., *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. Am. Acad. of Child & Adol. Psychiatry 116 (2017); Kristina Olson, et al., *Mental Health of Transgender Children who are Supported in Their Identities*, 137 Pediatrics 1 (2016). This same outcome has also been seen in a longitudinal study of transgender young people who underwent each of the three stages of transition outlined above. Annelou L.C. de Vries, et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014).

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33. Gender transition also can—and often does—alleviate co-occurring mental health issues a transgender young person experienced prior to transition. Following transition, transgender young people often see significant improvements in functioning and quality of life. Treating their gender dysphoria also increases a transgender young person’s capacity to develop and maintain better coping strategies to manage any co-occurring conditions. For example, a recent study found that after two years of hormone treatment, transgender youth experienced increases in positive affect and life satisfaction and decreases in depression and anxiety symptoms. Diane Chen, et al., *Psychosocial Functioning in Transgender Youth after Two Years of Hormones*, 388 N. Engl. J. Med. 240 (2023).

34. Research shows that gender transition significantly improves the mental health of transgender young people, bringing their mental health profiles into alignment with their non-transgender peers. Kristina Olson, et al., *Mental health of transgender children who are supported in their identities*, 137 Pediatrics 1 (2016);¹ see also Jack Turban, et al., *Pubertal suppression for transgender youth and risk of suicidal ideation*, 145 Pediatrics 1 (2020) (transgender people who accessed puberty suppression treatment were 70% less likely to contemplate suicide).

¹ Anxiety was the only area where transgender young people differed from the non-transgender controls. On that measure, transgender young people showed slightly elevated levels of anxiety, but were still in the pre-clinical range.

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35. Well-established research demonstrates the effectiveness of gender transition as treatment for gender dysphoria in adolescence. Jack Turban, Annelou DeVries & Kenneth Zucker, *Gender Incongruence & Gender Dysphoria*, in *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook*, (A Martin, et al., eds., 5th ed., 2018).

D. *The Role of Mental Health Providers in Assessing Necessity of Medical Treatments for Gender Dysphoria*

36. The first objective of a mental health provider treating a child or adolescent who appears to be experiencing gender dysphoria is to conduct a careful and thorough assessment. That assessment allows the provider to accurately diagnose the patient, including whether the patient meets the stringent criteria for gender dysphoria and any co-occurring conditions. The foundation of the assessment process is building a detailed history of the patient, such as prior treatment, trauma, substance misuse, among many other factors. That assessment also requires a developmentally informed exploration of the patient's relationship to their gender identity over time that includes information obtained from multiple informants whenever possible.

37. To appropriately conduct that assessment, the mental health provider must draw from their professional training and experience in working with transgender young people, exercise professional judgment, and tailor the assessment to each individual patient and their family. The number of sessions that assessment

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requires will vary depending on the patient's presentation and the complexity of the issues the patient is navigating. The assessment process also goes beyond gathering information from the patient and their family.

38. A detailed history and assessment are important to provide the context for developing an appropriate treatment plan. That comprehensive assessment is also needed to help inform possible future care plans, such as the patient's need for puberty blockers or hormone therapy.

39. A critical element of the standard of care is that it does not presume that being transgender is incompatible with a young person's short- and long-term health and well-being. That is consistent with DSM-5 diagnostic criteria which is "focus[ed] on dysphoria as the clinical problem, not identity per se." American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, 451 (2013). As a result, therapists practicing consistent with the standard of care will create a space where the patient can explore their gender identity, knowing that being transgender and not being transgender are both equally acceptable outcomes.²

² As observed in the context of research on gender identity conversion efforts and family rejection, attempting to influence a young person's gender identity development is harmful, ineffective, and unethical. For example, a recent study found that being exposed to gender identity conversion efforts was associated with greater odds of attempting suicide, especially for those who had those experiences in childhood. Jack Turban, et al., *Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults*, 77 JAMA Psychiatry 68 (2020).

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40. Providing that individualized mental health treatment means that mental health providers are not simply a rubber-stamp in the process for accessing treatment for gender dysphoria. Instead, as is the case with all effective mental health treatment, the focus of the treatment is supporting overall health and well-being, regardless of whether the young person continues to identify as transgender. As a result, I have had patients who presented with some symptoms of gender dysphoria, but who ultimately did not meet the diagnostic criteria for a variety of reasons, and therefore I recommended treatments other than transition to alleviate their psychological distress. My experience in working with and speaking with other gender specialists is that this is routine throughout the profession. Part of the rigor of the diagnostic protocol is distinguishing between youth who are engaged in gender exploration from youth who are transgender and who do or will need treatment for gender dysphoria.

41. For young people who do meet the diagnostic criteria for gender dysphoria, mental health treatment often involves referring a patient for medical treatments. That process involves an assessment of the patient's gender dysphoria, co-occurring conditions, and the medical treatment's likely effect on the patient's overall mental health and functioning. As part of that process, providers also discuss the risks, benefits, and alternatives to treatment with transgender young people and their parents.

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42. A patient's readiness to begin a particular course of medical treatment requires an evaluation of the patient's and the parent's/caregiver's understanding of the goals and potential limitations of the contemplated treatment. For example, for puberty-blocking medication, the provider will gauge the patient's ability to comprehend the effects of puberty on their body and mental health. An integral part of that discussion is evaluating a patient's grasp of the consequences of stopping those physical changes from occurring and alternatives to puberty-blocking treatment.

43. The mental health provider will then document the results of their assessment in a letter or note to the patient's treating physician. The letter or note documents the provider's diagnostic analysis as well as any professional opinions regarding the benefits of and readiness for the contemplated treatment. Ultimately, the appropriateness of any medical treatment is determined by a multidisciplinary team of mental health and medical care providers.

E. Assessing Co-Occurring Conditions & Necessity of Medical Treatment for Gender Dysphoria

44. The existence—and prevalence—of co-occurring conditions among transgender young people is unsurprising. Transgender young people must cope with many stressors from the fear of rejection from family and peers to pervasive societal discrimination. In addition, their underlying gender dysphoria can cause

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significant psychological distress, which, if left untreated, can result in the development of co-occurring conditions.

45. Transgender young people, however, are not outliers in this regard. Research and clinical experience show that most psychiatric conditions are highly correlated with other co-occurring psychiatric conditions. For example, young people with depression are very likely to have at least one other diagnosable condition, most often anxiety. *See, e.g., E. Jane Costello, et al., Prevalence and development of psychiatric disorders in childhood and adolescence*, 60 *Archives of Gen. Psychiatry* 837 (2003) (“There was strong heterotypic continuity from depression to anxiety” and finding approximately 30% of participants diagnosed with a depressive disorder were also diagnosed with an anxiety disorder). Likewise, a study on children diagnosed with Attention-Deficit/Hyperactivity Disorder found between 74-79% participants had additional co-occurring psychiatric conditions. Timothy Wilens, et al., *Psychiatric Comorbidity and Functioning in Clinically Referred Preschool Children and School-Age Youths With ADHD*, 41 *J. of Am. Academy of Child & Adol. Psychiatry* 262 (2002).

46. A comprehensive assessment—the cornerstone of the prevailing standards of care for the treatment of gender dysphoria—not only seeks to identify any co-occurring conditions, but also to evaluate the effect those conditions have on a transgender person’s functioning. This is equally true when assessing whether

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medical treatment for gender dysphoria is necessary from a mental health perspective.

47. The standards of care recognize that it is not possible for a transgender patient to resolve all co-occurring conditions prior to undergoing medical treatment, nor would it be ethical to impose such a requirement. Resolving all co-occurring conditions before medical treatment is not a requirement for other conditions. Gender dysphoria, by definition, is accompanied by clinically significant psychological distress. That distress can take on many different forms (*e.g.*, anxiety, mood disorders, and depression) and vary greatly in severity, resulting in co-occurring conditions. Because psychological distress is not easily compartmentalized, the distress associated with gender dysphoria can also amplify co-occurring conditions that developed independently of the gender dysphoria. In either situation, gender dysphoria limits the effectiveness of treatment of any co-occurring mental health conditions. Thus, treating the underlying gender dysphoria is essential to alleviating the psychological distress associated with co-occurring conditions.

48. Even assuming that it was possible to cure a patient's co-occurring conditions, delaying medical treatment can cause very real harms to a transgender person's physical and mental health. Without medical treatment, their gender dysphoria would continue to persist and often worsen. At a minimum, that increased

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distress would interfere with the treatment for the person's co-occurring conditions, subjecting them unnecessarily to a longer course of treatment. It is often seen that the gender dysphoria would eclipse the person's co-occurring conditions, not only entirely impeding treatment of those co-occurring conditions, but also resulting in an overall deterioration of their mental health. The increased distress from their gender dysphoria would translate to resorting to negative coping mechanisms (*i.e.*, self-harm), suicidal ideation, and suicide attempts—just as it could if that increased distress was attributable to a co-occurring condition.

49. Gender dysphoria is a real and serious medical condition that is highly treatable. There is a rigorous and comprehensive protocol for diagnosing an individual with the condition. There is also a well-established standard of care for the treatment of gender dysphoria, including for treatment of gender dysphoria in transgender youth with puberty blockers and hormone therapy. When that treatment is provided, transgender youth can thrive. There are studies that have demonstrated that, and my own experience confirms it.

50. Medical treatment for gender dysphoria has immense psychological benefits for youth, bringing their mental health to a level similar to their non-transgender peers. My understanding is that the rules challenged in this case will prevent transgender youth and adults in Florida who are diagnosed with gender dysphoria from getting essential medical care that they need. In my professional

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opinion, if transgender youth cannot get the medical care that they need, including puberty blockers and hormone therapy, they will suffer and their mental health will deteriorate.

F. *The Florida Boards' Informed Consent Forms for Transgender Minors Contain Many False and Misleading Statements that Undermine Rather than Enhance Informed Consent and Impose Unnecessary Mental Health Requirements*

51. It is my understanding that Florida Senate Bill 254 prohibits minors from being prescribed puberty blockers and hormone therapy after May 17, 2023. However, minors whose treatment was commenced before and still active on that date may continue to receive medications subject to using the required informed consent forms and complying with other requirements adopted by the Florida medical boards. I have reviewed the rules and informed consent forms adopted by the boards for continuing treatment of minors. In my opinion, those forms include many false and misleading statements, as well as imposing unnecessary mental health requirements that are inconsistent with the standards of care.

52. By way of example, the consent forms state: "Medical treatment of people with gender dysphoria is based on very limited, poor-quality research with only subtle improvements seen in some patient's psychological functioning in some, but not all, research studies. This practice is purely speculative, and the possible psychological benefits may not outweigh the substantial risks of medical treatments and, in many cases, the need for lifelong medical treatments." This is not correct. As

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discussed above, established research shows that medical treatment for gender dysphoria offers significant mental health benefits for transgender adolescents. The research demonstrating the safety and effectiveness of medical care for gender dysphoria is of a similar type as the research that medical professionals rely on in treating many other conditions.

53. The consent forms state that “psychological therapy with a mental health care provider” is an alternative treatment option for patients or parents who do not wish to start or continue treatment with puberty blockers or hormone therapy. This statement is incorrect to the extent it indicates that therapy alone is an effective alternative treatment for adolescents or adults for whom puberty blockers or hormone therapy are medically indicated. As noted, the focus of effective mental health treatment is supporting a person’s overall health and well-being. While therapy offers important benefits for many people, whether or not they are transgender, there is no evidence that therapy alone can alleviate gender dysphoria in adolescents for whom treatment with puberty blockers or hormone therapy is otherwise indicated.

54. The consent forms also state that treatment with puberty blockers or hormone therapy “will not prevent serious psychiatric events, including suicide.” This statement is incorrect to the extent it indicates that these medications are not likely to have a beneficial effect on a transgender adolescent’s mental health, or that

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these treatments cannot reduce suicidality. As discussed above, research and clinical experience establish that all stages of gender transition, including treatment with puberty blockers and hormone therapy when appropriate, significantly improve the mental and physical health of transgender adolescents and is the only demonstrably effective treatment for gender dysphoria.

55. The above statements represent just a few of the more significant examples of the false or misleading statements present in the consent forms adopted by the boards.

56. In addition to containing inaccurate statements, the informed consent forms also impose various requirements and conditions for treatment with puberty blockers and hormone therapy that have no medical basis. For example, to continue treatment, an adolescent must undergo “an annual mental health assessment to be performed by a board-certified Florida licensed psychiatrist or psychologist.” The WPATH Standards of Care do not require a that either initial or ongoing assessments may be performed only by a psychiatrist or psychologist. To the contrary, the standards recognize that different types of medical and mental health professionals may be qualified to assess a transgender adolescent or adult for puberty blockers or hormone therapy. The WPATH standards state that professionals working with transgender adolescents should hold appropriate licensing and qualifications in a relevant clinical field and have relevant training and expertise in gender identity, and

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they encourage care to be provided by a multidisciplinary team, but they do not limit mental health assessment or care to psychiatrists or psychologists only, and such a requirement appears to serve no purpose except to impede access to care. The WPATH standards specifically emphasize that “lack of available disciplines should not preclude a young person from accessing needed care in a timely manner.” WPATH SOC 8, Statement 6.9.

57. For similar reasons, there is no medical basis for a requirement that a transgender adolescent be re-evaluated by a psychiatrist or psychologist every year, for a requirement that all transgender adolescents receiving puberty blockers or hormone therapy receive a “suicide risk assessment by a licensed mental health care professional” every three months. As discussed above, medical treatment for gender dysphoria has enormous benefits for transgender adolescents. While many adolescents, transgender and non-transgender alike, experience suicidality and other mental health challenges, there is no evidence that treatment with puberty blockers or hormone therapy requires special ongoing mental health assessments not required for other adolescents. Ongoing mental health care and assessment depends on an adolescent’s individual needs and may be provided by primary care providers and/or mental health professionals. The WPATH Standards of Care encourage health care providers to maintain an ongoing relationship with transgender adolescents

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receiving medical treatment for gender dysphoria, but they do not require these types of formal mental health assessments. WPATH SOC 8, Statement 6.8.

58. There also is no evidence-based medical justification for an inflexible requirement that every adolescent receiving puberty blockers or hormone therapy must have “[c]ontinued counseling with a licensed mental health care professional during the treatment period, with the frequency recommended by the licensed mental health care professional.” The WPATH Standards of Care encourage health care providers to maintain an ongoing relationship that “provide space for adolescents and caregivers to share important psychosocial aspects of emotional well-being,” but they do not require ongoing mental health therapy or counseling in all cases. WPATH SOC 8, Statement 6.8.

59. The standards recognize that adolescents may experience barriers to care arising from their inability to access specific types of providers such as mental health professionals and urge flexibility in determining appropriate ongoing clinical relationships, and they also note that “many transgender adolescents are well-functioning and experience few if any mental health concerns.” WPATH SOC 8, Statement 6.12.d. For these youth, ongoing mental health therapy or counseling during treatment may be unnecessary.

60. The consent forms also require an in-person visit before an adolescent may be prescribed treatment, and in-person follow-up visits every six months. These

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requirements are unnecessary and contradict the standards of care, which emphasize that adolescents should not be prevented from obtaining treatment due to lack of access to medical resources. While regular follow-up is appropriate during treatment, there is no medical justification for inflexibly requiring all of those visits to be in person. Providing options such as virtual visits may better serve the needs of some patients and improve the frequency and quality of ongoing follow-up care.

61. S.B. 254 and the informed consent forms also impose an unnecessary and medically unjustified requirement that transgender patients (and their parent in the case of an adolescent patient) must sign the mandatory consent forms in an in-person meeting with their physician. A frank and candid discussion of the risks and benefits of puberty blockers and hormone therapy does not require an in-person visit and can easily be accomplished through other methods such as a video or audio conference. This requirement is not imposed for other patients or other medications, including the many other medications that pose greater risks.

62. I hold each of the opinions expressed in this report with a reasonable degree of scientific certainty, based on the materials I have reviewed and on my education, experience, and knowledge. I reserve the right to supplement, amend, or modify my opinions upon review of further information, including, but not limited to, testimony, documents, and reports I receive after

CONFIDENTIAL

the date of this report.

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

Executed this 16th day of August 2023.



Aron Janssen, M.D.

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Exhibit A
Curriculum Vitae

Curriculum Vitae

Aron Janssen, M.D.

Personal Data

Born Papillion, Nebraska
 Citizenship USA

Academic Appointments

2011-2017 Clinical Assistant Professor of Child and Adolescent Psychiatry
 2011-2019 Founder & Clinical Director, NYU Gender and Sexuality
 Service Director, LGBT Mental Health Elective, NYULMC
 2015-2019 Co-Director, NYU Pediatric Consultation Liaison Service New
 York University Department of Child and Adolescent
 Psychiatry 2017-present Clinical Associate Professor of Child
 and Adolescent Psychiatry
 2019-present Vice Chair, Pritzker Department of Psychiatry and Behavioral
 Health Ann and Robert H. Lurie Children's Hospital of
 Chicago
 2020-present Medical Director, Outpatient Psychiatric Services Ann and
 Robert H. Lurie Children's Hospital of Chicago

Education

Year	Degree	Field	Institution
6/97	Diploma		Liberty High School
5/01	B.A.	Biochemistry	University of Colorado
5/06	M.D.	Medicine	University of Colorado

Postdoctoral Training

2006-2009 Psychiatry Residency Ze'ev Levin, M.D. NYU Department of
 Psychiatry
 2009-2011 Child and Adolescent Psychiatry Fellowship – Fellow and Clinical
 Instructor Jess Shatkin, M.D. NYU Dept of Child/Adolescent
 Psychiatry

Licensure and Certification

2007-2018 New York State Medical License
 2017-present Illinois Medical License
 2011-present Certification in Adult Psychiatry, American Board of Psychiatry and
 Neurology 2013-present Certification in Child and Adolescent Psychiatry, ABPN

Academic Appointments

2009-2011 Clinical Instructor, NYU Department of Child and Adolescent
 Psychiatry 2011-2017 Clinical Asst Professor, NYU Dept of Child and
 Adolescent Psychiatry 2017-2019 Clinical Assoc Professor, NYU Dept of Child

and Adolescent Psychiatry 2011-2019 Clinical Director, NYU Gender and Sexuality Service

2015-2019 Co-Director, NYU Pediatric Consultation-Liaison Service

2019-present Associate Professor of Child and Adolescent Psychiatry,

Northwestern University 2019-present Vice Chair of Clinical Affairs, Pritzker Department of Psychiatry and Behavioral

Health, Lurie Children's Hospital of Chicago

Major Committee Assignments**International, National and Regional**

2021-present Sexual Orientation and Gender Identity Committee,
Chair, AACAP 2019-present WPATH Standards of Care Revision
Committee, Children
2019-present WPATH Standards of Care Revision Committee, Adult
Mental Health 2015-2019 Department of Child Psychiatry Diversity
Ambassador
2013-2021 Sexual Orientation and Gender Identity Committee
Member, AACAP 2012-2019 Founder and Director, Gender Variant Youth and
Family Network 2012-present Association of Gay and Lesbian
Psychiatrists, Transgender Health
Committee
2012-2019 NYULMC, Chair LGBTQ Advisory Council
2012-2019 NYULMC, Child Abuse and Protection
Committee 2013-2015 NYULMC, Pediatric Palliative Care
Team
2003-2004 American Association of Medical Colleges (AAMC), Medical
Education Delegate
2004-2006 AAMC, Western Regional
Chair Psychiatry Residency
2006-2009 Resident Member, Education Committee
2007-2008 Resident Member, Veterans Affairs (VA)
Committee Medical School
2002-2006 Chair, Diversity Curriculum Development Committee
2002-2006 AAMC, Student Representative
2003-2004 American Medical Student Assoc. (AMSA) World AIDS Day Coordinator
2003-2004 AMSA, Primary Care Week Coordinator
2004-2006 Chair, Humanism in Medicine Committee

Memberships, Offices, and Committee Assignments in Professional Societies

2006-present American Psychiatric Association (APA)
2009-present American Academy of Child and Adolescent Psychiatry
(AACAP) 2011-present World Professional Association for
Transgender Health (WPATH) 2011-2019 Director, Gender Variant Youth
and Family Network, NYC
2013-2019 Chair, NYU Langone Medical Center LGBTQ Council

Editorial Positions

2016-2018 Clinical Assistant Editor, *Transgender Health*
2014-present Ad Hoc Reviewer, *LGBT Health*.
2016-present Ad Hoc Reviewer, *JAACAP*
2018-present Associate Editor, *Transgender Health*
2020-present Ad Hoc Reviewer, *Pediatrics*

Principal Clinical and Hospital Service Responsibilities

2011-2019 Staff Psychiatrist, Pediatric Consultation Liaison

Service 2011-2019 Faculty Physician, NYU Child Study Center

2011-2019 Founder and Clinical Director, NYU Gender & Sexuality Service

2015-2019 Co-Director, Pediatric Consultation Liaison Service
 2019-present Vice Chair, Pritzker Dept of Psychiatry and
 Behavioral Health 2019-present Chief Psychiatrist, Gender
 Development Program
 2020-present Medical Director, Outpatient Psychiatry Services

Relevant Program Development

Gender and Sexuality Service

- founded by Aron Janssen in 2011, who continues to direct the service
- first mental health service dedicated to transgender youth in NYC
- served over 200 families in consultation, with 2-3 referrals to the gender clinic per week
- trained over 500 mental health practitioners in transgender mental health – 1 or 2 full day trainings in partnership with the Ackerman Institute’s Gender and Family Project (GFP) and with WPATH Global Educational Initiative (GEI)
- New hires in Adolescent Medicine, Psychology, Plastic Surgery, Urology, Gynecology, Endocrinology, Social Work, Department of Population Health with focus on transgender care has led to expansion of available services for transgender youth at NYULMC in partnership with the Gender and Sexuality Service
- development of partnerships with Ackerman Institute, Callen-Lorde Health Center – both institutions have been granted access to our IRB and have agreed to develop shared research and clinical priorities with the Gender and Sexuality Service.
- multiple IRB research projects underway, including in partnership with national and international clinics
- model has been internationally recognized

Clinical Specialties/Interests

Gender and Sexual Identity Development
 Co-Occurring Mental Health Disorders in Transgender children, adolescents and adults
 Pediatric Consultation/Liaison Psychiatry
 Psychotherapy
 Gender Affirmative Therapy, Supportive Psychotherapy, CBT, MI

Teaching Experience

2002-2006 Course Developer and Instructor, LGBT Health (University of Colorado School of Medicine)
 2011-2019 Instructor, Cultural Competency in Child Psychiatry (NYU Department of Child and Adolescent Psychiatry) – 4 hours per year
 2011-2019 Course Director, Instructor “Sex Matters: Identity, Behavior and Development” – 100 hours per year
 2011-2019 Course Director, LGBT Mental Health Elective (NYU Department of Psychiatry)

2011-2019	- 50 hours of direct supervision/instruction per year Course Director, Transgender Mental Health (NYU Department of Child and Adolescent Psychiatry – course to begin in Spring 2018).
2015-2019	Instructor, Gender & Health Selective (NYU School of Medicine) – 4 hours per year.

Academic Assignments/Course Development

New York University Department of Child and Adolescent Mental Health Studies
-Teacher and Course Director: “Sex Matters: Identity, Behavior and Development.”

A full semester 4 credit course, taught to approximately 50 student per year since 2011, with several students now in graduate school studying sexual and gender identity development as a result of my mentorship.

NYU Department of Child and Adolescent Psychiatry

-Instructor: Cultural Competency in Child and Adolescent Psychiatry

-Director: LGBTQ Mental Health

Elective World Professional Association of
Transgender Health

-Official Trainer: Global Education Initiative – one of two child psychiatrists charged with training providers in care of transgender youth and adults.

Peer Reviewed Publications

1. Janssen, A., Erickson-Schroth, L., “A New Generation of Gender: Learning Patience from our Gender Non-Conforming Patients,” *Journal of the American Academy of Child and Adolescent Psychiatry*, Volume 52, Issue 10, pp. 995-997, October, 2013.
2. Janssen, A., et. al. “Theory of Mind and the Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning Autism Spectrum
3. Janssen A, Huang H, and Duncan C., *Transgender Health*. February 2016, “Gender Variance Among Youth with Autism: A Retrospective Chart Review.” 1(1): 63-68. doi:10.1089/trgh.2015.0007.
4. Goedel WC, Reisner SL, Janssen AC, Poteat TC, Regan SD, Kreski NT, Confident G, Duncan DT. (2017). Acceptability and Feasibility of Using a Novel Geospatial Method to Measure Neighborhood Contexts and Mobility Among Transgender Women in New York City. *Transgender Health*. July 2017, 2(1): 96-106.
5. Janssen A., et. al., “Gender Variance Among Youth with ADHD: A Retrospective Chart Review,” in review
6. Janssen A., et. al., “Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents,” *Journal of Child & Adolescent Psychology*, 105-115, January 2018.
7. Janssen A., et. al., “A Review of Evidence Based Treatments for Transgender Youth Diagnosed with Social Anxiety Disorder,” *Transgender Health*, 3:1, 27–33, DOI: 10.1089/ trgh.2017.0037.
8. Janssen A., et. al., “The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study,” *Archives of Sexual Behavior*, 2019. # 3563492
9. Kimberly LL, Folkers KM, Friesen P, Sultan D, Quinn GP, Bateman-House A, Parent B, Konnoth C, Janssen A, Shah LD, Bluebond-Langner R, Salas-Humara C., “Ethical Issues in Gender-Affirming Care for Youth,” *Pediatrics*, 2018 Dec;142(6).
10. Strang JF, Janssen A, Tishelman A, Leibowitz SF, Kenworthy L, McGuire JK, Edwards-Leeper L, Mazefsky CA, Rofey D, Bascom J, Caplan R, Gomez-Lobo V, Berg D, Zaks Z, Wallace GL, Wimms H, Pine-Twaddell E, Shumer D, Register-Brown K, Sadikova E, Anthony LG., “Revisiting the Link: Evidence of the Rates of

Autism in Studies of Gender Diverse Individuals,” *Journal of the American Academy of Child and Adolescent Psychiatry*, 2018 Nov;57(11):885-887.

11. Goedel William C, Regan Seann D, Chaix Basile, Radix Asa, Reisner Sari L, Janssen Aron C, Duncan Dustin T, “Using global positioning system methods to explore mobility patterns and exposure to high HIV prevalence neighbourhoods among transgender women in New York City,” *Geospatial Health*, 2019 Jan; 14(2): 351-356.
12. Madora, M., Janssen, A., Junewicz, A., “Seizure-like episodes, but is it really epilepsy?” *Current Psychiatry*. 2019 Aug; 18(8): 42-47.
13. Janssen, A., Busa, S., Wernick, J., “The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study,” *Archives of Sexual Behavior*. 2019 Oct; 48(7): 2003-2009.
14. Wernick Jeremy A, Busa Samantha, Matouk Kareen, Nicholson Joey, Janssen Aron, “A Systematic Review of the Psychological Benefits of Gender-Affirming Surgery,” *Urol Clin North Am*. 2019 Nov; 46(4): 475-486.
15. Strang, J.F., Knauss, M., van der Miesen, A.I.R., McGuire, J., Kenworthy, L., Caplan, R., Freeman, A.J., Sadikova, E., Zacks, Z., Pervez, N., Balleur, A., Rowlands, D.W., Sibarium, E., McCool, M.A., Ehrbar, R.D., Wyss, S.E., Wimms, H., Tobing, J., Thomas, J., Austen, J., Pine, E., Willing, L., Griffin, A.D., Janssen, A., Gomez-Lobo, A., Brandt, A., Morgan, C., Meagher, H., Gohari, D., Kirby, L., Russell, L., Powers, M., & Anthony, L.G., (in press 2020). A clinical program for transgender and gender-diverse autistic/neurodiverse adolescents developed through community-based participatory design. *Journal of Clinical Child and Adolescent Psychology*. DOI 10.1080/15374416.2020.1731817
16. Coyne, C. A., Poquiz, J. L., Janssen, A., & Chen, D. Evidence-based psychological practice for transgender and non-binary youth: Defining the need, framework for treatment adaptation, and future directions. *Evidence-based Practice in Child and Adolescent Mental Health*.
17. Janssen, A., Voss, R.. Policies sanctioning discrimination against transgender patients flout scientific evidence and threaten health and safety. *Transgender Health*.
18. Dubin, S., Cook, T., Liss, A., Doty, G., Moore, K., Janssen, A. (In press 2020). Comparing Electronic Health Records Domains’ Utility to Identify Transgender Patients. *Transgender Health*, DOI 10.1089/trgh.2020.0069

Published Abstracts

1. Thrun, M., Janssen A., et. al. “Frequency of Patronage and Choice of Sexual Partners may Impact Likelihood of HIV Transmission in Bathhouses,” original research poster presented at the 2007 Conference on Retroviruses and Opportunistic Infections, February, 2007.
2. Janssen, A., “Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations.” Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting, October 2012.
3. Janssen, A., “Gender Variance in Childhood and Adolescents: Training the Next Generation of Psychiatrists,” 23rd Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, February 2014.

4. Janssen, A., "When Gender and Psychiatric Acuity/Comorbidities Overlap: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth," AACAP Annual Meeting, October 2014.
5. Janssen, A., "Patient Experiences as Drivers of Change: A unique model for reducing transgender health disparities as an academic medical center," Philadelphia Transgender Health Conference, June 2016.
6. Janssen, A., "How much is too much? Assessments & the Affirmative Approach to TGNC Youth," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
7. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
8. Janssen, A., "Gender Variance Among Youth with Autism: A Retrospective Chart Review," Research Poster, 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
9. Janssen, A., "Gender Fluidity and Gender Identity Development," Center for Disease Control – STD Prevention Conference, September 2016.
10. Janssen, A., "Transgender Identities Emerging During Adolescents' Struggles With Mental Health Problems," AACAP Annual Conference, October 2016.
11. Janssen, A., "How Much is Too Much? Assessments and the Affirmative Approach to Transgender and Gender Diverse Youth," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
12. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
13. Sutter ME, Bowman-Curci M, Nahata L, Tishelman AC, Janssen AC, Salas-Humara C, Quinn GP. Sexual and reproductive health among transgender and gender-expansive AYA: Implications for quality of life and cancer prevention. Oral presentation at the Oncofertility Consortium Conference, Chicago, IL. November 14, 2017.
14. Janssen, A., Sidhu, S., Gwynette, M., Turban, J., Myint, M., Petersen, D., "It's Complicated: Tackling Gender Dysphoria in Youth with Autism Spectrum Disorders from the Bible Belt to New York City," AACAP Annual Conference, October 2017.
15. May 2018: "A Primer in Working with Parents of Transgender Youth," APA Annual Meeting.
16. October 2018: "Gender Dysphoria Across Development" – Institute for AACAP Annual Conference.
17. November 2018: "Gender Variance Among Youth with Autism," World Professional Association for Transgender Health Biannual Conference.
18. March 2019: "Gender Trajectories in Child and Adolescent Development and Identity," Austin Riggs Grand Rounds.
19. Janssen, A., et al., "Ethical Principles in Gender Affirming Care," AACAP Annual Conference, October 2019.

20. Janssen, A., “Gender Diversity and Gender Dysphoria in Youth,” EPATH Conference, April 2019
21. Englander, E., Janssen A., et. al., “The Good, The Bad, and The Risky: Sexual Behaviors Online,” AACAP Annual Conference, October 2020
22. Englander, E., Janssen, A., et. al., “Love in Quarantine,” AACAP Annual Conference, October 2021
23. Janssen, A., Leibowitz, S., et. al., “The Evidence and Ethics for Transgender Youth Care: Updates on the International Standards of Care, 8th Edition,” AACAP Annual Conference, October 2021
24. Turban, J., Janssen, A., et. al., “Transgender Youth: Understanding “Detransition,” Nonlinear Gender Trajectories, and Dynamic Gender Identities,” AACAP Annual Conference, October 2021

Books

1. Janssen, A., Leibowitz, S (editors), *Affirmative Mental Health Care for Transgender and Gender Diverse Youth: A Clinical Casebook*, Springer Publishing, 2018.

Book Chapters

1. Janssen, A., Shatkin, J., “Atypical and Adjunctive Agents,” *Pharmacotherapy for Child and Adolescent Psychiatric Disorders*, 3rd Edition, Marcel Dekker, Inc, New York, 2012.
2. Janssen, A; Liaw, K: “Not by Convention: Working with People on the Sexual & Gender Continuum,” book chapter in *The Massachusetts General Hospital Textbook on Cultural Sensitivity and Diversity in Mental Health*. Humana Press, New York, Editor R. Parekh, January 2014.
3. Janssen, A; Glaeser, E., Liaw, K: “Paving their own paths: What kids & teens can teach us about sexual and gender identity,” book chapter in *Cultural Sensitivity in Child and Adolescent Mental Health*, MGH Psychiatry Academy Press, Editor R. Parekh, 2016
4. Janssen A., “Gender Identity,” *Textbook of Mental and Behavioral Disorders in Adolescence*, February 2018.
5. Busa S., Wernick, J., & Janssen, A. (In Review) *Gender Dysphoria in Childhood*. *Encyclopedia of Child and Adolescent Development*. Wiley, 2018.
6. Janssen A., Busa S., “Gender Dysphoria in Childhood and Adolescence,” *Complex Disorders in Pediatric Psychiatry: A Clinician’s Guide*, Elsevier, Editors Driver D., Thomas, S., 2018.
7. Wernick J.A., Busa S.M., Janssen A., Liaw K.R.L. “Not by Convention: Working with People on the Sexual and Gender Continuum.” Book chapter in *The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health*, editors Parekh R., Trinh NH. August, 2019.
8. Weis, R., Janssen, A., & Wernick, J. The implications of trauma for sexual and reproductive health in adolescence. In *Not Just a nightmare: Thinking beyond PTSD to help teens exposed to trauma*. 2019
9. Connors J., Irastorza, I., Janssen A., Kelly, B., “Child and Adolescent Medicine,” *The Equal Curriculum: The Student and Educator Guide to LGBTQ Health*, editors Lehman J., et al. November 2019.

10. Janssen, A., et. al., “Gender and Sexual Diversity in Childhood and Adolescence,” Dulcan’s Textbook of Child and Adolescent Psychiatry, 3rd edition, editor Dulcan, M., (in press)
11. Busa S., Wernick J, Janssen, A., “Gender Dysphoria,” The Encyclopedia of Child and Adolescent Development, DOI: 10.1002/9781119171492. Wiley, December 2020.

Invited Academic Seminars/Lectures

1. April 2006: “How to Talk to a Gay Medical Student” – presented at the National AAMC Meeting.
2. March 2011: “Kindling Inspiration: Two Model Curricula for Expanding the Role of Residents as Educators” – workshop presented at National AADPRT Meeting.
3. May 2011: Janssen, A., Shuster, A., “Sex Matters: Identity, Behavior and Development,” Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
4. March 2012: Janssen, A., Lothringer, L., “Gender Variance in Children and Adolescents,” Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
5. June 2012: Janssen, A., “Gender Variance in Childhood and Adolescence,” Grand Rounds Presentation, Woodhull Department of Psychiatry
6. October 2012: “Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations.” Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting.
7. March 2013: “Gender Variance in Childhood and Adolescence,” Sexual Health Across the Lifespan: Practical Applications, Denver, CO.
8. October 18th, 2013: “Gender Variance in Childhood and Adolescence,” Grand Rounds Presentation, NYU Department of Endocrinology.
9. October, 2014: GLMA Annual Conference: “Theory of Mind and Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning ASD,” Invited Presentation
10. October 2014: New York Transgender Health Conference: “Mental Health Assessment in Gender Variant Children,” Invited Presentation.
11. November, 2014: Gender Spectrum East: “Affirmative Clinical Work with Gender-Expansive Children and Youth: Complex Situations.”
12. October 2015: “Gender Dysphoria and Complex Psychiatric Co-Morbidity,” LGBT Health Conference, Invited Speaker
13. October 2015: “Transgender Health Disparities: Challenges and Opportunities,” Grand Rounds, Illinois Masonic Department of Medicine
14. November 2015: “Autism and Gender Variance,” Gender Conference East, Invited Speaker
15. February 2016: “Working with Gender Variant Youth,” New York State Office of Mental Health State Wide Grand Rounds, Invited Speaker
16. March, 2016: “Working with Gender Variant Youth,” National Council for Behavioral Health Annual Meeting, Invited Speaker

17. March 2016: “Gender Variance Among Youth with Autism: A Retrospective Chart Review and Case Presentation,” Working Group on Gender, Columbia University, Invited Speaker.
18. September, 2016: “Best Practices in Transgender Mental Health: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth,” DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell.
19. October, 2016: “LGBTQ Youth Psychiatric Care,” Midwest LGBTQ Health Symposium
20. October, 2016: “Gender Fluidity and Gender Identity Development,” NYU Health Disparities Conference.
21. February, 2017: “Best Practices in Transgender Mental Health,” Maimonides Grand Rounds
22. March, 2017: “Transgender Health: Challenges and Opportunities,” Invited speaker, Center for Disease Control STD Prevention Science Series.
23. September 2017: “Autism and Gender Dysphoria,” Grand Rounds, NYU Department of Neurology.
24. November 2017: “Consent and Assent in Transgender Adolescents,” Gender Conference East.
25. November 2017: “Transgender Mental Health: Challenges and Opportunities,” Grand Rounds, Lenox Hill Hospital.
26. April 2018: “Gender Trajectories in Childhood and Adolescent Development and Identity,” Sex, Sexuality and Gender Conference, Harvard Medical School.
27. September 2019: “Social and Psychological Challenges of Gender Diverse Youth,” Affirmative Mental Health Care for Gender Diverse Youth, University of Haifa.
28. October 2019: “Best Practices in Transgender Mental Health,” Grand Rounds, Rush Department of Psychiatry.
29. February 2020: “The Overlap of Autism and Gender Dysphoria,” Grand Rounds, Northwestern University Feinberg School of Medicine Department of Psychiatry
30. February 2020: “Gender Dysphoria and Autism,” Grand Rounds, University of Illinois at Chicago Department of Psychiatry
31. September 2021: “Gender Diversity and Autism,” Grand Rounds, Kaiser Permanente Department of Pediatrics
32. October 2021: “Gender Dysphoria and Autism,” Grand Rounds, Case Western Reserve University Department of Psychiatry.

Selected Invited Community Seminars/Lectures

1. April 2012: “Gender and Sexuality in Childhood and Adolescence,” Commission on Race, Gender and Ethnicity, NYU Steinhardt Speakers Series.
2. February 2013: “Supporting Transgender Students in School,” NYC Independent School LGBT Educators Panel, New York, NY.
3. June 2013: “LGBT Health,” Presentation for Neuropsychology Department
4. August 2013: “Chronic Fatigue Syndrome: Etiology, Diagnosis and Management,” invited presentation.
5. September 2013: Panelist, “LGBTQ Inclusive Sex Education.”
6. April 2015: Transgender Children, BBC News, BBCTwo, invited expert

7. January 2016: Gender Dysphoria and Autism – Ackerman Podcast - <http://ackerman.podbean.com/e/the-ackerman-podcast-22-gender-dysphoria-autism-with-aron-janssen-md/>
8. February 2016: “Best Practices in Transgender Mental Health,” APA District Branch Meeting, Invited Speaker.
9. May 2016: “Best Practices in Transgender Mental Health,” Washington D.C., District Branch, APA, Invited Speaker
10. July 2016: “Transgender Youth,” Union Square West
11. November 2017: “Understanding Gender: Raising Open, Accepting and Diverse Children,” Heard in Rye, Conversations in Parenting.
12. January 2018: “The Emotional Life of Boys,” Saint David’s School Panel, Invited Speaker
13. June 2018: “Supporting Youth Engaged in Gender Affirming Care,” NYU Child Study Center Workshop.
14. October 2018: “Medicine in Transition: Advances in Transgender Mental Health,” NYCPS HIV Psychiatry and LGBT Committee Meeting.
15. October 2018: “Understanding Gender Fluidity in Kids,” NYU Slope Pediatrics.
16. October, 2021: Issues of Ethical Importance: Health Care for Pediatric LGBTQ+ Patients, American Medical Association, Invited Talk

Major Research Interests

Gender and Sexual Identity Development
 Member, Research Consortium for Gender Identity
 Development Delirium: Assessment, Treatment and
 Management
 Suicide Prevention

Research Studies

<u>Study Title</u>	<u>IRB Study#</u>	<u>Dates</u>
Suicide Attempts Identified in a Children’s Hospital Before and During COVID-19	2021-4428	2/26/21-present
Lurie Children’s Sex & Gender Development Program Clinical Measure Collection	2019-2898	2019-present
Adolescent Gender Identity Research Study (principal investigator) - unfunded	s15-00431	4/15-5/19
Co-Occurrence of Autism Spectrum Disorders and Gender Variance: Retrospective Chart Review (principal investigator) - unfunded	s14-01930	10/14-5/19
Expert Consensus on Social Transitioning Among Prepubertal Children Presenting with Transgender Identity and/or Gender Variance: A Delphi Procedure Study (principal investigator) - unfunded	s13-00576	3/16-5/19

Co-Occurrence of ADHD/Gender Dysphoria (principal investigator) - unfunded	s16-00001	1/16-5/19
PICU Early Mobility- unfunded	s16-02261	12/16-5/19
Metformin for Overweight and Obese Children and Adolescents with Bipolar Spectrum Disorders Treated with Second-Generation Antipsychotics – Funded by PCORI	s16-01571	8/16-5/19

Other

Grant Funding:

Zero Suicide Initiative, PI Aron Janssen,
M.D. Awarded by Cardinal Health
Foundation, 9/2020 Total amount: \$100,000

Catalyst Fund, PI Aron Janssen, M.D.
Suicide Prevention in Pediatric
Primary Care Total amount: \$750,000

Selected Media Appearances:

Guest Expert on Gender Identity on Anderson, “When Your Husband Becomes Your
Wife,” Air Date February 8th, 2012

Guest Host, NYU About Our Kids on Sirius
XM, 2011 NYU Doctor Radio: LGBT Health,
September 2013 NYU Doctor Radio: LGBT
Kids, November 2013 NYU Doctor Radio:
LGBT Health, July 2014

NYU Doctor Radio: Gender Variance in Childhood,
December 2014 BBC Two: Transgender Youth, April 2015

NYU Doctor Radio: Transgender Youth, June 2015

Fox-5 News: Trump’s proposed military ban and Transgender Youth, July, 2017
Healthline.com: Mental Health Experts Call President’s Tweets ‘Devastating’ for
Trans Teens,
July, 2017

Huffington Post: What the Military Ban Says to Our Transgender Youth:
August, 2017 Metro: How to talk to your transgender kid about Trump,
August 2017

NYU Doctor Radio: Transgender Youth, August 2017

Exhibit B
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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE et al.,

Civil No. 4:23-cv-00114-RH-MAF

Plaintiffs,

v.

JOSEPH A. LADAPO et al.,

Defendants.

**EXPERT REPORT OF BRITTANY BRUGGEMAN, M.D.
ON BEHALF OF PLAINTIFFS**

August 16, 2023

Prepared by
Brittany Bruggeman, M.D.

CONFIDENTIAL

PL000626

TABLE OF CONTENTS

	PAGE
I. INTRODUCTION AND SUMMARY OF OPINIONS	1
A. Background and Qualifications.....	2
B. Bases for Opinions.....	5
C. Prior Testimony.....	6
D. Compensation	6
II. EXPERT OPINIONS	6
A. Standards of Care for Treating Gender Dysphoria Are Well-Established	6
B. Mental Health Evaluations Are Conducted Prior to Initiating Medical Treatment for Transgender Adolescents	10
C. Extensive Requirements Must Be Met before Medical Interventions Are Initiated For Transgender Adolescents	10
D. The Multidisciplinary Treatment Team Model.....	12
E. Puberty Blocking, Hormone Antagonist, and Hormone Therapies Are Safe and Effective Treatments for Transgender Youth	15
F. Harms of Withholding or Terminating Treatment for Transgender Adolescents with Gender Dysphoria	20
G. The Florida Board of Medicine Informed Consent Forms For Minors Are Medically Unsound and Misleading, Introduce Unnecessary and Harmful Requirements, Create Restrictions on Care, and Subvert The Clinician-Patient Relationship and Process of Informed Consent	22
H. Universal Inaccuracies and Harmful Restrictions on Care Are Repeated in All Three Consent Forms for Minors,	

	Subverting a Meaningful Discussion of Risks and Benefits of Treatment	24
I.	Specific Inaccuracies Within the Puberty Suppression Treatment Form for Minors.....	29
J.	Specific Inaccuracies Within the Masculinizing Medications Form for Minors.....	30
K.	Specific Inaccuracies Within the Feminizing Medications Form for Minors.....	30
III.	CONCLUSION.....	31

I. INTRODUCTION AND SUMMARY OF OPINIONS

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

2. In summary, there is no medical basis for the bans on access to medical care for transgender youth diagnosed with gender dysphoria promulgated by the Florida Boards of Medicine and Osteopathic Medicine and by the Florida Legislature through SB 254 and its implementing rules. There is also no basis upon which to deny parents the right to determine appropriate medical treatment for their child and to deny qualified medical providers the right to provide evidence-based treatment aligned with authoritative standards of care. As with any treatment for a minor, treatments for gender dysphoria depend on an open informed consent discussion between a qualified medical provider, their patient, and the patient's parent or guardian. The mental health problems present in transgender youth, which are exacerbated by untreated gender dysphoria, are significant and well-documented.

3. Further, the "informed consent forms" created by the Florida Boards of Medicine communicate medically inaccurate and misleading information, require inappropriate testing and restrictions, and undermine the clinician-patient relationship and trustworthiness of the process of informed consent.

4. The Florida Boards of Medicines' bans, SB 254, and the Boards' mandatory "informed consent forms" prohibit doctors from adequately caring for their patients and meeting their Hippocratic Oath.

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A. *Background and Qualifications*

5. I am a licensed physician in Florida and am Double Board Certified by the American Board of Pediatrics in Pediatric Endocrinology and Pediatrics.

6. I am a pediatric endocrinologist at the University of Florida in Gainesville, Florida, and an Assistant Professor at the University of Florida College of Medicine in the Department of Pediatric Endocrinology. I am speaking on behalf of myself as a subject matter expert and not as a representative of the University.

7. I graduated with a Bachelor of Science degree in Interdisciplinary Studies, Basic Biology and Medicine, from the University of Florida. I received my medical degree from the University of Florida College of Medicine, graduating with Honors in Research.

8. I completed my Residency in Pediatrics and a Fellowship in Endocrinology at the UF Health Shands Children's Hospital.

9. I trained under Dr. Michael Haller, M.D., Professor and Chief of Pediatric Endocrinology at UF, Dr. Janet Silverstein, M.D., founder of the UF Health Youth Gender Program, and Dr. Kristin Dayton, M.D., Director of the UF Health Youth Gender Program. Drs. Haller and Silverstein have each trained hundreds of medical providers, participated in the development of national and international guidelines, treated thousands of children, held numerous NIH grants and published more than 200 and 140 peer reviewed papers respectively.

10. As a pediatric endocrinologist working in the UF Health Youth Gender Program, I have extensive experience providing treatment for gender dysphoria to transgender minors through a multidisciplinary care model. The Youth Gender Program uses evidence-based standards and practices and has provided social, medical, and mental health support for transgender and gender diverse patients across the state of Florida since 2016.

11. During my time at UF, I received numerous scholarly awards. Most recently, I received the 2022 UF College of Medicine Exemplary Teacher Award that recognizes the top 10% of College of Medicine faculty, and the 2020 Douglas J. Barrett, MD Academic Fellowship Award that recognizes pediatric clinicians or researchers for displaying the highest qualities in research, teaching and patient care. Other awards include the Audrey Lincourt Schiebler Award for Excellence in Child Advocacy (2018), Pediatric Clerkship Excellence in Medical Student Education (2018-19), the Inaugural McJunkin Family Type 1 Diabetes Fellow (2018-19), induction into the Gold Humanism Honor Society (2015), Association of Pathology Chairs Award, UF College of Medicine (2013), Distinguished Service Award, UF College of Medicine (2013), and International Medical Outreach Service Award (2013).

12. I have been a member of the American Academy of Pediatrics (AAP) since 2011, a Diplomat and Fellow of the AAP since 2018, I am a member of the AAP Section on Endocrinology and I served as the AAP's Executive Coordinator of Resident Initiatives for the Section on Pediatric Trainees and the AAP Section on Endocrinology Executive Board fellow representative; I am also a member of the Florida Chapter of the AAP; I have been a Diplomat with the American Board of Pediatric Endocrinology since 2021 and a member of the Pediatric Endocrine Society since 2018; I am a member of the American Diabetes Association, the Florida Medical Association, the Alachua County Medical Society, and Type 1 Diabetes TrialNet, an international network of endocrinologists at the forefront of Type 1 diabetes research.

13. I have served as a Pediatric Attending Physician with the Equal Access Clinic of the UF College of Medicine, a free healthcare clinic, and I have served as both a Camp Physician and volunteer at the Florida Diabetes Camp since 2012.

14. In 2018 as a pediatric endocrinology fellow I began working with transgender children, adolescents and young adults through a multidisciplinary youth gender program. I have provided care for approximately two-hundred transgender young people for gender dysphoria. The best current estimate of the number of transgender patients the multidisciplinary clinic itself has cared for is approximately five-hundred patients. The number of adolescent patients who have been prescribed hormone blocking medications and/or hormone therapy represent only a portion of all young people who are seen by the clinical team. Therapeutic decisions are individualized- some adolescents are seen in clinic and never receive these treatments, and others are not ready for, or are not candidates for, these medications.

15. Multidisciplinary youth gender clinics provide social, medical and mental health support to gender-diverse youth and young adults and their families. We educate our patients and their families about gender identity development and gender nonconformity, and help empower our patients and families to make informed decisions with accurate information. Teams of professionals include pediatric endocrinologists, psychologists, psychiatrists, pediatricians, social workers, medical-legal partners, and patient care advocates. The care provided is consistent with the World Professional Association for Transgender Health (WPATH) Standards of Care and focuses on the biological, psychological, as well as social (biopsychosocial) components of transgender health. Services provided include consultation, psychotherapy, and assessment of medical indication for hormone blocking medications and/or hormone therapy. In addition to providing expert care, one goal is to provide a safe environment where patients and their families can receive social and emotional supports.

16. In my practice, I strive to provide the highest quality, evidence-based, individualized and compassionate care for my patients and their families.

Ultimately, I strive to empower each patient to achieve their optimal physical, mental, emotional and social health, and want each person to feel that they are accepted and valued for who they are.

17. The information provided regarding my professional background, experiences, publications, and presentations is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as **Exhibit A**.

B. *Bases for Opinions*

18. In preparing this report, I have relied upon my training and clinical experience, as set out in my curriculum vitae, and on the materials listed therein. I have also reviewed the materials listed in the attached bibliography, Exhibit B. The sources cited therein are authoritative, scientific peer-reviewed publications. These are the same types of materials that experts in my field of study regularly rely upon when formulating opinions on the subject.

19. 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.

20. In addition, I have reviewed the rules promulgated by the Florida Board of Medicine, Rule 64B8-9.019, *Standards of Practice for the Treatment of Gender Dysphoria in Minors*, Fla. Admin. Code (effective March 16, 2023), and the Florida Board of Osteopathic Medicine, Rule 64B15-14.014, *Standards of Practice for the Treatment of Gender Dysphoria in Minors*, Fla. Admin. Code (effective March 28, 2023), which restrict the ability of Florida physicians from providing treatments for gender dysphoria to minors. I have also reviewed SB 254, and its implementing emergency rules and the “informed consent forms”

promulgated by the Florida Boards of Medicine pertaining to minors (“Masculinizing Medications for Patients with Gender Dysphoria Patient Information and Informed Parental Consent and Assent for Minors” (DH5081-MQA (Rev. 06/23); “Feminizing Medications for Patients with Gender Dysphoria Patient Information and Informed Parental Consent and Assent for Minors” (DH5080-MQA (Rev. 06/23); and “Puberty Suppression Treatment for Patients with Gender Dysphoria Patient Information and Informed Parental Consent and Assent for Minors” (DH5079-MQA (Rev. 06/23)).

21. My opinions are based solely on my extensive background and experience treating transgender patients.

C. *Prior Testimony*

22. I have not testified as an expert at trial or by deposition in the past four years.

D. *Compensation*

23. I am being compensated for my work on this matter at an hourly rate of \$350.00 for preparation of declarations and expert reports, and deposition and 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. *Standards of Care for Treating Gender Dysphoria Are Well-Established*

24. According to the 2022 *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), Text Revision*, gender dysphoria is a diagnosis defined as an individual having clinically significant psychological distress or impairment in social, occupational or other important areas of functioning that results from a marked incongruence between their sex assigned at birth and the

person's gender identity (the gender with which the individual identifies). Gender dysphoria may manifest in childhood, at the onset of puberty, or in adulthood, and when left untreated it can result in adverse mental health outcomes such as severe anxiety, depression, suicidal ideation and self-harm.

25. I stay updated on the latest medical science and treatment protocols for the treatment of gender dysphoria in adolescents and young adults to ensure that I am providing the highest quality evidence-based care for my patient population. The available treatments for gender dysphoria are well established in the medical profession and the potential benefits of treatments are well-documented in the literature.

26. Comprehensive standards of care and clinical practice guidelines directing this treatment have been developed by the World Professional Association for Transgender Health (WPATH)¹ and by the Endocrine Society.² These guidelines have been adopted into practice by the profession as a standard of care. These standards of care are based on decades of scientific and medical research representing the best evidence-based practice information available for treating this condition. The treatment of gender dysphoria with transition-related care is recognized by nearly every major medical professional association, including the American Medical Association, American Academy of Pediatrics, Society for Adolescent Health and Medicine, American Psychiatric Association, and the American Academy of Family Physicians, among others.

¹ WPATH was founded in 1979 and aims to promote evidence-based care, education, research, public policy, and respect in transgender health. Internationally accepted Standards of Care (SOC) for health professionals are updated and revised as new scientific information becomes available. SOC8 was informed by a systematic review of the evidence and assessment of benefits and harms of alternative care options. Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health*. 2022 Sep 6;23(Suppl 1):S1-S259.

² Specifically, an Endocrine Society-appointed task force whose Clinical Practice Guidelines were published in The Journal of Clinical Endocrinology & Metabolism in 2017. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017 Nov 1;102(11): 3869–3903.

27. The current version of the WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC-8), was released in September 2022. The prior SOC, Version 7, had been in place for more than a decade. Standards of care for treating gender dysphoria differ for prepubertal children (minors who have not started puberty), adolescents, and adults.

28. Treatment for gender dysphoria is aimed at eliminating the clinically significant distress that patients suffer by helping them explore, define, and express their gender identity openly and respectfully. This care model is referred to as “transition-related care,” “gender transition,” or “gender-affirming care.”

29. Medications for treating gender dysphoria are not recommended for or prescribed to prepubertal children. Instead, support for a prepubertal transgender child may include social transition, which means allowing a child to live and be socially recognized in accordance with their gender identity rather than their sex assigned at birth. The social transition may include allowing the child to choose clothing, hairstyle, name, pronouns, and activities that correspond to that individual’s gender identity.

30. Many transgender minors experience exacerbation of gender dysphoria when puberty begins. The development of secondary sex characteristics – breast development, body fat redistribution, facial changes, and onset of menses for transgender boys; androgenized hair growth, voice deepening, facial changes, and increased musculature for transgender girls – has caused significantly heightened stress and anxiety in many of my transgender adolescent patients. In my experience treating transgender adolescents, without treatment for their gender dysphoria many patients can experience anxiety, interpersonal conflicts, depression, academic decline, social withdrawal, disordered eating patterns, and suicidal thoughts and attempts.

31. Once a transgender adolescent begins puberty, medications can be prescribed to temporarily halt the physical changes of puberty, avoiding the exacerbation of gender dysphoria and mitigating harms that can accompany the development of secondary sex characteristics. Then, if later in adolescence the patient, family, and healthcare team decide that initiation of hormone therapy is in the patient's best interest, they may be able to avoid physical changes inconsistent with their gender identity.

32. Puberty is initiated by the pulsatile release of the hormone GnRH from the hypothalamus. GnRH then stimulates the pituitary gland to produce Follicle Stimulating Hormone (FSH) and Luteinizing Hormone (LH). These hormones, FSH and LH, then lead to the production of estrogen and testosterone in individuals with ovaries and testes, respectively. Pubertal suppression involves the administration of a medication that prevents the release of FSH and LH, thereby inhibiting the production of estrogen and testosterone. By inhibiting that production, the further development of secondary sex characteristics halts. This pause in puberty limits the further influence of a person's endogenous sex hormones on the body. Stopping the medication resumes the production of FSH and LH and allows puberty to resume with no residual effects on fertility or secondary sex characteristics.

33. For some transgender adolescents, undergoing pubertal development consistent with their gender identity through hormone therapy may also be medically necessary and in their best interest. When prescribed hormone therapy—testosterone for transgender boys, and estrogen in combination with a testosterone-suppressing medication for transgender girls—adolescents experience physical changes consistent with their gender identity.

B. *Mental Health Evaluations Are Conducted Prior to Initiating Medical Treatment for Transgender Adolescents*

34. WPATH SOC-8 recommends a multidisciplinary assessment that involves several domains for the patient seeking treatment for gender dysphoria. A licensed mental health professional with expertise in the treatment of transgender and gender diverse adolescents assesses the patient's gender identity development, social development, and the support structure for the patient, including an investigation of the effects of gender minority stress, family dynamics and any other aspect that might contribute to the individual's social development. Additionally, co-occurring mental health and/or developmental concerns are addressed. The mental health professional also assesses whether the minor has the emotional and cognitive maturity to provide informed assent for any treatment. This process of consent and assent involves an evaluation of the minor's and guardian's understanding of the medical information and treatment, including the option to not receive treatment, risks and reversible and irreversible effects of treatment, and fertility options and considerations during an open discussion about the patient's goals and expectations of treatment.

35. The Endocrine Society Guideline specifies that mental health clinicians who diagnose gender dysphoria should be trained "in child and adolescent developmental psychology and psychopathology," competent in using the DSM and/or ICD diagnostically, and able to understand the individual's mental health, social conditions and ability to consent. This process is highly individualized; a nuanced approach is indicated as each patient has unique medical needs.

C. *Extensive Requirements Must Be Met before Medical Interventions Are Initiated For Transgender Adolescents*

36. Medications for the treatment of gender dysphoria are not appropriate for every patient. The WPATH SOC-8 advises that "it is important to establish the

young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones.”³ Similarly, the Endocrine Society Guideline provides that prior to the initiation of any medical intervention, “transgender individuals should be encouraged to experience living in the new gender role and assess whether this improves their quality of life.”⁴

37. Pursuant to the Endocrine Society Guideline, transgender adolescents with gender dysphoria may be eligible for pubertal blocking medication if a qualified mental health professional has confirmed that: (i) the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed); (ii) gender dysphoria worsened with the onset of puberty; (iii) any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent’s situation and functioning are stable enough to start treatment; and (iv) the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment.

38. Further, the adolescent must: (i) have been informed of the effects and side effects of treatment (including potential impacts on fertility *if* the individual subsequently continues with life-long sex hormone treatment) and options to preserve fertility; and (ii) has given informed consent and the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

39. Lastly, a pediatric endocrinologist or other clinician experienced in pubertal assessment should: (i) agree with the indication for GnRH agonist

³ Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health*. 2022 Sep 6;23(Suppl 1):S60.

⁴ Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017 Nov 1;102(11):3876.

treatment; (ii) confirm that puberty has started in the adolescent; and (iii) confirm that there are no medical contraindications to GnRH agonist treatment.²

40. For transgender adolescents to be eligible for hormone therapy, the Endocrine Society Guideline directs that a qualified mental health professional confirms: (i) the persistence of gender dysphoria; (ii) any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start hormone therapy; and (iii) the adolescent has sufficient mental capacity to estimate the consequences of this treatment, weigh the benefits and risks, and give informed consent to this treatment.²

41. Further, the adolescent needs to have: (i) been informed of the effects and side effects of treatment (including options to preserve fertility); (ii) given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

42. And lastly, a pediatric endocrinologist or other clinician experienced in pubertal induction: (i) agrees with the indication for hormone therapy; and (ii) has confirmed that there are no medical contraindications to hormone therapy.²

D. *The Multidisciplinary Treatment Team Model*

43. I treat transgender patients as part of a multidisciplinary treatment team, which includes psychologists, psychiatrists, pediatricians, pediatric endocrinologists, medical-legal partners, and patient care advocates, all of whom are experienced in providing care to transgender minor patients.

44. We follow the process outlined in the WPATH SOC-8 and the Endocrine Society Guidelines.

45. Keeping with the American Medical Association's Code of Medical Ethics, I follow a comprehensive informed consent process prior to initiating treatment.

46. Some patients are referred to the clinic by a mental health provider with expertise in transgender health, while others are referred by their pediatrician or another provider. If the patient does not already have a mental health provider, I refer the patient to one to begin the mental health evaluation prior to providing any treatment. We then work together collaboratively to assess the patient in accordance with the WPATH standards and Endocrine Society guidelines.

47. The mental health provider assesses the patient in the domains described in paragraph 33 and 36. I then review the mental health assessment and confirm that there is a diagnosis of gender incongruence and that it has been consistent, persistent and insistent, along with confirming other relevant criteria. For most of my patients, gender dysphoria has been present for years prior to their first visit with the youth gender clinic. I further assess the patient for any medical or psychosocial conditions that might affect treatment. My interview with the patient and parent or guardian includes a thorough discussion of the patient's individual needs, goals, and their process of coming to understand and live in accordance with their gender identity.

48. Once both a mental health professional and I have each confirmed the diagnosis of gender dysphoria, I meet with the patient and parent or guardian as many times as is necessary for them to fully understand the risks and benefits of treatment options in their individual circumstance and come to an informed decision. As part of my evaluation, I order bloodwork, and in some circumstances a DEXA scan or other necessary evaluation to assess the general health of the

patient prior to initiating therapy. I also thoroughly discuss the potential impacts on fertility, fertility preservation options, and make appropriate referrals as necessary.

49. As part of my informed consent process, I fully review a packet of information with the adolescent and guardian, which discusses in detail the risks, benefits, and reversible and long-term effects of the relevant medications (pubertal suppressants and/or hormone therapies), and alternatives to treatment. As part of this process, I ask detailed questions to the patient and guardian to ensure understanding of the range of potential treatment options and outcomes. Additional resources and a follow-up protocol are also items in the packet that are reviewed.

50. The patient and guardian then take the informational packet home for self-study. I offer additional reading material when necessary. Once a full evaluation has been completed; the patient, family, and healthcare team are all in agreement that a treatment is in the best interest of the patient; and risks and benefits are well understood, informed consent and assent are obtained and treatment can commence.

51. Once the patient begins their medical treatment as prescribed, I meet with the patient and family for follow up on a regular basis and their progress is monitored at regular intervals. I assess the patient's progress, presence of gender dysphoria, physical and mental health, efficacy of the treatment, satisfaction with the treatment, side effects, and hormone levels and laboratory screening for treatment side effects. At these follow-up appointments, we carefully reassess patient progress and make medication adjustments as appropriate. The patients are strongly encouraged to remain in therapy with a mental health provider throughout this process.

52. Consistent with the established treatment guidelines described above, I consider prescribing puberty blocking treatment starting at pubertal Tanner Stages

II–III. Please refer to paragraph 52 for a detailed discussion of pubertal timing and other uses of pubertal suppressive medications. Depending on the needs of the patient, the pubertal stage they are in, and any changes that may have already resulted from endogenous puberty, patients may first initiate puberty blocking medication, followed by hormone therapy *if and when* it is medically indicated and the patient and family desire this treatment; or they may initiate hormone therapy alone or in conjunction with androgen receptor antagonists or pubertal suppressants at later stages of puberty. The goal of the treatment is to minimize the patient’s gender dysphoria and to allow the patient to experience secondary sex characteristics consistent with their gender identity if medically indicated and agreed upon by the healthcare team, patient and family.

53. In my clinical experience, I have witnessed first-hand the significant and substantial benefits that access to puberty blocking, hormone antagonist, and hormone therapies, when medically necessary for the individual, can have on an adolescents’ overall health and well-being.

E. *Puberty Blocking, Hormone Antagonist, and Hormone Therapies Are Safe and Effective Treatments for Transgender Youth*

54. I have read the Florida Boards of Medicine and Osteopathic Medicine rules that bar doctors from prescribing puberty blocking, hormone antagonist, and hormone therapies for transgender youth. I have also read SB 254, which takes the further extraordinary step of criminalizing doctors like myself for prescribing these evidence-based treatments for transgender youth. These bans stand in direct contrast to the authoritative standards of care for the treatment of gender dysphoria. Based on my expert opinion, unless enjoined these bans will continue to cause harm to my patients and countless other transgender adolescents in the state of Florida.

55. The Endocrine Society’s and WPATH’s treatment protocols for prescribing puberty blocking medications and hormone therapies provide an

evidence-based, safe and effective treatment approach for gender dysphoria. The American Academy of Pediatrics, which was founded in 1930 and represents more than 67,000 pediatricians in this country, is one of many reputable medical associations in the United States which supports the use of puberty blocking medications and hormone therapy to treat gender dysphoria in adolescent patients when medically indicated.

56. Puberty blocking treatment works by pausing endogenous puberty at whatever stage it is at when the treatment begins, limiting the further influence of endogenous hormones until the treatment is ended. Puberty blocking medications are not new for the treatment of gender dysphoria, as their use began in Amsterdam in 1998 and expanded to the United States in 2010. There is over 30 years' worth of data on the safety of puberty blockers regarding children who experience precocious puberty that can be applied to the transgender population. In appropriate candidates, the benefits of treating gender dysphoria with puberty blocking medication can greatly outweigh the small potential for short- or long-term side effects. Moreover, for youth with gender dysphoria, as compared to those treated for precocious puberty, the treatment is typically used for a much shorter period to pause development before either initiating puberty with hormone therapy or resuming endogenous puberty.

57. Pubertal development has a wide variation among individuals. The onset of puberty in individuals whose sex assigned at birth is male begins, on average, at age 11-12 but can range from age 9 to 14. In those whose sex assigned at birth is female, the onset of puberty typically begins at age 10-11, but can range from age 8 to 13. Once puberty begins, completion on average occurs 3.5–4 years later. Generally speaking, pubertal suppression occurs for up to 2-3 years. The use of puberty blockers in transgender males (whose sex assigned at birth is female) allows for decreased chest development, reducing the need for breast binding and

potential surgical intervention in adulthood. The use of puberty blockers in transgender females (whose sex assigned at birth is male), limits facial and body hair growth, voice deepening, and testosterone-driven cartilage and bone structure changes, which greatly reduce distress both at the time of treatment and later in life reduce the need for future interventions such as voice therapy, hair removal, and facial feminization surgery.

58. The use of puberty blocking medications are safe and effective, and the rare side effects are thoroughly discussed with the patient and their family prior to starting any treatment. To address the risk of lower bone mineral density that can be associated with prolonged use of puberty blockers, we conduct regular screening for vitamin D and calcium deficiency (and treat deficiencies when needed), advise regular weight-bearing exercise, conduct bone mineral density scans at regular intervals, and limit the number of years a patient is on puberty blocking medication. Decades of data on the use of puberty blockers as treatment for precocious puberty has demonstrated that puberty blocking medication does not have long-term implications for fertility.⁵⁶

59. Puberty blocking medications may also be used by transgender females (whose sex assigned at birth is male) in conjunction with estrogen therapy to suppress that individual's endogenous production of testosterone. It is standard protocol to include a testosterone-suppressive agent when an individual begins estrogen. Hormone receptor antagonist therapies can also be used to suppress the endogenous action of testosterone. There are some instances where puberty-blocking medications are used in the latter stages of puberty to prevent unwanted secondary sex characteristics such as an Adam's apple, increased facial hair, a lower

⁵ Guaraldi F, Beccuti G, Gori D, Ghizzoni L. MANAGEMENT OF ENDOCRINE DISEASE: Long-term outcomes of the treatment of central precocious puberty. *Eur J Endocrinol*. 2016 Mar;174(3):R79-87.

⁶ Martinierie L, de Mouzon J, Blumberg J, di Nicola L, Maisonneuve P, Carel JC; PREFER study group. Fertility of Women Treated during Childhood with Triptorelin (Depot Formulation) for Central Precocious Puberty: The PREFER Study. *Horm Res Paediatr*. 2020;93(9-10):529-538.

voice or late-stage breast development, depending on the individualized needs and assessment of the patient.

60. In a 2020 study published in the American Academy of Pediatrics' official journal *Pediatrics*, researchers queried a group of 20,619 transgender individuals and found a lower odds of lifetime suicidal ideation for those who received pubertal suppression when they were adolescents compared with a group that desired pubertal suppression but did not receive it.⁷ Suicidality is of particular concern because the estimated lifetime prevalence of suicide attempts among the transgender population is as high as 40%.

61. Under the Endocrine Society Guidelines and WPATH SOC-8, hormone therapy is appropriate for transgender adolescents with gender dysphoria when their experience of gender incongruence is marked and sustained over time, the adolescent demonstrates emotional and cognitive maturity required to provide informed consent/assent for treatment, other mental health concerns (if any) that may interfere with diagnostic clarity and capacity to consent have been addressed, and the adolescent has discussed reproductive options with their provider. For adolescents who meet these criteria, it may be in the patient's best interest to provide hormone therapy to initiate puberty consistent with the patient's gender identity. The parent or guardian is critical to the assessment and treatment process for minors and must provide informed consent for any individual under the age of majority.

62. Hormone therapy is safe and has been used in non-transgender patients for reasons unrelated to the treatment of gender dysphoria. There are a variety of medical conditions in childhood and adulthood where estrogen or testosterone are prescribed, such as polycystic ovary syndrome, menorrhagia (heavy menstrual bleeding), acne, contraception, menopause, post-chemotherapy, premature ovarian

⁷ Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. 2020 Feb;145(2):e20191725.

failure, pubertal delay, and testosterone deficiency. Patients with various intersex conditions, such as Turner Syndrome or Klinefelter Syndrome, also often receive hormone therapy. Those individuals with the conditions described often need hormone therapy for the duration of their entire lives.

63. As with puberty blocking medications, I discuss the risks and benefits of hormone therapy at length with adolescent patients and their families prior to initiation of treatment. Potential impact on fertility is always discussed along with fertility preservation options. If desired after our discussion, patients are referred to a reproductive endocrinologist for further discussion of fertility preservation, a procedure that also may be recommended prior to certain chemotherapy regimens or due to ovarian or testicular insufficiency.

64. Many transgender adults have been on hormone therapy for decades. No reputable medical organization or reliable study has concluded that the risk of any negative outcome would categorically outweigh the substantial benefit of treatment in appropriate candidates for therapy.

65. The goal of hormone therapy is to lessen gender dysphoria, improve functioning and avoid unwanted secondary sex characteristics while developing characteristics that align with gender identity. Studies have showed improved psychological functioning, body image and mental health, and less gender dysphoria, suicidality, depression and anxiety with treatment for gender dysphoria. Some of my patients who are receiving medical treatment for gender dysphoria experienced suicidal ideation and attempts prior to beginning treatment. I have witnessed patients transform from individuals with significant levels of psychological distress to functional, psychologically stable, thriving individuals. I fear that categorically denying puberty blockers, hormone antagonists, and hormones to transgender adolescents who meet criteria for care will lead to distress and psychological harm.

66. After medications are initiated, the patient's functioning, psychosocial situation, physical changes, satisfaction with therapy, hormone levels, and treatment side effects are assessed frequently. Patient care is individualized and in consultation with their doctor, patients may decide to stop therapy, continue, or be evaluated for adjustment of their medication in response to medical need.

67. In summary, the interventions described above are effective and safe, and access is essential for the wellbeing of those transgender adolescent patients for whom they are indicated. The treatments are provided only with assent from the patient and consent from the parent or guardian. My patients who receive medically necessary treatment for gender dysphoria often experience significant improvement in their mental health and quality of life. Medical treatment recommended for and provided to transgender adolescents with gender dysphoria can substantially reduce lifelong gender dysphoria and can eliminate the potential need for later, more invasive treatments. Access to medications to treat gender dysphoria is vital and can improve the short- and long-term health outcomes for transgender adolescents.

F. *Harms of Withholding or Terminating Treatment for Transgender Adolescents with Gender Dysphoria*

68. I have reviewed the medical bans promulgated by the Florida Boards of Medicine and Osteopathic Medicine and by the Florida Legislature (SB 254). Based on my review, I understand those bans to prohibit board-certified physicians like myself from following accepted standard of care in providing medical treatment for gender dysphoria for minors who had not received treatment prior to March 16, 2023 and March 28, 2023 (Boards of Medicine and Osteopathic rules, respectively) and May 17, 2023 (SB 254).

69. Puberty blocking medications and hormone therapies have improved the physical and mental well-being of many of my patients. Withholding this well-established, necessary medical care from patients will worsen their mental health

outcomes. Being denied the only medical therapies that can legitimately treat their gender dysphoria will render their conditions more recalcitrant. Refusing medical care in this way without a sound medical basis violates my professional and ethical obligations by forcing me to withhold necessary treatment from my patients.

70. Since the Boards' rules have become effective, I have met with numerous new patients who were candidates for puberty blocking medication or hormone therapy, but physicians, including myself, are not permitted to prescribe them under the law. The parents of these adolescents are angry and concerned for their children. They want to ensure their children get the medical care that they need to live happy, productive and healthy lives. There are several families who are taking active steps to move out of the state of Florida. It is devastating that these parents feel that they have no other option but to leave and find a safe place for their children, who will be denied critical medical treatment if they remain in Florida.

71. In my clinical experience, I can attest that medications to treat gender dysphoria significantly improve the health and well-being of adolescents who are transgender, and for whom the care is medically indicated. I have witnessed the tremendous impacts of treatment on my transgender patients, including developing improved relationships with their family members and peers, improved academic performance and feelings of belonging at school, the ability to develop healthy romantic relationships with their partners, and feeling hopeful about their future and the opportunities life has to offer.

72. Many of my transgender patients' anxiety, depression, and self-harming behaviors have improved following the initiation of treatment for gender dysphoria. I have witnessed myriad patients transform from being withdrawn, sullen, and unable to connect, to thriving socially, developing self-confidence, and developing close friendships. Not only have I seen this growth in my patients during our clinical visits, but many of my patients' parents have expressed to me

how their teenage child blossomed and came out of their shell after receiving treatment for gender dysphoria. Many of my patients' parents have also shared with me how crippling and painful it was as a parent to watch their child struggle without access to necessary medical care, and it haunts me to know that under the medical care bans created by the Boards of Medicine and the Florida Legislature, so many more parents are going to have to watch their children suffer without access to effective treatment for their gender dysphoria.

G. *The Florida Board of Medicine Informed Consent Forms For Minors Are Medically Unsound and Misleading, Introduce Unnecessary and Harmful Requirements, Create Restrictions on Care, and Subvert The Clinician-Patient Relationship and Process of Informed Consent*

73. The “Informed Consent” forms were created by the Boards of Medicine pursuant to SB 254, which required the Boards to “consider requirements for physicians to obtain informed consent from such patient’s parent or legal guardian[.]”

74. Further, SB 254 required that “consent must be voluntary, informed, and in writing on forms adopted in rule by the Board of Medicine and the Board of Osteopathic Medicine[;]” and “[c]onsent to sex-reassignment prescriptions or procedures is voluntary and informed only if the physician who is to prescribe or administer the pharmaceutical product or perform the procedure has, at a minimum, while physically present in the same room:

- (a) Informed the patient of the nature and risks of the prescription or procedure in order for the patient to make a prudent decision;
- (b) Provided the informed consent form, as adopted in rule by the Board of Medicine and the Board of Osteopathic Medicine, to the patient; and

(c) Received the patient’s written acknowledgment, before the prescription or procedure is prescribed, administered, or performed, that the information required to be provided under this subsection has been provided.”

75. Pursuant to SB 254, the Boards of Medicine created the following forms for the treatment of gender dysphoria in minors: “Masculinizing Medications for Patients with Gender Dysphoria Patient Information and Informed Parental Consent and Assent for Minors” (DH5081-MQA (Rev. 06/23); “Feminizing Medications for Patients with Gender Dysphoria Patient Information and Informed Parental Consent and Assent for Minors” (DH5080-MQA (Rev. 06/23); and “Puberty Suppression Treatment for Patients with Gender Dysphoria Patient Information and Informed Parental Consent and Assent for Minors” (DH5079-MQA (Rev. 06/23).

76. Informed consent for treatment is a fundamental process of communication within the clinician-patient relationship that allows patients, and in the case of pediatrics, their parents or legal guardians, to receive accurate information that a reasonable person would want to know prior to making a healthcare decision.⁸

77. Informed consent discussions include a dialogue between the clinician and patient about the medical condition being treated, potential treatment options, and potential risks and benefits of these treatment options. Clinicians must ensure that the patient and parents of minor patients have the capacity to understand risks and benefits and agree to a treatment plan.

78. The consent forms created by the Florida Board of Medicine communicate medically inaccurate and misleading information, require inappropriate testing and restrictions on care, and undermine the clinician-patient

⁸ AMA Code of Medical Ethics Opinion 2.1.1: Informed Consent. <https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent>

relationship and trustworthiness of the process of informed consent. For this reason, these forms subvert informed consent rather than promoting it.

79. By providing inaccurate and misleading information, creating restrictions on care and introducing needless medical procedures and testing, and subverting the process of informed consent, these “consent forms” breach the ethical principles of patient autonomy and provider non-maleficence. The process of informed consent as distorted by the mandatory forms is no longer an honest, accurate, and compassionate dialogue between clinician and patient, but rather a “form [that] contains information required to be disclosed to you by Florida law and does not necessarily reflect the views or opinions of your physician.”

80. The clinical practice guidelines and standards of care published by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society provide context for my specific comments related to the content of the Board of Medicine consent forms.

H. Universal Inaccuracies and Harmful Restrictions on Care Are Repeated in All Three Consent Forms for Minors, Subverting a Meaningful Discussion of Risks and Benefits of Treatment

81. Each of the three consent forms for minors (hereinafter, referred to as “Minor Consent Forms” when referencing all three) begins by stating that “medical treatment of people with gender dysphoria is based on very limited, poor-quality research with only subtle improvements seen in some patient’s psychological functioning in some, but not all, research studies. This practice is purely speculative...” (Minor Consent Forms, at p.1). This paragraph is inaccurate and misleading- medical treatment of people with gender dysphoria is evidence-based and associated with significant improvements in psychosocial outcomes. It is not speculative but is well-established and based on decades of clinical experience and data.

82. Each form presents pubertal suppression and hormone therapies prescribed for gender dysphoria as “not being used for their intended purpose.” (Minor Consent Forms, at p. 1). This statement is misleading and likely to confuse patients. Off-label use of medications, especially within pediatrics, is common. In fact, one in five prescriptions written today are for off-label use.⁹ The FDA states that a healthcare provider may prescribe a drug off-label when “there might not be an approved drug to treat your disease or medical condition.”

83. Each form requires that Tanner staging be confirmed by a physician before proceeding with treatment. (Minor Consent Forms, at p. 3). This is not supported by guidelines, which state that “a pediatric endocrinologist or other clinician experienced in pubertal assessment” may confirm.¹⁰ Other clinicians such as APRNs may meet this qualification and be able to perform this exam in accordance with clinical practice guidelines.

84. Each form requires the clinician to discuss “the medical and social risks and benefits of sex reassignment surgery.” (Minor Consent Forms, at p. 3). It is inappropriate and unnecessary to discuss the risks and benefits of a procedure that is not being recommended within the informed consent discussion about a completely different treatment.

85. The forms for masculinizing and feminizing medications require that a psychological and social evaluation be performed by a Florida licensed board-certified psychiatrist or a Florida licensed psychologist prior to beginning treatment. Additionally, all three forms require annual mental health assessments by a board-certified Florida licensed psychiatrist or psychologist. (Minor Consent Forms, at p. 3). There is no medical reason for this requirement, which serves as an unnecessary

⁹<https://www.ahrq.gov/patients-consumers/patient-involvement/off-label-drug-usage.html#:~:text=Off%2Dlabel%20prescribing%20is%20when,are%20for%20off%2Dlabel%20use.>

¹⁰ Supra FN 4, Hembree et al. (“Endocrine Society Clinical Practice Guideline”), at p. 3878.

and potentially insurmountable barrier to care. There is a severe shortage of child and adolescent psychiatrists in Florida, with only 12 available per 100,000 Florida children.¹¹ There is also a severe shortage of board-certified psychologists in the state of Florida. Healthcare professionals evaluating patients for medical treatment of gender dysphoria should have expertise in mental health across the developmental spectrum, in gender diversity across the lifespan, and in assessing capacity to consent/assent.¹² This may include therapists or licensed social workers in addition to psychologists or psychiatrists. Indeed, therapists and licensed social workers may have a deeper understanding of their patient's gender dysphoria than the patient's psychiatrist, who is often primarily managing psychotropic medications rather than facilitating exploration of gender identity which may be primarily the therapist's role.

86. Relatedly, each form requires that a suicide risk assessment be performed by a licensed mental health care professional at least every three months. (Minor Consent Forms, at p. 3). The frequency of mental health evaluations for patients undergoing medical treatment for gender dysphoria should be individualized according to the needs of the patient. It is inappropriate to mandate assessments every three months for all patients.

87. SB 254 mandated that physicians execute the informed consent forms "while physically present in the same room" as the patient. (Fla Stat 456.52(2)). However, there is no medical justification for this requirement. Pursuant to SB 254, each form requires that the consent form be signed "*in person*" (Minor Consent Forms, at p. 1), and also requires "in-person" evaluations by the prescribing physician at least every 6 months (*id.*, at p. 3). There are few clinicians across

¹¹ The American Academy of Child and Adolescent Psychiatry, Practicing Child and Adolescent Psychiatrists (AACAP Workforce Maps by State), available at: https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx (last accessed August 16, 2023).

¹² *Supra* FN 3, Coleman et al. ("Standards of Care V. 8")

Florida who provide medical treatment for gender dysphoria in minors. Requiring all patients to complete the consent forms in person, and to have in-person visits every 6 months, rather than allowing for telehealth visits when appropriate, creates a barrier to care for patients, who may have to travel up to 5-6 hours to receive care from their nearest clinic. Further, there is no medical justification for these in-person requirements.

88. Each form requires laboratory assessments at least every 4 months. (Minor Consent Forms, at p. 3). This interval is not supported by clinical practice guidelines - the Endocrine Society guidelines suggest, but do not mandate, laboratory testing every 6-12 months during pubertal suppression and for masculinizing therapy and every 3 months in the first year and then annually for feminizing therapy.¹³ The frequency of laboratory testing should be individualized according to the needs of the patient.

89. Each form requires a bone age x-ray be obtained at least once yearly if the minor is still growing. (Minor Informed Consent Forms, at p. 3) (the forms for masculinizing and feminizing medications impose the requirement “at least once a year if the minor is still growing” while the form for puberty suppression medication imposes this requirement “no less than once a year.”). This is often unnecessary unless there is a concern for the patient’s final adult height, and not recommended in Endocrine Society guidelines unless clinically indicated. Exposing patients to unnecessary laboratory draws and x-rays violates the ethical principle of non-maleficence.

90. Each form also requires annual DEXA scans to evaluate bone mineral density. (Minor Consent Forms, at p. 3). This is not supported by clinical practice guidelines. Endocrine Society guidelines suggest, but do not mandate, DEXA scans

¹³ Supra FN 4, Hembree et al. (“Endocrine Society Clinical Practice Guideline”), at p. 3871, 3888-89.

every 1-2 years.¹⁴ In fact, as bone mineral density changes very slowly over time, annual DEXA scans may not show meaningful change, and scans performed every other year may be more appropriate. The frequency of imaging for bone mineral density should be individualized according to the needs of the patient.

91. Each form states that medical treatment for gender dysphoria “will not prevent serious psychiatric events such as suicide.” (Masculinizing medication form, at p. 7; feminizing medication form, at p. 6; puberty suppressing medication form, at p. 4). Medications for the treatment of gender dysphoria are associated with improved mental health outcomes. A categorical statement that these medications will not prevent serious psychiatric events for an individual patient is not consistent with individualized informed consent.

92. Each form contains an inordinate number of points that patients must initial individually, including obvious statements already previously covered. For example, the Masculinizing medication form states that “[t]aking testosterone causes changes that other people will notice” (at p. 7), and also contains information about drug interactions with blood thinners such as Warfarin, which are very infrequently used in the pediatric population (*id.* at 4); and contraindications to treatment including uncontrolled coronary artery disease (*id.* at 6), which I have never seen in an adolescent population throughout my years of medical practice. Similarly, the Feminizing Medication Form discusses estrogen-dependent cancers (at p. 6), which are also exceedingly rare in the adolescent population. This serves to lengthen the form, seemingly to serve the purpose of intimidating patients with an extensive and unwieldy document that must be initialed 44 times by both the parent and the patient in the case of the Feminizing Medications Consent form. This does not facilitate informed consent, and instead focuses the patient on potential

¹⁴ *Id.* at 3883-84.

risks that are not applicable to their individual care, usurping a discussion of the actual risks and benefits of treatment.

93. The Masculinizing and Feminizing Medication Forms for minors state that “this medicine and dose that is recommended is based solely on the judgement and experience of the minor’s prescribing physician.” (at, p. 6). This is inaccurate, as clinical practice guidelines including the Endocrine Society Guidelines are followed by myself and other clinicians to guide treatment regimens.

94. The Masculinizing and Feminizing Medication Forms for minors state that “taking too much” medication “will not make changes happen more quickly or more significantly.” (masculinizing medication form, at p. 7; feminizing medication form, at p. 6). While not recommended, this statement is inaccurate.

I. *Specific Inaccuracies Within the Puberty Suppression Treatment Form for Minors*

95. On Page 4 of the document, it states that the puberty blocking effect may be permanent even after stopping medical treatment. This is incorrect and is never part of the informed consent discussion for patients with precocious puberty or for patients with gender dysphoria, as it is false information.

96. Also on Page 4, the document states that “it cannot be predicted how quickly or slowly or even if a minor’s body will respond to the medication.” The effect of GnRH agonists on pubertal suppression is very predictable and the physiologic impact is well understood.

97. Also on Page 4, the document states that “puberty blockers can interfere with fertility.” Puberty blockers themselves have no long-term impact on fertility once they are stopped; this statement is misleading and inaccurate.

98. Also on Page 4, the document states that “the adverse effects and safety of puberty blockers used for the treatment of gender dysphoria in minors is not well known.” This is inaccurate, as described in Paragraphs 55-57.

99. The laundry list of side effects included on Pages 5-6 of the form is misleading. These are side effects that were reported most commonly for the 6-month GnRH agonist (which, interestingly, is not listed as a treatment option on the consent form itself), but may have been reported equally among the treatment and placebo group in clinical trials.¹⁵ In fact, the only commonly listed side effects for the 3-month GnRH agonist formulation, which is most commonly prescribed, are injection site reactions, weight gain, headache, and mood changes.¹⁶ Having a laundry list of potential side effects without highlighting the most common or potentially severe again disrupts a meaningful discussion of risks and benefits of treatment.

J. *Specific Inaccuracies Within the Masculinizing Medications Form for Minors*

100. The document states on page 5 that “the following changes could be permanent, but may improve if I stop taking testosterone.” However, many of these changes are known to be non-permanent, and so this paragraph is inaccurate.

101. Currently, data do not support that testosterone increases the risk of endometrial, ovarian, or breast cancer, and so stating definitively that treatment does increase these risks is inaccurate. Testosterone also does not cause or worsen migraines. (Page 7).

K. *Specific Inaccuracies Within the Feminizing Medications Form for Minors*

102. On Page 4, it states that “If a minor takes estrogen, the following changes in a minor’s breast will occur,” and then lists “a milky discharge from the nipples.” This is not an expected change from estrogen therapy and should not be listed within this paragraph.

¹⁵ <https://www.lupron.com/isi.html>

¹⁶ *Id.*

103. On Page 5, it states that “Even if a minor stops taking feminizing medications, the following changes may occur.” However, the changes listed are reversible, and not irreversible, effects of estrogen therapy.

104. On Page 7, it states that “Estrogen should be used **WITH CAUTION** and only after a full discussion of risks by anyone who... has high levels of cholesterol.” However, in most studies estrogen therapy does not increase levels of LDL and can result in a more favorable lipid profile.¹⁷

105. Also on Page 7, it states that “Taking estrogen can increase the deposits of fat around internal organs, which increases the risk for diabetes and heart disease, which in turn increases the risk of heart attack and stroke.” However, recent studies show no change in visceral fat with estrogen therapy.¹⁸

106. Also on Page 7, it states that “Taking estrogen can raise blood pressure, which increases the risk of heart attack and stroke.” However, recent studies show that estrogen therapy actually tends to lower systolic blood pressure.¹⁹

III. CONCLUSION

107. Transgender persons account for 0.6% of our population in the United States. This marginalized population has had the misfortune of having their medical care targeted and banned despite the existence of evidence-based medical standards that have been reviewed and adopted by major medical organizations and providers with extensive expertise in this field of medicine. As with any treatment for a minor, treatments for gender dysphoria rely on an open informed consent discussion

¹⁷ Masumori N, Nakatsuka M. Cardiovascular Risk in Transgender People With Gender-Affirming Hormone Treatment. *Circ Rep.* 2023 Mar 28;5(4):105-113. doi: 10.1253/circrep.CR-23-0021. PMID: 37025940; PMCID: PMC10072899.

¹⁸ Klaver M, van Velzen D, de Blok C, Nota N, Wiepjes C, Defreyne J, Schreiner T, Fisher A, Twisk J, Seidell J, T'Sjoen G, den Heijer M, de Mutsert R. Change in Visceral Fat and Total Body Fat and the Effect on Cardiometabolic Risk Factors During Transgender Hormone Therapy. *J Clin Endocrinol Metab.* 2022 Jan 1;107(1):e153-e164. doi: 10.1210/clinem/dgab616.

¹⁹ Banks K, Kyinn M, Leemaqz SY, Sarkodie E, Goldstein D, Irwig MS. Blood Pressure Effects of Gender-Affirming Hormone Therapy in Transgender and Gender-Diverse Adults. *Hypertension.* 2021 Jun;77(6):2066-2074. doi: 10.1161/HYPERTENSIONAHA.120.16839.

between a qualified medical provider, their patient, and the patient's parent or guardian. There is no sound medical justification for prohibiting the medical treatment provided to this one particular population, and no basis upon which to deny parents the right to determine appropriate medical treatment for their child and to deny qualified medical providers the right to provide evidence-based treatment aligned with authoritative standards of care. Further, the "informed consent forms" created by the Florida Boards of Medicine communicate medically inaccurate and misleading information, require potentially inappropriate testing and restrictions on care, and undermine the clinician-patient relationship and trustworthiness of the process of informed consent. The mental health disparities present in this population that are exacerbated by untreated gender dysphoria are significant and well-documented. The Florida Boards of Medicine's bans, SB 254, and the recently promulgated "informed consent forms," prohibit doctors from caring for their patients and abiding by the Hippocratic Oath.

I declare under penalty of perjury that the foregoing is true and correct.
Executed this 16th day of August, 2023.



BRITTANY BRUGGEMAN, M.D.

Exhibit A

Brittany S. Bruggeman*Curriculum Vitae*

Assistant Professor of Pediatric Endocrinology

E-mail: bruggemanbr@gmail.com*Phone:* 321-537-8832

UF Health Shands Children's Hospital

University of Florida Gainesville, FL 32608

Education **University of Florida**, Gainesville, FL**B.S.**, Basic Biology and Medicine 2008-2012

Minor, Music Performance

Summa cum laude

Thesis: "Development and Optimization of a Bioartificial Pancreas as a Therapy for Type 1 Diabetes."

M.D., College of Medicine 2011-2015

Medical Honors Program

*With Honors in Research***UF Health Shands Children's Hospital**, Gainesville, FL**Pediatric Residency** 2015-2018*Research Track***Endocrinology Fellowship** 2018-2021**Qualifications & Licensure**

USMLE Step 1: 247 2013

USMLE Step 2: 267 2014

USMLE Step 3: 242 2015

Diplomat, American Board of Pediatrics 2018-present

Fellow, American Academy of Pediatrics 2018-present

Florida Medical Licensure: ME 137728 2018-present

Diplomat, American Board of Pediatric Endocrinology 2021-present

Current Appointments

Assistant Professor of Pediatric Endocrinology, Tenure-eligible

University of Florida | Gainesville, FL

July 2021-present

Honors and Awards***Internal*****UF College of Medicine Exemplary Teacher Award** 2022

Annual award that recognizes the top 10% of College of Medicine faculty in teaching excellence and mentorship.

2020 Douglas J. Barrett, MD Academic Fellowship Award 2020-2021

Awarded to one rising third or fourth year pediatric clinical or research fellow displaying the highest qualities of scholarly activity in research, teaching and patient care. Funds one year of fellowship training.

Pediatric Clerkship Excellence in Medical Student Education x3, 2018-2019
Medical students recognize one resident or faculty who most positively impacted their education during their pediatric clerkship.

Inaugural McJunkin Family Type 1 Diabetes Fellow 2018-2019
Awarded to fellows committed to careers as clinician-scientists in type 1 diabetes. Funds one year of pediatric endocrinology fellowship.

Audrey Lincourt Schiebler Award for Excellence in Child Advocacy 2018
Awarded to one UF pediatric trainee for superior efforts in child advocacy.

Best Resident/Fellow Poster, UF Pediatric Science Day May 2017
“Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydratic Fundus Camera.”

Gold Humanism Honor Society, UF Chapter Jan. 2015- present
15% of the fourth-year medical school class selected for exemplary behavior that promotes humanism in medicine.

Association of Pathology Chairs Award, UF College of Medicine May 2013

Distinguished Service Award, UF College of Medicine (COM) May 2013

International Medical Outreach Service Award, UF COM May 2013

External

NIH NIDDK Travel Award June 2022
One of six abstracts chosen for oral presentation at the “Integrated Physiology of the Exocrine and Endocrine Compartments in Pancreatic Diseases Workshop.”

CAPER 2022 PancreasFest Travel Grant May 2022
Awarded to trainees and early career faculty dedicated to pancreatic research.

Runner-Up, Best Case Presentation ISPAD Science School May 2021
Awarded to the top five case presentations at the ISPAD Science School for Physicians in May 2021. Winning presentations were developed into modules on the ISPAD e-learning platform.

American Academy of Pediatrics (AAP) Top Ten Resolution 2019
First-authored resolution, “Affordable Insulin Access for All Children with Diabetes” voted by AAP leadership to be a top 10 policy priority in 2019 out of 60+ accepted proposals.

Endocrine Society Presidential Poster Competition Participant March 2019

First-authored top-scoring abstract for presentation at the Annual Meeting.

Third Place Oral Presentation, FCAAP Pediatric Medical Student Research Forum Aug. 2014

“Comparison of effectiveness of Glulisine, Lispro, and Aspart in decreasing post-prandial hyperglycemia in a real-world setting.”

Service and Leadership

Internal

Equal Access Clinic, UF College of Medicine

Pediatric Attending Physician 2018-present

UF College of Medicine student-run free healthcare clinic

Gainesville Healthy Smiles Day

Founder and Organizer April 2016 & June 2017

Pediatric Residents trained in oral health exams and provided free basic dental care, education, and referrals in an underserved area of Gainesville.

Global Health Outreach Medical Missions

Trip Member, Nicaragua 2012, 2014, 2015

Trip Leader, Nicaragua 2013

PACE Center for Girls

UF College of Medicine Careers in Medicine Day July 2022

UF College of Medicine

LCME Accreditation Review Jan. 2023

Pediatric Residency Advocacy Rotation Co-Director July 2022-present

Research Accountability Team member December 2021-present

Collaborative Learning Group Leader July 2021-present

Team Lead, FL DOH CMS Endocrine Disease Mgmt. Contract 2020-2022

Pediatric Interest Group Treasurer 2012-2013

UF College of Medicine White Coat Company

Vocal coach and participant Aug. 2011-May 2013

External

Alachua County Medical Society

Secretary/Treasurer May 2021-present

Trainee Advisory Board Member 2018-2021

American Academy of Pediatrics

Adopted first-authored resolution: “Equitable Parental Leave Recommendations for Pediatric Trainees”	Aug. 2021
Section on Endocrinology Executive Board Fellow Member	2019-2021
Executive Coordinator of Internal Process for the Section on Pediatric Trainees (SOPT)	2018-2019
Executive Coordinator of Resident Initiatives, SOPT	2017-2018
Resolutions Task Force, SOPT	2017-2018
District X Resident Representative, SOPT	2016-2017
District X Assistant District Coordinator, SOPT	2015-2016
Residency Program Delegate	2015-2018

American Diabetes Association

National Advocacy Committee Member	Jan 2021-present
Early Career Advisory Group Member	March 2021-present
Legislative and Regulatory Subcommittee Member	2019-2020
Call to Congress Participant	April 2019

Florida Chapter of the American Academy of Pediatrics

Early Career Committee Member	2019-2021
Legislative Committee Co-Chair	Nov. 2022-present

Florida Diabetes Camp

Volunteer	July 2012, 2014, 2016 & 2017
Camp Physician	July 2018, 2022

The Environmental Determinants of Diabetes in the Young Study

Diet Committee	2022-present

Type 1 Diabetes TrialNet

Microbiome Working Group	2021-present
Populations Working Group	2019-2022
Psychosocial Committee	2023-present

Professional Affiliations

American Academy of Pediatrics (AAP), Member	2011-present
Alachua County Medical Society, Member	2017-present
AAP Section on Endocrinology, Member	2018-present
American Diabetes Association, Member	2018-present
Florida Medical Association, Member	2018-present
Network for Pancreatic Organ Donors with Diabetes, Investigator	2018-present
Pediatric Endocrine Society, Member	2018-present

Professional Development

American Academy of Pediatrics (AAP)

Washington, DC Legislative Office Internship	April 2018
Annual Legislative Conference	2017, 2018
Section on Pediatric Trainees Planning Meeting	2016, 2018, 2019
District IX/X Annual Meeting	2016, 2017
National Conference and Exhibition	Annually 2012-2020

Florida Chapter of the AAP

Annual Meeting Residency Brain Bowl Participant	2016 & 2017
Annual Conference	2014, 2016-2018, 2020-2022

American Diabetes Association

Focus on Fellows Annual Meeting	Annually 2018-2021
Scientific Sessions	Annually 2018-2022

American Pediatric Society/Society for Pediatric Research

APS SPR Journeys & Frontiers in Pediatric Research Program	2021-2022

Association for Clinical and Translational Science

Annual Meeting	2022
Mock NIH K Study Section	2022

Children with Diabetes Friends for Life

Fellows Program	2018
Annual Meeting	2018

Collaborative Alliance for Pancreatic Education and Research

CAPER PancreasFest Annual Meeting	2022

The Endocrine Society

Fellows Series: Type 1 Diabetes Care and Management Conference	2019
Annual Meeting	2019

Florida Medical Association

Legislative Visitation Program	April 2019
Annual Conference Delegate	2017, 2022

International Society for Pediatric and Adolescent Diabetes

Science School for Physicians	May 2021

Network for Pancreatic Organ Donors with Diabetes (nPOD)

Annual Meeting	2020, 2022, 2023

NIH NIDDK

Integrated Physiology of the Exocrine and Endocrine Compartments in Pancreatic Diseases Workshop	2022

Pediatric Academic Societies

Annual Conference 2013

Pediatric Endocrine Society

Annual Meeting 2019, 2021, 2022

Southern Pediatric Endocrine Society

Annual Meeting 2019

The Environmental Determinants of Diabetes in the Young (TEDDY)

Steering Committee Meeting 2022

Type 1 Diabetes TrialNet

Steering Committee Meeting 2019, 2020, 2022

UF Graduate-Level Research Courses Completed

GMS6945 Team Science Fall 2021

PHC6052 Introduction to Biostatistical Methods Fall 2021

GMS6875 Ethical/Policy Issues in Clinical Research Spring 2022

GMS6885 Translational Health Research Design Fall 2022

Reviewer**Alachua County Medical Society**

ACMS Poster Symposium Judge 2021, 2022

American Academy of Pediatrics

Legislative Conference Scholarships, Section on Pediatric Trainees (SOPT) 2017, 2018

Anne E. Dyson Child Advocacy Award, SOPT 2017, 2018

National Conference Resident Clinical Case Presentations 2016- 2018

Pediatric Endocrine Society

2023 Annual Meeting Abstracts 2023

Ad hoc reviewer for:*Case Reports in Endocrinology* 2020-present*Diabetes Care* 2018-present*Diabetes Technology and Therapeutics* 2019-present*Diabetes Therapy* 2019-present*Diabetes UK* 2022-present*Diabetologia* 2019-present*JMIR Diabetes* 2021-present*Pediatric Diabetes* 2018-present*Pediatrics* 2020-present

Pediatrics in Review

2021-present

Mentorship**University of Florida Undergraduate Research Assistants**

Logan Brunson	Oct. 2018-May 2020
McKayla Massey	Oct. 2018-May 2020
Daniel Rodriguez	Oct. 2018-May 2020
Michael Guyot	June 2022-present
Christopher Georgas	Nov. 2022-present
Danielle Elliott	Nov. 2022-present

UF COM Medical Student Research Assistants

Savanna Gornisiewicz	June 2022-present
Ryan Grabau	June 2022-present
Camila Sarcone	June 2022-present
Rebecca Oyetoro	June 2020-March 2021
Amanda LaPorte	June 2015-Dec. 2018

UF Pediatric Residency Intern Mentorship Program

Iriyise Oloruntoba-Oju	July 2021-present

UF Pediatric Endocrinology Fellow Scholarship Oversight Committee

Israa Ismail	October 2021-present

Mentee Awards

Savanna Gornisiewicz, *2022 Alachua County Medical Society Poster Symposium finalist*, “Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes.” Received \$500 scholarship.

Camila Sarcone, *2022 Medical Student Research Program Symposium semi-finalist*, “Chronic pancreatitis and acinar atrophy by histopathology characterize young nPOD donors with reduced pancreas organ weight and may precede this finding in the progression to type 1 diabetes.” Received \$100 prize.

Michael Guyot, *2023-2024 University of Florida AI Scholars Program*, “The development of a MACSima imaging cyclic staining (MICS) panel to evaluate exocrine pancreatic pathology in type 1 diabetes (T1D).” Received \$1750 scholarship.

Invited Panels***Internal***

UF College of Medicine

BMS 6091: Health Outcomes and Policy 1, Expert Panel Consult Jan. 2020, 2021
Intern 101 Pediatric Pathway: LGBTQ Panel May 2022

External

American Academy of Pediatrics

National Conference and Exhibition Residency Admissions Panel Nov. 2018

Network for Pancreatic Organ Donors with Diabetes (nPOD)

15th Annual Scientific Meeting “WIELD panel: What Brings You Joy? How to Choose a Career Path in T1D Women in Diabetes Research” March 2023

WGCU Public Media

“Blood Sugar Rising” Panel Discussion Nov. 2020

Invited Lectures

Internal

Medi-Gators Virtual Shadowing Program

“A Day in the Life of a Pediatric Endocrinologist.” October 2021

UF Child & Adolescent Psychiatry Fellowship Program

“Hormonal Treatment for Gender Dysphoria.” March 2022

UF College of Medicine

BMS 6632: “Intro to Diabetes: Types, Stigma, & Complications.” 2022, 2023

BMS 6632: “DKA & HHS: Case-based Learning.” 2022, 2023

Intern 101 Pediatric Pathway: “Diabetes in Children.” May 2022

UF Neonatal Grand Rounds

“Sexual Differentiation and Related Disorders.” Nov. 2021, March 2023

UF OB/GYN Grand Rounds

“OB/GYN care of transgender and gender-diverse patients.” Nov. 2021

UF OB/GYN Clerkship

Case-based conference: “Amenorrhea and delayed puberty.” March 2023

UF Pediatric Grand Rounds

“Hot Topics- 3 Minute Talks. Natural History and Mechanisms of Exocrine Dysfunction in Pre-Type 1 Diabetes.” May 2021

“Pediatric Obesity: Avoiding the Pitfalls of Stigma, Bias, and Inertia in Patient Care.” October 2021

UF Pediatric Endocrinology Core Lectures

“Placental Passage of Hormones” February 2022
 “Sexual Differentiation and Related Disorders.” March 2023

UF Pediatric Residency Program

“Diabetes Logistics” July 2019
 “Precocious Puberty” July 2019, Aug 2022

UF Pensacola Pediatric Residency Program

“Cushing Syndrome” March 2021

External

American Academy of Pediatrics

Section on Oral Health Webinar “Adding Oral Health to Your Advocacy Agenda.” Feb. 2018
 National Conference and Exhibition Section on Pediatric Trainees Resident Breakout, “SOPT Delegate 101.” Nov. 2018

American Diabetes Association

ADA Focus on Fellows, “Patient Advocacy.” June 2021
 ADA Focus on Fellows, “Identifying Funding.” June 2021
 Webinar, “Standards of Care in Diabetes 2023 Update for Early Career Professionals.” Jan. 2023

Lohman Family Diabetes & Wellness Conference

“Advancements & Opportunities in the Care of Children with Diabetes” Nov 2021

Right Care Alliance

UF Town Hall, “Insulin Access and Affordability.” July 2018
 UF Diabetes Awareness Fair, “Insulin Access and Affordability.” Nov. 2018

Southern Pediatric Endocrine Society

Annual Meeting, “Insulin Affordability for Pediatric Diabetes Patients.” Feb. 2019

Rotary Club of Marco Island

“The COVID-19 Pandemic and Diabetes Care” Jan. 2021

Bibliography

Peer-Reviewed Manuscripts

1. **Bruggeman BS**, Walker AF, Peters AL, D’Avolio LW, Haller MJ. “Blue Circle Health: A novel patient-centered model of health care delivery for low-income patients with type 1 diabetes.” *J Diabetes Sci Technol.* 2023;0(0). <https://doi.org/10.1177/19322968221149008>

2. So M, O'Rourke C, Ylescupidez A, Bahnson HT, Steck AK, Wentworth JM, **Bruggeman BS**, Lord S, Greenbaum CJ, Speake C. "Characterizing the Age-dependent Effects of Risk Factors on Type 1 Diabetes Progression." *Diabetologia* 2022 Apr;65(4):684-694. <https://doi.org/10.1007/s00125-021-05647-5>
3. Crossen SS, **Bruggeman BS**, Haller MJ, Raymond JK. "Challenges and Opportunities in Utilizing Telehealth for Diabetes Care." *Diabetes Spectr.* 2022 Feb 15;35(1):33-42. <https://doi.org/10.2337/dsi21-0018>
4. Zimmerman C, Ilstad-Minnihan A, **Bruggeman B**, Bruggeman B, Dayton K, Joseph N, Moas D, Rohrs H. "Thyroid Storm Caused by Hyperemesis Gravidarum." *AACE Clin. Case Rep.* 2022 Jan 3;8(3):124-127. <https://doi.org/10.1016/j.aace.2021.12.005>
5. **Bruggeman BS**, Campbell-Thompson M, Filipp SL, Gurka MJ, Atkinson MA, Schatz DA, Jacobsen LM. "Substance use affects type 1 diabetes pancreas pathology: implications for future studies." *Front Endocrinol.* 2021 Nov;12:1553. <https://doi.org/10.3389/fendo.2021.778912>
6. **Bruggeman BS**, Bemier A. "Hirsutism and Menstrual Irregularity in a 16-year-old Girl." *Pediatr Rev.* 2021 Aug;42(8):449-452. <https://doi.org/10.1542/pir.2020-002089>
7. Lin AS, Mack JA, **Bruggeman B**, Jacobsen LM, Posgai AL, Wasserfall CH, Brusko TM, Atkinson MA, Gitelman SE, Gottlieb PA, Gurka MJ, Mathews CE, Schatz DA, Haller MJ. "Low-dose ATG/GCSF in Established Type 1 Diabetes: A Five-Year Follow-up Report." *Diabetes.* 2021 May;70(5):1123-1129. <https://doi.org/10.2337/db20-1103>
8. **Bruggeman B**,* Zimmerman C,* LaPorte A, Stalvey M, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. "Barriers to Retinopathy Screening in Youth and Young Adults with Type 1 Diabetes." *Pediatr Diabetes.* 2021 May;22(3):469-473. <https://doi.org/10.1111/pedi.13171> *Equal first authorship
9. Foster TP, **Bruggeman B**, Guedes B, Dayton K. "Seizure Activity in a 3-year-old Girl." *Pediatr Rev.* 2021 Jan;42(S1):S85-S88. <https://doi.org/10.1542/pir.2019-0252>
10. Foster TP, **Bruggeman B**, Campbell-Thompson M, Atkinson MA, Haller MJ, Schatz DA. "Exocrine Pancreas Dysfunction in Type 1 Diabetes." *Endocr Pract.* 2020 Dec;26(12):1505-1513. <https://doi.org/10.4158/EP-2020-0295>
11. **Bruggeman BS**, Vincent HK, Chi X, Filipp SL, Mercado R, Modave F, Guo Y, Gurka MJ, Bernier A. "Simple tests of cardiorespiratory fitness in a

pediatric population.” *PLOS ONE*. 2020 Sep;15(9):e0238863.

<https://doi.org/10.1371/journal.pone.0238863>

12. Zimmerman C,* **Bruggeman B**,* LaPorte A, Kaushal S, Stalvey M, Beauchamp G, Dayton K, Hiers P, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. “Real-world Screening for Retinopathy in Youth with Type 1 Diabetes Using a Non-mydratic Fundus Camera.” *Diabetes Spectr*. 2020 Sep; ds200017. <https://doi.org/10.2337/ds20-0017> *Equal first authorship
13. Morris HL, Donahoo WT, **Bruggeman B**, Zimmerman C, Hiers P, Zhong VW, Schatz D. “An Iterative Process for Identifying Pediatric Patients with Type 1 Diabetes: Retrospective Observational Study.” *JMIR Med Inform*. 2020 Sep;8(9):e18874. <https://doi.org/10.2196/18874>
14. Walker AF, Haller MJ, Gurka MJ, **Bruggeman B**, Miller K, Foster N, Anez Zabala C, Schatz DA. “Addressing Health Disparities in Type 1 Diabetes through Peer Mentorship.” *Pediatr Diabetes*. 2020 Feb;21(1):120-127. <https://doi.org/10.1111/pedi.12935>
15. **Bruggeman BS**, Albanese-O'Neill, A. “From Pediatric to Adult Diabetes Care: Strategies for Success.” *Practical Diabetology*. 2019 Aug. Retrieved from: <https://www.diabetesselfmanagement.com/practical-diabetology/news-tools/pediatric-adult-diabetes-care-strategies-success/>
16. **Bruggeman BS**, Schatz DA. “Enhanced Understanding of the Natural History of Pre-Type 1 Diabetes: Fundamental to Prevention.” *Pediatr Endocrinol Rev*. 2019 Mar;16(3):359-368. <https://doi.org/10.17458/per.vol16.2019.bs.pretype1diabetes>

Expert Commentary

1. **Bruggeman BS**, Schatz DA. “The ISPAD Clinical Practice Consensus Guidelines 2022: how far we have come and the distance still to go.” *Lancet Diabetes Endocrinol*. 2023 Mar 24;S2213-8587(23)00083-9. [https://doi.org/10.1016/S2213-8587\(23\)00083-9](https://doi.org/10.1016/S2213-8587(23)00083-9)
2. **Bruggeman BS**, Campbell-Thompson MC. Expert Commentary, “2-Year Remission of Type 2 Diabetes and Pancreas Morphology.” *Practice Update* October 2020. <https://www.practiceupdate.com/content/2-year-remission-of-type-2-diabetes-and-pancreas-morphology/107876>
3. **Bruggeman BS**. “Fertile, fat, and forty.” *The Yale Journal for Humanities in Medicine*. 11 May 2014. <http://yjhm.yale.edu/essays/bbruggeman20140511.htm>

Peer-Reviewed Conference Proceedings and Abstracts

International/National Presentations

1. Guyot M, Williams M, Bumgarner BM, Brusko M, Campbell-Thompson M, Wasserfall C, **Bruggeman B**. “The development of a MACSima imaging cyclic staining (MICS) panel to evaluate exocrine pancreatic pathology in type 1 diabetes (T1D).” Poster at *Network for Pancreatic Organ Donors with Diabetes 15th Annual Meeting*, February 2023.
2. Sarcone C, Turk L, Jacobsen L, Campbell-Thompson M, **Bruggeman B**. “Chronic Pancreatitis and Acinar Atrophy by Histopathology Characterize Young nPOD Donors with Reduced Pancreas Organ Weight and May Precede this Finding in the Progression to Type 1 Diabetes.” Poster at *Network for Pancreatic Organ Donors with Diabetes 15th Annual Meeting*, February 2023.
3. **Bruggeman BS**, Gomisiewicz S, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D. “Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes.” Oral presentation at *NIH NIDDK Integrated Physiology of the Exocrine and Endocrine Compartments in Pancreatic Diseases Workshop*, June 2022.
4. **Bruggeman BS**, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D. “A Serum Exocrine Enzyme as a Biomarker of Response to Immunotherapy in Type 1 Diabetes.” Poster at *CAPER PancreasFest*, July 2022.
5. **Bruggeman BS**, Gomisiewicz S, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D. “Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes.” Oral presentation at *NIH NIDDK Integrated Physiology of the Exocrine and Endocrine Compartments in Pancreatic Diseases Workshop*, June 2022.
6. Gornisiewicz S, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D, **Bruggeman BS**. “Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes.” Poster at *NIH NIDDK Integrated Physiology of the Exocrine and Endocrine Compartments in Pancreatic Diseases Workshop*, June 2022.
7. **Bruggeman BS**, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D. “A Serum Exocrine Enzyme as a Biomarker of Response to Immunotherapy in Type 1 Diabetes.” Poster at *Association for Clinical and Translational Science Annual Meeting*, April 2022. <https://doi.org/10.1017/cts.2022.192>
8. **Bruggeman BS**, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D. “A Serum Exocrine Enzyme as a Biomarker of Response to Immunotherapy in Type 1 Diabetes.” Poster at *Pediatric Endocrine Society Annual Meeting*, April 2022.

9. Zimmerman C, Ilstad-Minnihan A, **Bruggeman B**, Bruggeman B, Dayton K, Joseph N, Moas D, Rohrs H. "Thyroid Storm Caused by Hyperemesis Gravidarum." Poster at *American Association of Clinical Endocrinology Annual Meeting 2021: Envision*. Virtual. May-June 2021.
10. **Bruggeman B**. "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes." Oral Presentation at *Seventh Annual Endocrine Fellows Foundation Diabetes, Obesity, and Metabolism Research Forum*. February 2021.
11. **Bruggeman BS**, Beachy D, Jacobsen LM, Nick HS, Atkinson MA, Schatz D, Wasserfall C. "Role of mTORC1 Regulation in the T1D Organ Donor Pancreas." Poster at *American Diabetes Association Annual Meeting*, June 2020. <https://doi.org/10.2337/db20-1637-P>
12. **Bruggeman BS**, Bernier A. "Ovarian Venous Sampling Supports the Diagnosis of a Rare Virilizing Tumor in a Pediatric Patient." Poster at *Pediatric Endocrine Society Annual Meeting*, April 2020 (meeting canceled).
13. **Bruggeman BS**, Campbell-Thompson MA, Posgai AL, Atkinson MA, Schatz D, Jacobsen LM. "Effect of Substance Use on Type 1 Diabetes Pancreas Histopathology." Poster at *American Diabetes Association Annual Meeting*, June 2019. <https://doi.org/10.2337/db19-1366-P>
14. **Bruggeman BS**, Vincent HK, Chi X, Filipp SL, Mercado R, Modave F, Guo Y, Gurka MJ, Bernier A. "Simple Tests of Cardiorespiratory Fitness in a Pediatric Population: A Feasibility Study." Poster at *Pediatric Academic Society Annual Meeting*, April 2019.
15. **Bruggeman B**, Dayton K. "An Unusual Presentation of Pseudohypoparathyroidism Type 1a Associated with a Novel GNAS Mutation and Vitamin D Deficiency." Guided Presidential Poster Session at *Endocrine Society Annual Meeting*, March 2019. <https://doi.org/10.1210/js.2019-MON-252>
16. Morris HL, Donahoo WT, **Bruggeman B**, Zimmerman C, Hiers P, Zhong VW, Schatz D. "Development of a Computable Phenotype for Youth with Type 1 Diabetes." Poster at *American Public Health Association Annual Meeting*, Nov. 2018.
17. Walker AF, Haller MJ, Gurka MJ, Morris HL, Anez-Zabala C, **Bruggeman BS**, Guiffre D, Rohrs H, Atkinson MA, Schatz D. "Promoting Health Equity in Type 1 Diabetes through Peer Mentorship- Findings from the All for ONE Randomized Controlled Trial." Moderated Poster Discussion at *American Diabetes Association Annual Meeting*, June 2018. <https://doi.org/10.2337/db18-1371-P>

18. Walker AF, Johnson C, Anez-Zabala C, Dorvil SR, Haller MJ, Gurka MJ, **Bruggeman BS**, Guiffre D, Atkinson MA, Schatz I, Schatz D. "A Content Analysis of Text Messages in a Type 1 Diabetes Peer Mentoring Program-The Importance of Shared Interests." Poster at *American Diabetes Association Annual Meeting*, June 2018. <https://doi.org/10.2337/db18-844-P>
19. Zimmerman C, **Bruggeman B**, LaPorte A, Kaushal S, Stalvey M, Beauchamp G, Dayton K, Hiers P, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. "Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydriatic Fundus Camera." Poster at *American Diabetes Association Annual Meeting*, Aug. 2017.
20. **Sorensen B**, Silverstein J. "Comparison of effectiveness of Glulisine, Lispro, and Aspart in decreasing post-prandial hyperglycemia in a real-world setting." Poster at *Pediatric Academic Societies Annual Meeting*, May 2013.

Regional Presentations

1. Gornisiewicz S, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D, **Bruggeman BS**. "Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes." Poster at *FCAAP 8th Annual Pediatric Research Forum for Medical Students*, September 2022.
2. **Bruggeman B**, Zimmerman C, LaPorte A, Kaushal S, Stalvey M, Beauchamp G, Dayton K, Hiers P, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. "Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydriatic Fundus Camera." Poster at *Children with Diabetes Friends for Life Conference*, July 2018.
3. **Bruggeman B**, Zimmerman C, LaPorte A, Kaushal S, Stalvey M, Beauchamp G, Dayton K, Hiers P, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. "Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydriatic Fundus Camera." Poster at *Florida Medical Association David A. Paulus, MD Poster Symposium*, Aug. 2017.
4. **Bruggeman B**. "Comparison of effectiveness of Glulisine, Lispro, and Aspart in decreasing post-prandial hyperglycemia in a real-world setting." Oral presentation at *FCAAP Pediatric Medical Student Research Forum*, Aug. 2014.
5. **Sorensen B**, Simpson N. "Developing methods to optimize efficacy of a bioartificial pancreas as a therapy for type 1 diabetes in a C3H/HeN mouse model." Poster at *Furman Engaged Research Symposium*, April 2011.

6. **Sorensen B**, Simpson N. “Developing methods to optimize efficacy of a bioartificial pancreas as a therapy for type 1 diabetes in a C3H/HeN mouse model.” Poster at *Florida Statewide Student Research Symposium*, March 2011.

Local Presentations

1. Guyot M, Williams M, Bumgarner BM, Brusko M, Campbell-Thompson M, Wasserfall C, **Bruggeman B**. “The development of a MACSima imaging cyclic staining (MICS) panel to evaluate exocrine pancreatic pathology in type 1 diabetes (T1D).” Poster at *2023 Spring Undergraduate Research Symposium*, April 2023.
2. Guyot M, Williams M, Bumgarner BM, Brusko M, Campbell-Thompson M, Wasserfall C, **Bruggeman B**. “The development of a MACSima imaging cyclic staining (MICS) panel to evaluate exocrine pancreatic pathology in type 1 diabetes (T1D).” Poster at *STEM at UF Research Symposium*, March 2023.
3. Guyot M, Williams M, Bumgarner BM, Brusko M, Campbell-Thompson M, Wasserfall C, **Bruggeman B**. “The development of a MACSima imaging cyclic staining (MICS) panel to evaluate exocrine pancreatic pathology in type 1 diabetes (T1D).” Poster at *13th annual UF College of Medicine Celebration of Research*, February 2023.
4. Sarcone C, Turk L, Jacobsen L, Campbell-Thompson M, **Bruggeman B**. “Chronic Pancreatitis and Acinar Atrophy by Histopathology Characterize Young nPOD Donors with Reduced Pancreas Organ Weight and May Precede this Finding in the Progression to Type 1 Diabetes.” Poster at *13th annual UF College of Medicine Celebration of Research*, February 2023.
5. Gornisiewicz S, McGrail K, Gonzalez N, Wasserfall C, Campbell-Thompson M, Atkinson M, Haller M, Schatz D, **Bruggeman BS**. “Serum Exocrine Enzymes as Biomarkers of Response to Immunotherapy in Type 1 Diabetes.” Poster at *13th annual UF College of Medicine Celebration of Research*, February 2023.
6. **Bruggeman BS**. “Exocrine Pancreas Pathology in Type 1 Diabetes.” Oral Presentation at *UF Pediatrics Fellows Research Conference*, January 2021.
7. **Bruggeman BS**. “Exocrine Pancreas Pathology in Type 1 Diabetes.” Oral Presentation at *UF Pediatrics Fellows Research Conference*, May 2020.
8. **Bruggeman BS**, Campbell-Thompson MA, Posgai AL, Atkinson MA, Schatz D, Jacobsen LM. “Effect of Substance Use on Type 1 Diabetes Pancreas Histopathology.” Poster at *UF Diabetes Institute World Diabetes Day Poster Session*, Nov. 2019.

9. **Bruggeman BS**. “Simple Tests of Cardiorespiratory Fitness in a Pediatric Population: A Feasibility Study.” Oral Presentation at *UF Pediatric Science Day*, June 2019.
10. **Bruggeman BS**, Campbell-Thompson MA, Posgai AL, Atkinson MA, Schatz D, Jacobsen LM. “Effect of Substance Use on Type 1 Diabetes Pancreas Histopathology.” Poster at *UF Pediatric Science Day*, June 2019.
11. Zimmerman C, Morris HL, Donahoo WT, **Bruggeman B**, Hiers P, Zhong VW, Schatz D. “Development of a Computable Phenotype for Youth with Type 1 Diabetes.” Poster at *UF Pediatric Science Day*, June 2018.
12. **Bruggeman B**, Guiffre D, Walker A. “Improving Type 1 Diabetes Compliance Using a Mentorship Program.” Poster at *UF Health Pediatric Residency Quality Improvement Symposium*, Aug. 2017.
13. **Bruggeman B**, Zimmerman C, LaPorte A, Kaushal S, Stalvey M, Beauchamp G, Dayton K, Hiers P, Filipp SL, Gurka MJ, Silverstein JH, Jacobsen LJ. “Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydratic Fundus Camera.” Poster at *UF Pediatric Science Day*, May 2017.
14. **Bruggeman BS**, Zimmerman C. “Prevalence and Characterization of Retinopathy in Children with Type 1 Diabetes Using a Non-mydratic Fundus Camera.” Oral Presentation at *UF Pediatrics Fellows Research Conference*, Nov. 2016.
15. **Sorensen B**, Silverstein J. “Comparison of effectiveness of Glulisine, Lispro, and Aspart in decreasing post-prandial hyperglycemia in a real-world setting.” Poster at *University of Florida Medical Student Research Day*, April 2013.
16. **Sorensen B**, Simpson N. “Developing methods to optimize efficacy of a bioartificial pancreas as a therapy for type 1 diabetes in a C3H/HeN mouse model.” Poster at *Junior Honors Medical Program Research Symposium*, April 2011.
17. **Sorensen B**, Simpson N. “Developing methods to optimize efficacy of a bioartificial pancreas as a therapy for type 1 diabetes in a C3H/HeN mouse model.” Poster at *HHMI Creativity in the Arts and Sciences Event*, Jan. 2011.

Ongoing Research Support

NIH NIDDK K23 Career Development Award

Role: Mentored PI

January 2023-November 2026

Title: “Natural History and Mechanisms of Exocrine Pancreatic Dysfunction in Pre-Type 1 Diabetes.”

This project aims to investigate the natural history and role of exocrine loss in pre-T1D while cultivating the skills and experience necessary to establish an independent career as a physician scientist in T1D clinical and translational research.

Georgia Center for Diabetes Translation Research 2022 Pilot and Feasibility Program Cycle

Role: PI February 2023-January 2024

Title: “A Provider-Facing EHR-Based Dashboard to Improve Health Equity in Type 1 Diabetes.”

This project aims to conceptualize and create capacity for a T1D Technology Health Equity Dashboard within the University of Florida and Emory University Health systems.

NIH NIDDK Extramural Loan Repayment Program for Pediatric Research

Role: Mentored PI July 2022-June 2024

Title: “Natural History and Mechanisms of Exocrine Pancreatic Dysfunction in Pre-Type 1 Diabetes.”

This project aims to investigate the natural history of exocrine loss in T1D by measuring fecal elastase throughout the course of pre-T1D and to investigate exocrine autoimmunity as a potential mechanism for exocrine dysfunction in T1D while cultivating the skills and experience necessary to establish an independent career as a physician scientist in T1D clinical and translational research.

NIH NIDDK R03: New Investigator Gateway Awards for Collaborative T1D Research

Role: PI September 2021-August 2023

Title: “Natural History and Mechanisms of Exocrine Dysfunction in Pre-Type 1 Diabetes.”

This project aims to investigate the natural history of exocrine loss in T1D by measuring fecal elastase throughout the course of pre-T1D within two different cohorts: The Environmental Determinants of Diabetes in the Young (TEDDY) study and a T1D TrialNet prospective ancillary study.

Pediatric Endocrine Society Clinical Scholar Award

Role: Mentored PI July 2021-June 2023

Title: “Natural History and Mechanisms of Exocrine Dysfunction in Pre-Type 1 Diabetes.”

This project aims to investigate the natural history of exocrine loss in T1D by measuring fecal elastase throughout the course of pre-T1D and to investigate exocrine autoimmunity as a potential mechanism for exocrine dysfunction in T1D.

Completed Grants

University of Florida Clinical and Translational Research Institute KL2 Career Development Award

Role: Mentored PI

July 2021-June 2023

Title: "Natural History and Mechanisms of Exocrine Dysfunction in Pre-Type 1 Diabetes."

This project aims to investigate the natural history of exocrine loss in T1D by measuring fecal elastase throughout the course of pre-T1D and to investigate exocrine autoimmunity as a potential mechanism for exocrine dysfunction in T1D while cultivating the skills and experience necessary to establish an independent career as a physician scientist in T1D clinical and translational research.

UF Medical Student Research Program Grant

June 2011-July 2011

Role: Mentored PI

Title: "Comparison of Effectiveness of Glulisine, Lispro, and Aspart in decreasing post-prandial hyperglycemia in a real-world setting."

This project was a randomized, open-label trial that aimed to compare the glycemic excursion following food intake and post-meal injection of Apidra, Humalog, and Novolog insulins in a diabetes camp for children.

American Academy of Pediatrics Community Access to Child Health (CATCH) Resident Grant

June 2018-August 2019

Role: Mentored co-PI

Title: "Health Smiles Day Initiative."

This project trained pediatric residents in oral health exams and provide free basic dental care, education, and referrals in an underserved area of Gainesville on an annual to biannual basis.

UF Children's Miracle Network Fellow Grant

June 2018-June 2019

Role: Mentored co-PI

Title: "Fundal Photography as a Screening Tool for Diabetic Retinopathy in Pediatric Type 2 Diabetes."

This project aimed to assess the feasibility of screening for retinopathy in the pediatric type 2 diabetes patient population using a non-mydratic fundus camera.

Inaugural McJunkin Family Type 1 Diabetes Fellow

July 2018-July 2019

Role: PI

Awarded to fellows committed to careers as clinician-scientists in type 1 diabetes. Funds one year of pediatric endocrinology fellowship.

UF Children's Miracle Network Fellow Grant

June 2019-June 2020

Role: Mentored PI

Title: "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes."

This project aims to elucidate the relationship between AUC C-peptide, markers of immune function, and serum markers of exocrine pancreatic function in subjects enrolled in the clinical trial: "Antithymocyte Globulin (ATG) and pegylated granulocyte colony stimulating factor (GCSF) in New Onset Type 1 Diabetes."

Pediatric Endocrine Society Rising Star Award Jan. 2019-March 2021

Role: Mentored PI

Title: "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes."

This project aims to elucidate the relationship between AUC C-peptide, markers of immune function, and serum markers of exocrine pancreatic function in subjects enrolled in the clinical trial: "Antithymocyte Globulin (ATG) and pegylated granulocyte colony stimulating factor (GCSF) in New Onset Type 1 Diabetes."

University of Florida Clinical and Translational Research Institute

Pilot Award

July 2019-June 2021

Role: Mentored PI

Title: "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes."

This project aims to elucidate the relationship between AUC C-peptide, markers of immune function, and serum markers of exocrine pancreatic function in subjects enrolled in the clinical trial: "Antithymocyte Globulin (ATG) and pegylated granulocyte colony stimulating factor (GCSF) in New Onset Type 1 Diabetes."

Douglas J. Barrett, MD Academic Fellowship Award June 2020-June 2021

Role: PI

Title: "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes."

Awarded to one fellow per year for highest qualities of scholarly activity in research, teaching, and patient care. Funds one year of pediatric endocrinology fellowship.

Endocrine Fellows Foundation Research Grant Jan. 2019-Dec. 2021

Role: Mentored PI

Title: "Mechanisms of Exocrine Dysfunction in Type 1 Diabetes."

This project aims to elucidate the relationship between AUC C-peptide, markers of immune function, and serum markers of exocrine pancreatic function in subjects enrolled in the clinical trial: "Antithymocyte Globulin (ATG) and pegylated granulocyte colony stimulating factor (GCSF) in New Onset Type 1 Diabetes."

Exhibit B

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE et al.,

Plaintiffs,

Civil No. 4:23-cv-00114-RH-MAF

v.

JOSEPH A. LADAPO et al.,

Defendants.

**EXPERT REPORT OF DAN H. KARASIC, M.D.
ON BEHALF OF PLAINTIFFS**

August 16, 2023

Prepared by
Dan H. Karasic, M.D.

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PL000684

TABLE OF CONTENTS

	Page
I. INTRODUCTION AND SUMMARY OF OPINIONS	1
A. Qualifications.....	1
B. Compensation	5
C. Previous Testimony.....	5
D. Bases for Opinions.....	6
II. EXPERT OPINIONS	7
A. The Boards’ Informed Consent Forms Undermine Informed Consent Because They Are Riddled with False and Misleading Statements.	7
B. The Boards’ Informed Consent Forms Impose Arbitrary and Unnecessary Mental Health Requirements That Contradict the Standards of Care and Have No Medical Basis.....	13
C. Additional Requirements Imposed by the Law Are Harmful, Unnecessary, and Have No Medical Basis.....	18
III. CONCLUSION.....	19

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I. INTRODUCTION AND SUMMARY OF OPINIONS

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

2. In summary, Florida's informed consent requirements conflict with well-established medical research on treatment of transgender people with gender dysphoria. Decades of medical research and clinical experience demonstrate that the medical treatments Florida seeks to limit are safe, effective, and medically necessary to relieve gender dysphoria for transgender people. This research is recognized by major medical and mental health professional associations in the United States. Placing substantial obstacles to accessing gender-affirming medical care for transgender people for whom it is medically necessary puts their health and wellbeing at risk, including causing a heightened risk of depression and suicidality.

A. *Qualifications*

3. 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**.

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4. I am a Professor Emeritus of Psychiatry at the University of California – San Francisco (UCSF) Weill Institute for Neurosciences. I have been on faculty at UCSF since 1991. I have also had a telepsychiatry private practice since 2020.

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 (UCLA) 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 30 years, I have worked with patients with gender dysphoria.

7. I am a Distinguished Life Fellow of the American Psychiatric Association and 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.

8. Over the past 30 years, I have provided care for thousands of transgender patients. For 17 years, I was the psychiatrist for the Dimensions Clinic, for transgender youth ages 12–25 years old, in San Francisco.

9. I previously sat on the Board of Directors of the World Professional Association for Transgender Health (WPATH) and am lead author of the Mental Health chapter of WPATH's *Standards of Care for the Health of Gender Diverse*

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and Transgender People Version 8 (WPATH SOC 8), which are the internationally accepted guidelines designed to promote the health and welfare of transgender, transsexual, and gender variant persons. I was also a co-author of WPATH SOC 7.

10. As a member of the WPATH Global Education Initiative, I helped develop a specialty certification program in transgender health and helped train over 2,000 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.

11. I have worked with the San Francisco Department of Public Health, having helped develop and implement their 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.

12. I have held numerous clinical positions concurrent to my clinical professorship at UCSF. Among these, I served as an attending psychiatrist for San

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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 the Dimensions Clinic at Castro Mission Health Center, and as the co-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 the California Department of Corrections and Rehabilitation.

13. As part of my psychiatric practice treating individuals diagnosed with gender dysphoria and who receive medical and surgical treatment for that condition, as well as a co-author of the WPATH Standards of Care and UCSF's *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*, I am and must be familiar with additional aspects of medical care for the diagnosis of gender dysphoria, beyond mental health treatment, assessment, and diagnosis.

14. 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

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Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation.

15. Since 2018, I have performed over 100 independent medical reviews for the State of California to determine the medical necessity of transgender care in appeals of denial of insurance coverage.

B. Compensation

16. 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.

C. Previous Testimony

17. Over the past four years, I have given expert testimony at trial or by deposition in the following cases: *C.P. v. Blue Cross Blue Shield of Illinois*, No. 3:20-cv-06145-RJB (W.D. Wash.); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C.); *Fain v. Crouch*, 3:20-cv-00740 (S.D.W. Va.); *Brandt v. Rutledge*, No. 4:21-cv-00450 (E.D. Ark.); *K.C. et al. vs Individual Members of the Indiana Licensing Board, et al.*, and *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-00325-RH-MAF. 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.

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D. *Bases for Opinions*

18. 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, as documented in my curriculum vitae, which is attached hereto as **Exhibit A**.

19. I have also reviewed the materials cited in the text of this report and/or listed in the bibliography attached hereto as **Exhibit B**. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as supportive examples in particular sections of this report.

20. Additionally, I reviewed the text of Florida Senate Bill 254, and the text of the emergency rules adopted by the Florida Boards of Medicine and Osteopathic Medicine entitled “Sex-reassignment Standards of Practice in Minors” (64B8ER23-7, 64B15ER23-9) and “Mandatory Standardized Informed Consent for Sex-reassignment Prescriptions or Procedures in Adults” (64B15ER23-10), along with the informed consent forms that the rules incorporate by reference.

21. 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

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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.

22. 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. I may also further supplement these opinions in response to information produced by Defendants in discovery and in response to additional information from Defendants' designated experts.

II. EXPERT OPINIONS

A. The Boards' Informed Consent Forms Undermine Informed Consent Because They Are Riddled with False and Misleading Statements.

23. I understand that while Florida Senate Bill 254 prohibits minors from being prescribed puberty blockers or hormone therapy after May 17, 2023, minors who had begun treatment before that date may continue to receive these medications but only if they comply with the required consent forms and other requirements imposed by the Florida medical boards. I understand that transgender adults may also receive medical treatments for gender dysphoria if they comply with the required consent forms and other requirements imposed by the Florida medical boards. I have reviewed the informed consent forms adopted by the boards for

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continuing treatment of minors and treatment of adults. In my opinion, those forms include many false and misleading statements, as well as imposing unnecessary requirements that have no medical justification, conflict with standard care, and serve only to cause harm by deterring individuals from obtaining needed medical care.

24. The “informed consent” forms required by SB 254 for feminizing hormones, masculinizing hormones, and sex-reassignments surgeries are riddled with false and misleading statements. All three forms state the following: “Medical treatment of people with gender dysphoria is based on very limited, poor-quality research with only subtle improvements seen in some patient’s psychological functioning in some, but not all, research studies. This practice is purely speculative, and the possible psychological benefits may not outweigh the substantial risks of medical treatments and, in many cases, the need for lifelong medical treatments.”

25. The forms undermine informed consent because these statements are false. Substantial research has confirmed that transgender patients derive significant benefit from hormone therapy and surgeries.

26. Gender-affirming medical and surgical interventions in accordance with the WPATH SOC 7 and Endocrine Society Guidelines are widely recognized in the medical community as safe, effective, and medically necessary for many transgender people with gender dysphoria. (*See American Academy of Pediatrics,*

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2018; the American Medical Association, 2021; the Endocrine Society, 2020, the Pediatric Endocrine Society, 2021; the American Psychiatric Association, 2018; the American Psychological Association, 2021; the American Congress of Obstetricians and Gynecologists, 2021; the American Academy of Family Physicians, 2020; WPATH, 2012).

27. There is substantial evidence that gender-affirming medical and surgical care is effective in treating gender dysphoria. This evidence includes scientific studies assessing mental health outcomes for transgender people who are treated with these interventions, including adolescents, and decades of clinical experience.

28. The research and studies supporting the necessity, safety, and effectiveness of medical and surgical care for gender dysphoria are the same type of evidence-based data that the medical community routinely relies upon when treating other medical disorders.

29. Medical treatment for gender dysphoria has been studied for over half a century, and there is substantial evidence that it improves quality of life and measures of mental health in both youth and adults. (Chen, et al, 2023; Tordoff, et al., 2022; Green, et al., 2022, Allen, et al., 2019; de Vries, et al, 2014; Turban, et al, 2020; Almazan, et al., 2021; Baker et al., 2021; Murad, et al., 2010; Nobili et al.,

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2018; Pfafflin & Junge, 1998; T’Sjoen et al., 2019; van de Grift et al., 2018; White Hughto and Reisner, 2016; Wierckx et al., 2014).

30. A systematic review of 20 studies showed improved quality of life, decreased depression, and decreased anxiety with hormonal treatment in transgender people. (Baker, et al., 2021). Another systematic review showed improvement in mental health and quality of life measures in transgender people with hormonal treatment (White Hughto and Reisner, 2016).

31. In a secondary analysis of data from the U.S. Transgender Survey, having had genital surgery was associated with decreased psychological distress and suicidal ideation. (Almazan, et al., 2021). In transgender patients followed 4–6 years after surgery, satisfaction was very high (over 90%) and regret was low. (van de Grift et al., 2018). The Cornell “What We Know” systematic review of 55 studies from 1991-2017 strongly supported that gender-affirming hormone and surgical treatment improved the wellbeing of transgender individuals. (What We Know, 2018). Regret rates after surgery in the largest systematic review (Bustos, et al, 2021) were 1%. A recent cross-sectional study (Bruce, et al, 2023) of transgender patients who underwent gender-affirming mastectomies found very low levels of decisional regret and very high levels of satisfaction 2.0 to 23.6 years after surgery.

32. The studies on gender-affirming medical care for treatment of dysphoria are consistent with decades of clinical experience of mental health

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providers across the U.S. and around the world. At professional conferences and other settings in which I interact with colleagues, clinicians report that gender affirming medical care, for those for whom it is indicated, provides great clinical benefit. In my over 30 years of clinical experience treating gender dysphoric patients, I have seen the benefits of gender-affirming medical care on my patients' health and well-being. I have seen many patients show improvements in mental health, as well as in performance in school, in social functioning with peers, and in family relationships when they experience relief from gender dysphoria with gender affirming medical care.

33. The consent forms for hormone therapy state that “psychological therapy with a mental health provider” is an “option” for patients who do not wish to start or continue hormone therapy. This statement is false insofar as it suggests that psychological therapy is an effective alternative treatment for transgender people for whom hormone therapy is medically indicated. While psychological therapy can be beneficial for many people, including transgender people, there is no evidence that psychological therapy can alleviate gender dysphoria in those for whom gender affirming medical care is indicated. This is true for both adults and minors.

34. The consent forms for hormone therapy also state: “Treatment with femininizing [or masculinizing] medications will not prevent serious psychiatric

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events, including suicide.” This statement is false insofar as it suggests that hormone therapy does not or is not likely to have a positive impact on a transgender patient’s mental health, including the reduction of suicidality. In fact, as described above, substantial research shows that hormone therapy likely improves gender dysphoria, psychological function, comorbidities (e.g., depression, anxiety, and suicidality), and overall quality of life. While no treatment can provide an absolute guarantee against “psychiatric events, including suicide,” it is false to suggest that hormone therapy is ineffective in improving psychological health, including reducing suicidality.

35. In addition to conveying false and misleading information, the consent forms also undermine informed consent by forcing providers to give patients information about medications that the patient is not being prescribed. To be effective, consent must be specific to what is being prescribed. For example, if a patient is being prescribe a specific drug to treat cardiovascular disease or depression, the provider does not give them a list of all cardiovascular medications or all medications used to treat depression, which would defeat the purpose of informed consent. Providing such a laundry list would be confusing and stifles the critical back and forth that is integral to securing informed consent, which requires a provider to engage in discussion with the patient about the specific drug. The laundry list approach mandated by these forms contradicts medical practice and

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impedes providers from fulfilling their professional responsibilities. It is not only ineffective, but harmful—because it makes it far less likely that the provider is transmitting the information the patient needs. Most people do not absorb everything that is stated on informed consent forms upon initial reading; that is why it is important to focus on what is prescribed and allow for further discussion between patient and provider about the specific drug.

B. The Boards’ Informed Consent Forms Impose Arbitrary and Unnecessary Mental Health Requirements That Contradict the Standards of Care and Have No Medical Basis.

36. The consent forms for puberty blockers and hormone therapy require transgender patients to undergo a psychological and social evaluation by a Florida licensed board-certified psychiatrist or a Florida licensed psychologist before beginning or continuing puberty blockers or hormone therapy and “every two years thereafter.” There is no medical basis for these requirements. The WPATH Standards of Care states that a wide range of health care professionals are qualified to evaluate a transgender adolescent or adult transgender patient for puberty blockers or hormone replacement therapy (HRT).

37. WPATH Standards of Care Version 8 explains that health care professionals working with transgender adolescents should have appropriate licensing and qualifications in a relevant clinical field and have relevant training and expertise in gender identity. They also encourage care to be provided by a

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multidisciplinary team. However, they do not limit mental health assessment or care to psychiatrists or psychologists only, which serves no medical purpose and causes harm by creating an arbitrary barrier to care. The WPATH standards stress that “lack of available disciplines should not preclude a young person from accessing needed care in a timely manner.”

38. Similarly, WPATH Standards of Care Version 8 states that health professionals providing the initial assessment for adults should be knowledgeable in performing this assessment, and adults can be assessed either by the provider providing the gender affirming medical care, or by another knowledgeable health professional, including mental health professionals. Primary care providers have safely assessed adult patients for hormones and prescribed hormones for over 30 years (Deutsch, 2012). Many primary care providers are nurse practitioners or physician assistants, and many mental health providers are licensed clinical social workers or other licensed therapists. These care providers are allowed to work with non-transgender patients, and for many patients are the only available care providers. Restricting care provision to psychiatrists and psychologists is without an evidence base and appears to serve no purpose other than to limit access to care.

39. In addition, there is no evidence base for a requirement that a transgender patient, undergo an additional evaluation or re-evaluation by a psychiatrist or psychologist “every two years.” The health provider prescribing the

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medications sees their patient regularly and can refer them to a mental health provider if necessary. Primary care providers treat 60% of cases of depression in the US and provide 79% of antidepressants prescribed. (Barkil-Oteo, 2013). With these patients, primary care providers are screening for suicidality and referring to mental health professionals when appropriate. To require a psychiatrist or psychologist to do this periodic screening has no medical justification and serves only to limit care.

40. The forms include additional stipulations in order to receive care, stating, “The following may also be recommended by your prescribing physician.” While physicians may exercise their best judgment on recommendations made to patients to receive any care, the presence of this additional list suggests to physicians and patients that this list reflects restrictions that might routinely be imposed on patients, when in fact they diverge from practice guidelines and usual care.

41. One of these additional stipulations is that transgender patients undergo ongoing psychotherapy throughout the course of hormonal treatment in order for the treatment to be maintained. Not all people benefit from psychotherapy, and cost and access issues will effectively bar the ability to obtain care for many transgender people. WPATH Standards of Care Version 8 states that psychotherapy should not be a requirement in order to receive care (Coleman, et al., 2022). There is no reason

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to require transgender people to undergo repeated mental health evaluations or lifelong psychotherapy in order to maintain medical care.

Similarly, there is no medical justification for requiring a transgender adolescent receiving puberty blockers or hormone therapy to receive a “suicide risk assessment by a licensed mental health professional” every three months or to have “[c]ontinued counseling with a licensed mental health care professional during the treatment period.” Many adolescents, both transgender and non-transgender, experience suicidality, but there is no evidence that being treated with puberty blockers or hormone therapy puts youth at increased risk of suicidality (as noted above, the opposite is true) or requires this type of special ongoing mental health assessment without regard to the individual circumstances of a particular patient. WPATH Standards of Care Version 8 encourages health care providers to maintain an ongoing relationship that “provides space for adolescents and caregivers to share important psychosocial aspects of emotional well-being” but do not require ongoing psychotherapy in all cases. The WPATH Standards of Care Version 8 also notes that “many transgender adolescents are well-functioning and experience few if any mental health concerns.” Requiring all transgender adolescents receiving medical care to undergo continuing, ongoing psychotherapy has no medical basis and would serve only as an arbitrary impediment to needed care.

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42. The consent forms for hormone therapy state: “HRT, the use of androgen blockers and antiandrogens, and the treatment process can affect your mood. Therefore, you must be under the care of a licensed mental health care professional while undergoing treatment.” This requirement contradicts the Standards of Care and has no medical basis. There is no need for every transgender person using hormone therapy to be under the care of a licensed mental health professional.

43. This requirement also singles out transgender patients for no legitimate reason. The same medications prescribed for gender-affirming care are commonly prescribed for other purposes to non-transgender patients, with no requirement for being under the care of a mental health professional. For example, men with prostate cancer are often prescribed anti-androgens and many post-menopausal women receive hormone replacement therapy, yet neither are required to see a licensed mental health professional.

44. Many other medications (such as beta blockers or birth control pills) can also affect mood, but none are subject to a similar requirement that an adult patient be under the care of a licensed mental health professional for that reason. Prescribed opioids led to over 16,000 overdose deaths in 2021 (National Institute on Drug Overdose), but have no requirement for mental health monitoring.

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45. The consent forms for hormone therapy also falsely state that because the Food and Drug Administration (FDA) has not specifically approved HRT for treating gender dysphoria, this means that these medications are “not being used for their intended purposes.” That statement is grossly misleading, as the off-label use of FDA-approved medications is extremely common and in no way medically inappropriate. This statement (like many others in these forms) seems designed to engender irrational fear and deter transgender patients from seeking medical care, rather than convey useful or accurate information.

C. Additional Requirements Imposed by the Law Are Harmful, Unnecessary, and Have No Medical Basis.

46. SB 254 also prohibits advanced practice registered nurses (APRNs) from prescribing and administering hormone therapy for transgender patients. There is no medical reason for this restriction for youth or adults, which will only harm transgender patients by artificially curtailing the pool of available providers. This requirement does not protect the health, safety, or well-being of transgender people.

47. SB 254 also requires physicians to be physically present while obtaining a transgender patient’s informed consent. There is no medical justification for this restriction for youth or adults. Obtaining informed consent involves a conversation with patients, not a physical exam. This requirement is irrational and arbitrary and seems designed only to deter transgender patients from obtaining care.

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III. CONCLUSION

48. Florida's informed consent requirements are contrary to widely accepted medical protocols for the treatment of transgender people with gender dysphoria that are recognized by major medical and mental health professional associations in the United States.

49. Decades of medical research and clinical experience have demonstrated that the medical treatments Florida seeks to limit are safe, effective, and medically necessary to relieve gender dysphoria for transgender people. Any conclusion otherwise is not supported by medical evidence or consensus.

50. Placing substantial burdens on access to gender-affirming medical care to transgender people for whom it is medically indicated puts them at risk of significant harm to their health and wellbeing, including heightened risk of depression and suicidality.

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

Executed this 16th day of August 2023.



Dan H. Karasic, M.D.

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EXHIBIT A
Curriculum Vitae

University of California, San Francisco**CURRICULUM VITAE****Name:** Dan H. Karasic, MD**Position:** Professor Emeritus
Psychiatry
School of Medicine

Voice: 415-935-1511

Fax: 888-232-9336

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; American Heart Association, California Affiliate	Summer Student Research Fellow	UCLA Medicine
1986 - 1987	Yale University School of Medicine; American Heart Association,	Medical Student Research Fellow	Psychiatry

1990 - 1991	Connecticut Affiliate University of California, Los Angeles	Postdoctoral Sociology Fellow	
1991 - 2001	SFGH Consultation-Liaison Service; AIDS Care	Attending Psychiatry	Psychiatrist
1991 - 2001	AIDS Consultation-Liaison Medical Student Elective	Course Director	Psychiatry
1991 - present	UCSF Positive Health Program at San Francisco General Hospital (Ward 86)	HIV/AIDS Outpatient Psychiatrist	Psychiatry
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 Clinical Director Psychiatry and Study (The H.O.M.E. study: Health Outcomes of Mood Enhancement)		Medicine
2003 - 2020	Transgender Life Care Program and Dimensions Clinic, Castro Mission Health	Psychiatrist Clinic Center	Dimensions
2013 - 2020	UCSF Alliance Health Project, Co-lead, Team	Co-Lead and Psychiatry Transgender Psychiatrist	

HONORS AND AWARDS

1981	Phi Beta Kappa Honor Society	Phi Beta Kappa

1990	NIMH Postdoctoral Fellowship in Mental Health Services for People with AIDS (1990-1991)	National Institute of Mental Health
2001	Lesbian Gay Bisexual Transgender Psychiatry Leadership Award, LGBT Task Force of the Cultural Competence and Diversity Program	SFGH Department of
2006	Distinguished Fellow	American Psychiatric
Association 2012		Chancellor's Award for
Leadership in		UCSF
	LGBT Health	
2023	Alumni Seal Award for Professional Achievement	Occidental College

MEMBERSHIPS

1992 - present Northern California Psychiatric
Society 1992 - present American Psychiatric
Association

2000 - 2019 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 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 Chair Lesbian Psychiatrists	
1994 - 1995	Educational Program, Association of Gay and Lesbian Psychiatrists, 1995 Annual Meeting	Director

1994 - 1998 Board of Directors, BAY Positives

Member 1994 - 2020 Committee on Lesbian, Gay, Bisexual
and Transgender Member
Issues, Northern California Psychiatric Society

1995 - 1997 Board of Directors, Bay Area Young Positives. BAY President

Positives is the nation's first community-based organization providing psychosocial and recreational services to HIV-positive youth

- 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, Member
Lesbian, Gay Bisexual Transgender Advisory Committee
- 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 Chair
American Psychiatric Association
- 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 -2022 World Professional Association for Transgender Care
Member
- Standards of Care Workgroup and Committee (writing
seventh and eighth revisions of the WPATH Standards of
Care, which is used internationally for transgender care.)
- 2010 - 2018 ICD 11 Advisory Committee, World Professional Association for Transgender Health Member
- 2012 - 2014 Psychiatry and Diagnosis Track Co-chair, Scientific Committee, 2014 WPATH Biennial Symposium, Bangkok Member
- 2014 - 2016 Scientific Committee, 2016 WPATH Biennial Symposium, Member
- Amsterdam 2014 - 2018 Board of Directors
- (elected to 4 year term), World Member
- Professional Association for Transgender Health

2014 - 2018	Public Policy Committee, World Professional Association for Transgender Health
2014 - 2018	WPATH Global Education Initiative: Training providers and specialty certification in transgender health Trainer Steering Committee Member

2014 - 2016 American Psychiatric Association Workgroup on Gender Dysphoria
Member
2016 - present American Psychiatric Association Workgroup on Gender Dysphoria
Chair

2016	USPATH: Inaugural WPATH U.S. Conference, Los Angeles, 2017	Conference

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), Cuba	Invited Speaker Havana,
2013	Swedish Gender Clinics Annual Meeting, Stockholm, Sweden	Keynote Speaker
2013	Conference on International Issues in Transgender care, Expert Consultant United Nations Development Programme - The Lancet, Beijing, China	
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, Tel Aviv	Invited Speaker
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,	Invited Speaker

Amsterdam
201
7 Brazil
Professional
Association for
Transgender Health,
Sao Paulo

2017 Vietnam- United Nations Development Programme
Asia Transgender Health Conference, Hanoi

2018 United Nations Development Programme Asia
Conference on Transgender Health and Human Rights,
Bangkok

2018 World Professional Association for Transgender Health, Invited Speaker
Buenos Aires

2021 Manitoba Psychiatric Association, Keynote Speaker

2022 World Professional Association for Public Health, invited speaker, Montreal

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,
Symposium San Diego Speaker

1994 American Psychiatric Association 150th Annual Meeting, Workshop
Chair Philadelphia

1994 American Psychiatric Association 150th Annual Meeting, Workshop
Speaker Philadelphia

1994 American Psychiatric Association 150th Annual Meeting, Paper
Session Co- Philadelphia chair

1995 Spring Meeting of the Association of Gay and Lesbian Symposium
Chair Psychiatrists, Miami Beach

1996 American Psychiatric Association 152nd Annual Meeting, Workshop
Speaker New York

1997	American Psychiatric Association Annual Meeting, San Workshop Speaker Diego	
1997	Gay and Lesbian Medical Association Annual Invited Speaker Symposium	
1998	American Psychiatric Association Annual Meeting, Workshop Chair Toronto	
1998	American Psychiatric Association Annual Meeting, Workshop Chair Toronto	
1998	American Psychiatric Association Annual Meeting, Media Session Toronto Chair	
1998	American Psychiatric Association Annual Meeting, Media Session Toronto Chair	
1999	American Psychiatric Association Annual Symposium Chair Meeting, Washington, D.C.	
1999	American Psychiatric Association Annual Symposium Meeting, Washington, D.C.	
1999	American Psychiatric Association Annual Workshop Chair Meeting, Washington, D.C.	
2000	American Psychiatric Association Annual Workshop Chair Meeting, Chicago	
2000	National Youth Leadership Forum On Medicine, Invited Speaker University of California, Berkeley	
2001	American Psychiatric Association Annual Meeting, New Workshop Chair Orleans	
2001	American Psychiatric Association Annual Meeting, New Media Program Orleans Chair	
2001	Association of Gay and Lesbian Psychiatrists Chair Symposium, New Orleans	
2001	Harry Benjamin International Gender Dysphoria Invited Speaker Association Biennial Meeting, Galveston, Texas	
2002	American Psychiatric Association Annual Meeting, Media Program Philadelphia Chair	
2002	American Psychiatric Association Annual Meeting, Workshop Chair Philadelphia	
2002	American Psychiatric Association Annual Meeting, Workshop Chair Philadelphia	

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, Speaker Toronto	Workshop
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 Faculty Global Education Initiative, Fort Lauderdale, FL	Course
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
2019	American Society for Adolescent Psychiatry Annual Meeting, San Francisco, Speaker
2019	American Psychiatric Association Annual Meeting, San Francisco, Session Chair
2020	Psychiatric Congress, Invited Speaker
2022	World Professional Association for Transgender Health, Montreal, invited speaker
2023	National Transgender Health Summit, San Francisco, invited speaker
2023	American Psychiatric Association Annual Meeting, San Francisco, invite d speaker

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 Symposiu m 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	Invited Speaker
1996	UCSF AIDS Health Project Psychotherapy Internship Training Program	
1996	UCSF/SFGH Department of Medicine AIDS Quarterly Update	Invited Speaker
1996	San Francisco General Hospital, Division of Addiction Medicine	Invited Speaker
1996	UCSF Langley Porter Psychiatric Hospital and Clinics Rounds	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	Invited Speaker Grand Rounds
1997	San Francisco General Hospital Department of Psychiatry	Invited Speaker Grand Rounds
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	Invited Speaker Grand Rounds
1999	Northern California Psychiatric Society Annual Meeting,	Invited Speaker Santa Rosa
1999	Northern California Psychiatric Society Annual Meeting,	Invited Speaker Santa Rosa
1999	University of California, Davis, Department of Psychiatry	Invited Speaker Grand Rounds
1999	California Pacific Medical Center Department of Psychiatry Grand Rounds	Invited Speaker
1999	San Francisco General Hospital Department of Psychiatry	Discussant Departmental Case Conference
2000	Langley Porter Psychiatric Hospital and Clinics	Invited Speaker Consultation Liaison Seminar

2000	San Francisco General Hospital, Psychopharmacology Speaker Seminar	Invited
2000	UCSF Transgender Health Conference, Laurel Heights Speaker Conference Center	Invited
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 Speaker Grand Rounds	Invited
2001	Psychiatry Course for UCSF Second Year Medical Lecturer Students	Invited
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 HIV Prevention and Care, San Francisco	Invited Speaker
2005	San Francisco General Hospital Department of Psychiatry Speaker Grand Rounds.	Invited
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 Symposium, San Francisco LGBT Community Center	Invited Speaker
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 Speaker	Invited
2008	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker

2010	Northern California Psychiatric Society Annual Meeting, Invited Speaker Monterey, CA
2011	Transgender Mental Health Care Across the Life Span, Invited Speaker Stanford University
2011	San Francisco General Hospital Department of Psychiatry Invited Speaker Grand Rounds
2012	UCSF AIDS Health Project Invited Speaker 2012 San Francisco Veterans Affairs Medical Center.

		Invited Speaker
2013	Association of Family and Conciliation Courts Conference, Invited	
Speaker Los	Angeles, CA	
2014	UCSF Transgender Health elective	Invited Speaker
2014	UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2014	California Pacific Medical Center Department of Psychaitry Grand Rounds	Invited Speaker
2014	UCLA Semel Institute Department of Psychiatry Grand Rounds	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
	series	
) 2016	Zuckerberg San Francisco General Department of Psychiatry Grand Rounds	Invited Speaker
2016	UCSF Mini-Medical School Lectures to the Public	Invited Speaker
2021	Los Angeles County Department of Mental Health,	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

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 has an 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 have been 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 of 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 2000 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 – 2003 HIV/AIDS Task Force Member

1992 - 1993 HIV Research Group Member

1992 - 1997	Space Committee	Member

1992 - 2003	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 Member
Transgender Health

2010 - 2013 Steering Committee, Child Adolescent Gender Center

Membe

r 2011 – 2017 Mental Health Track, National Transgender Health Summit

Chair

DEPARTMENTAL SERVICE

- 1991 - 2003 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 - 2020 San Francisco Department of Public Health Gender Member Competence Trainings Committee
- 2013 - 2020 San Francisco Department of Public Health Transgender Member Health Implementation Task Force
- 2014 - 2020 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

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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>

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Rehabilitation 2021 Expert, Kadel v. Folwell, 1:19-cv-00272

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2021 Expert, Drew Glass v. City of Forest Park - Case No. 1:20-cv-914
(Southern District Ohio)

2021-2022 Expert, Brandt et al v. Rutledge et al. 4:21-cv-00450 (E.D. Ark.)

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE et al.,

Plaintiffs,

Civil No. 4:23-cv-00114-RH-MAF

v.

JOSEPH A. LADAPO et al.,

Defendants.

**EXPERT REPORT OF DANIEL SHUMER, M.D.
ON BEHALF OF PLAINTIFFS**

August 16, 2023

Prepared by
Daniel Shumer, M.D.

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PL000736

TABLE OF CONTENTS

	<u>Page</u>
I. INTRODUCTION AND SUMMARY OF OPINIONS	1
A. Qualifications.....	2
B. Prior Testimony.....	6
C. Compensation	7
D. Bases for Opinions.....	7
II. EXPERT OPINIONS	9
A. Medical and Scientific Background On Sex and Gender Identity.....	9
B. Rationale for Medical Treatment of Gender Dysphoria in Adolescents	12
C. Assessment of Gender Dysphoria in Children and Adolescents.....	13
D. Evidence-Based Clinical Practice Guidelines for the Treatment of Gender Dysphoria in Children, Adolescents, and Adults	15
E. Treatment Protocols for Gender Dysphoria in Children, Adolescents, and Adults	20
F. Safety and Efficacy of Puberty-Delaying Medications and Hormone Therapy to Treat Gender Dysphoria	27
G. Harms Associated with Prohibiting and Discontinuing Treatment	32
H. The Boards’ Informed Consent Documents Are Medically Inaccurate, Impose Medically Unwarranted and Harmful Requirements, and Undermine Rather Than Facilitate Informed Consent.....	33
I. The “Puberty Suppression Treatment” Form.....	35
J. The “Masculinizing Medications” Forms	40

CONFIDENTIAL

K.	The “Feminizing Medications” Forms	47
L.	Other Restrictions Imposed By SB 254 Have No Medical Basis and Will Serve Only to Deter Transgender Patients from Obtaining Needed Medical Care	49
III.	CONCLUSION.....	50

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I. INTRODUCTION AND SUMMARY OF OPINIONS

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

2. In summary, prohibiting adolescent children from receiving transition-related health care is contrary to evidence-based best practices and standards of care for the treatment of gender dysphoria. Gender dysphoria is treatable through individualized assessment and care, which may include social transition, psychotherapy, pubertal suppression, and hormonal therapy. These treatments are supported by all major medical bodies in the field of transgender medicine and pediatrics. Banning care and access to effective treatment for gender dysphoria will not eliminate transgender youth. Rather, it will lead to an increase in mental health problems and suicidality in transgender youth and needlessly stigmatize this already vulnerable population.

3. Moreover, the informed consent forms required by the State Boards of Medicine and Osteopathic Medicine state misinformation about care provided to transgender persons, including for adults and adolescents, establish requirements for ongoing treatment of such persons that have no legitimate medical justification,

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undermine rather than advance informed consent, and create unwarranted and harmful barriers to essential medical care.

A. *Qualifications*

4. I am a Pediatric Endocrinologist, Associate Professor of Pediatrics, and the Clinical Director of the Child and Adolescent Gender Clinic at Mott Children's Hospital at Michigan Medicine. I am also the Medical Director of the Comprehensive Gender Services Program at Michigan Medicine, University of Michigan.

5. I am Board Certified in Pediatrics and Pediatric Endocrinology by the American Board of Pediatrics and licensed to practice medicine in the state of Michigan.

6. I received my medical degree from Northwestern University in 2008. After completing a Residency in Pediatrics at Vermont Children's Hospital, I began a Fellowship in Pediatric Endocrinology at Harvard University's Boston Children's Hospital. As a Fellow at Harvard, I trained at the Gender Management Services Clinic (GeMS) at Boston Children's Hospital where I became a clinical expert in the field of transgender medicine within Pediatric Endocrinology and began conducting research on gender identity, gender dysphoria, and the evaluation and management of gender dysphoria in children, adolescents, and young adults. Concurrent with the

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Fellowship, I completed a Master of Public Health from Harvard's T.H. Chan School of Public Health. I completed both the Fellowship and the MPH degree in 2015.

7. I have extensive experience in working with and treating children, adolescents, and young adults with endocrine conditions including differences in sex development (DSD) (also referred to as intersex conditions), gender dysphoria, type 1 diabetes, thyroid disorders, growth problems, and delayed or precocious puberty. I have been treating patients with gender dysphoria since 2015.

8. A major focus of my clinical, teaching, and research work pertains to the assessment and management of transgender adolescents and young adults.

9. I have published extensively on the topic of gender identity in pediatrics and the treatment of gender dysphoria, as well as reviewed the peer-reviewed literature concerning medical treatments for gender dysphoria, the current standards of care for the treatment of gender dysphoria, and research articles on a variety of topics with a focus on mental health in transgender adolescents and young adults.

10. I am involved in the education of medical trainees. I am the Fellowship Director in the Division of Pediatric Endocrinology, Education Lead for the Division of Pediatric Endocrinology, and Course Director for a medical student elective in Transgender Medicine. My additional academic duties as an Associate Professor include teaching several lectures, including those entitled "Puberty," "Transgender Medicine," and "Pediatric Growth and Development."

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11. As a Fellow at Harvard, I was mentored by Dr. Norman Spack. Dr. Spack established the Gender Management Services Clinic (GeMS) at Boston Children's Hospital. While working and training at GeMS, I became a clinical expert in the field of transgender medicine within Pediatric Endocrinology and began conducting research on gender identity, gender dysphoria, and the evaluation and management of gender dysphoria in children and adolescents.

12. Based on my work at GeMS, I was recruited to establish a similar program assessing and treating gender diverse and transgender children and adolescents at the C.S. Mott Children's Hospital in Ann Arbor. In October 2015, I founded the hospital's Child and Adolescent Gender Services Clinic.

13. The Child and Adolescent Gender Services Clinic has treated over 600 patients since its founding. The clinic provides comprehensive assessment, and when appropriate, treatment with pubertal suppression and hormonal therapies, to patients diagnosed with gender dysphoria. I have personally evaluated and treated over 400 patients with gender dysphoria. The majority of the patients receiving care range between 10 and 24 years old. Most patients attending clinic live in Michigan or Ohio. As the Clinical Director, I oversee the clinical practice, which currently includes 4 physicians (including 1 psychiatrist), 1 nurse practitioner, 2 social workers, 1 research coordinator, as well as nursing and administrative staff. I also

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actively conduct research related to transgender medicine, gender dysphoria treatment, and mental health concerns specific to transgender youth.

14. I also provide care in the Differences/Disorders of Sex Development (DSD) Clinic at Michigan Medicine at Mott Children's Hospital. The DSD Clinic is a multidisciplinary clinic focused on providing care to infants and children with differences in the typical path of sex development, which may be influenced by the arrangement of sex chromosomes, the functioning of our gonads (i.e. testes, ovaries), and our bodies' response to hormones. The clinic is comprised of members from Pediatric Endocrinology, Genetics, Psychology, Urology, Gynecology, Surgery, and Social Work. In this clinic I have assessed and treated over 100 patients with DSD. In my role as Medical Director of the Comprehensive Gender Services Program (CGSP), I lead Michigan Medicine's broader efforts related to transgender services. CGSP is comprised of providers from across the health system including pediatric care, adult hormone provision, gynecologic services, adult surgical services, speech/language therapy, mental health services, and primary care. I run monthly meetings with representatives from these areas to help coordinate communication between Departments. I coordinate strategic planning aimed to improve care within the health system related to our transgender population. I also serve as the medical representative for CGSP in discussions with health system administrators and outside entities.

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15. I have authored numerous peer-reviewed articles related to treatment of transgender youth. I have also co-authored chapters of medical textbooks related to medical management of transgender patients. I have been invited to speak at numerous hospitals, clinics, and conferences on topics related to clinical care and standards for treating transgender children and youth.

16. The information provided regarding my professional background, experiences, publications, and presentations is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as **Exhibit A**.

B. *Prior Testimony*

17. In the past four years, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Loe v. Texas*, (District Court of Travis County, Texas); *Doe v. Norman*, (N.D. Georgia). *Dekker v. Weida*, No. 4:22- cv-00325 (N.D. Fla.); *K.C. v. The Individual Members of the Medical Licensing Board of Indiana*, No. 1:23-cv-00595 (S.D. Ind.);; *Roe et al v. Utah High School Activities Association et al* (Third District Court in and for Salt Lake County, UT); *Menefee v. City of Huntsville Bd. of Educ.*, No. 5:18- cv-01481 (N.D. Ala.); and *Cooper v. USA Powerlifting and Powerlifting Minnesota*, No. 62-CV-21-211 (Ramsey Cnty. Dist. Ct., Minn.). I also provided expert witness testimony on behalf of a parent in a custody dispute involving a transgender child in the following case: *In the Interest of Younger*, No. DF-15-09887 (Dallas County, Texas).

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C. *Compensation*

18. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of \$325 per hour for any review of records, preparation of reports, declarations, and deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

D. *Bases for Opinions*

19. In preparing this report, I reviewed the text of the Standards of Practice for the Treatment of Gender Dysphoria in Minors issued by the Florida Board of Medicine and Florida Board of Osteopathic Medicine in 2023. I reviewed the text of documents adopted by the Florida Board of Medicine titled, “Puberty Suppression Treatment for Patients with Gender Dysphoria: Patient Information and Parental Consent and Assent for Minors” (DH5079-MQA, Rev. 06/23), “Masculinizing Medications for Patients with Gender Dysphoria: Patient Information and Parental Consent and Assent for Minors” (DH5081-MQA, Rev. 06/23), “Feminizing Medications for Patients with Gender Dysphoria: Patient Information and Parental Consent and Assent for Minors” (DH5080-MQA, Rev. 06/23), “Masculinizing Medications for Patients with Gender Dysphoria: Patient Information and Informed Consent” (DH5082-MQA, Rev. 06/23), and “Feminizing Medications for Patients

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with Gender Dysphoria: Patient Information and Informed Consent” (DH5083-MQA, Rev. 06/23).

20. I have also reviewed the materials listed in the bibliography attached as **Exhibit B** to this report, as well as the materials listed within my curriculum vitae, which is attached as **Exhibit A**. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as supportive examples in particular sections of this report. I may rely on these materials as additional support for my opinions.

21. In addition, I have relied on my scientific education, training, and years of clinical and research experience, and my knowledge of the scientific literature in the pertinent fields.

22. 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 these subjects.

23. To the best of my knowledge, I have not met or spoken with the minor Plaintiffs or their parents, or the adult Plaintiffs. My opinions are based solely on my extensive background and experience treating transgender patients.

24. I may wish to supplement or revise these opinions or the bases for them due to new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

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II. EXPERT OPINIONS

A. *Medical and Scientific Background On Sex and Gender Identity*

25. *Sex* is comprised of several components, including, among others, internal reproductive organs, external genitalia, chromosomes, hormones, gender identity, and secondary sex characteristics (IOM, 2011).

26. *Gender identity* is the medical term for a person's internal, innate sense of belonging to a particular sex. Everyone has a gender identity. Diversity of gender identity and incongruence between assigned sex at birth and gender identity are naturally occurring sources of human biological diversity (IOM, 2011). The term *transgender* refers to individuals whose gender identity does not align with their sex assigned at birth (Shumer, et al., 2013).

27. The terms *gender role* and *gender identity* refer to different things. *Gender roles* are behaviors, attitudes, and personality traits that a particular society considers masculine or feminine, or associates with male or female social roles. For example, the convention that girls wear pink and have longer hair, or that boys wear blue and have shorter hair, are socially constructed gender roles from a particular culture and historical period. By contrast, *gender identity* does not refer to socially contingent behaviors, attitudes, or personality traits. It is an internal and largely biological phenomenon, as reviewed below. Living consistent with one's gender

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identity is critical to the health and well-being of any person, including transgender people (Hidalgo, et al., 2013; Shumer, et al., 2013; White Hughto, et al., 2015).

28. A person's understanding of their gender identity may evolve over time in the natural course of their life, however, attempts to "cure" transgender individuals by forcing their gender identity into alignment with their birth sex has been found to be both harmful and ineffective. In one study, transgender adults who recall previous attempts from healthcare professionals to alter their gender identity reported an increase in lifetime suicide attempts and higher rates of severe psychological distress in the present (Turban, et al., 2020a). In another study, exposure to these types of attempts were found to increase the likelihood that a transgender adolescent will attempt suicide by 55% and more than double the risk for running away from home (Campbell, et al., 2002). Those practices have been denounced as unethical by all major professional associations of medical and mental health professionals, such as the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association, among others (Fish, et al., 2022).

29. Scientific research and medical literature across disciplines demonstrates that gender identity, like other components of sex, has a strong biological foundation. For example, there are numerous studies detailing the similarities in the brain structures of transgender and non-transgender people with

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the same gender identity (Luders, et al., 2009; Rametti, et al., 2011; Berglund, et al., 2008). In one such study, the volume of the bed nucleus of the *stria terminalis* (a collection of cells in the central brain) in transgender women was equivalent to the volume found in non-transgender women (Chung, et al., 2002).

30. There are also studies highlighting the genetic components of gender identity. Twin studies are a helpful way to understand genetic influences on human diversity. Identical twins share the same DNA, while fraternal twins share roughly 50% of the same DNA, however both types of twins share the same environment. Therefore, studies comparing differences between identical and fraternal twin pairs can help isolate the genetic contribution of human characteristics. Twin studies have shown that if an identical twin is transgender, the other twin is much more likely to be transgender compared to fraternal twins, a finding which points to genetic underpinnings to gender identity development (Heylens, et al., 2012).

31. There is also ongoing research on how differences in fetal exposures to hormones may influence gender identity. This influence can be examined by studying a medical condition called congenital adrenal hyperplasia. Female fetuses affected by congenital adrenal hyperplasia produce much higher levels of testosterone compared to fetuses without the condition. While most females with congenital adrenal hyperplasia have a female gender identity in adulthood, the percentage of those with gender dysphoria is higher than that of the general

CONFIDENTIAL

population. This suggests that fetal hormone exposures contribute to the later development of gender identity (Dessens, et al, 2005).

32. There has also been research examining specific genetic differences that appear associated with gender identity formation (Rosenthal, 2014). For example, one study examining differences in the estrogen receptor gene among transgender women and non-transgender male controls found that the transgender individuals were more likely to have a genetic difference in this gene (Henningsson, et al., 2005).

33. The above studies are representative examples of scientific research demonstrating biological influences on gender identity. Gender identity, like other complex human characteristics, is rooted in biology with important contributions from neuroanatomic, genetic and hormonal variation (Roselli, 2018).

B. *Rationale for Medical Treatment of Gender Dysphoria in Adolescents*

34. All medical interventions, including treatment for gender dysphoria, require rigorous study and evidence base.

35. There are several studies demonstrating positive results of transition-related care in adolescents (de Vries, et al., 2014; de Vries, et al., 2011; Green, et al., 2022; Smith, et al., 2005; Turban, et al., 2022). These studies consistently demonstrate improvement of gender dysphoria with associated improvement of psychological functioning. A 2014 long-term follow-up study following patients

CONFIDENTIAL

from early adolescence through young adulthood showed that gender transition treatments allowed transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender with positive outcomes as young adults (de Vries, et al., 2014). More recently, Green et al. (2022) describe that hormone therapy is correlated with reduced rates of depression and suicidality among transgender adolescents. Turban et al. (2022) documented that access to hormone therapy in adolescence is associated with favorable mental health outcomes in adulthood, when compared to individuals who desired but could not access hormonal interventions.

C. Assessment of Gender Dysphoria in Children and Adolescents

36. Due to the incongruence between their assigned sex and gender identity, transgender people experience varying degrees of gender dysphoria, a serious medical condition defined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5 TR) (APA, 2022). *Gender Dysphoria* is defined as an incongruence between a patient's assigned sex and their gender identity present for at least six months, which causes clinically important distress in the person's life. This distress is further defined as impairment in social, occupational, or other important areas of functioning (APA, 2022). Additional features may include a strong desire to be rid of one's primary or secondary sex characteristics, a strong desire to be treated as a member of the

CONFIDENTIAL

identified gender, or a strong conviction that one has the typical feelings of identified gender (APA, 2022).

37. The World Health Organization's International Classification of Diseases (ICD), the diagnostic and coding compendia for mental health and medical professionals, codifies Gender Incongruence as the diagnosis resulting from the incongruity between one's gender identity and birth sex. The Gender Incongruence diagnosis is part of a new "Conditions related to sexual health" chapter in the ICD-11, which is the most recent iteration of the ICD published in 2019 (Costa, et al., 2015; WHO, 2019). This reflects evidence that transgender and gender diverse identities are not conditions of mental ill health and classifying them as such can cause enormous stigma.

38. In children and adolescents, the diagnosis of gender dysphoria is made by a health provider including but not limited to a psychiatrist, psychologist, social worker, or therapist with expertise in gender identity concerns. It is recommended that children and adolescents diagnosed with gender dysphoria engage with a multidisciplinary team of mental health and medical professionals to formulate a treatment plan, in coordination with the parent(s) or guardian(s), with a goal of reduction of gender dysphoria. The *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* ("SOC 8"), published by the World Professional Association for Transgender Health (WPATH), provides guidance to

CONFIDENTIAL

providers on how to provide comprehensive assessment and care to this patient population based on medical evidence. These standards recommend involving relevant disciplines, including mental health and medical professionals, to reach a decision with families about whether medical interventions are appropriate and remain indicated through the course of treatment. Multidisciplinary clinics, such as the Child and Adolescent Gender Clinic where I practice, have structured their programs around this model, as guided by the WPATH SOC.

D. *Evidence-Based Clinical Practice Guidelines for the Treatment of Gender Dysphoria in Children, Adolescents, and Adults*

39. The goal of any intervention for gender dysphoria is to reduce dysphoria, improve functioning, and prevent the harms caused by untreated gender dysphoria.

40. Gender dysphoria is highly treatable and can be effectively managed. If left untreated, however, it can result in severe anxiety and depression, eating disorders, substance abuse, self-harm, and suicidality (Reisner, et al., 2015).

41. Based on longitudinal data, and my own clinical experience, when transgender adolescents are provided with appropriate medical treatment and have parental and social support, they are more likely to thrive and grow into healthy adults (de Vries, et al., 2014).

42. In children and adolescents, a comprehensive biopsychosocial assessment is typically the first step in evaluation, performed by a mental health

CONFIDENTIAL

provider with experience in gender identity. The goals of this assessment are to develop a deep understanding of the young person's experience with gender identity, to consider whether the child or adolescent meets criteria for a diagnosis of gender dysphoria, and to understand what options may be desired and helpful for the adolescent (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009).

43. For children younger than pubertal age, the only recommended treatments do not involve medications. For adolescents, additional treatments involving medications may be appropriate.

44. For pre-pubertal children with gender dysphoria, treatments may include supportive therapy, encouraging support from loved ones, and assisting the young person through elements of a social transition. Social transition may include adopting a new name and pronouns, appearance, and clothing, and correcting identity documents.

45. Options for treatment after the onset of puberty include the use of gonadotropin-releasing hormone agonists ("GnRHa") for purposes of preventing progression of pubertal development, and hormonal interventions such as testosterone and estrogen administration. These treatment options are based on robust research and clinical experience, which consistently demonstrate safety and efficacy.

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46. Clinical practice guidelines have been published by several long-standing and well-respected medical bodies: the World Professional Association for Transgender Health (WPATH) and the Endocrine Society (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009), as well as the UCSF Center for Excellence in Transgender Health (Deutsch (ed.), 2016). The clinical practice guidelines and standards of care published by these organizations provide a framework for treatment of gender dysphoria in adolescents.

47. WPATH has been recognized as the standard-setting organization for the treatment of gender dysphoria since its founding in 1979. The most recent WPATH Standards of Care (SOC 8) were published in 2022 and represent expert consensus for clinicians related to medical care for transgender people, based on the best available science and clinical experience (Coleman, et al., 2022).

48. The purpose of the WPATH Standards of Care is to assist health providers in delivering necessary medical care to transgender people, to maximize their patients' overall health, psychological well-being, and self-fulfillment. The WPATH Standards of Care serve as one of the foundations for the care provided in my own clinic.

49. The WPATH SOC 8 is based on rigorous review of the best available science and expert professional consensus in transgender health. International professionals were selected to serve on the SOC 8 writing committee.

CONFIDENTIAL

Recommendation statements were developed based on data derived from independent systemic literature reviews. Grading of evidence was performed by an Evidence Review Team which determined the strength of evidence presented in each individual study relied upon in the document (Coleman, et al., 2022).

50. The previous version (SOC 7), published in 2012 (Coleman, et al., 2012), was similar to SOC 8 in the basic tenets of management for transgender adolescents; however, SOC 8 further reinforces these guidelines with data published since the release of SOC 7.

51. In addition, the Endocrine Society is a 100-year-old global membership organization representing professionals in the field of adult and pediatric endocrinology. In 2017, the Endocrine Society published clinical practice guidelines on treatment recommendations for the medical management of gender dysphoria, in collaboration with Pediatric Endocrine Society, the European Societies for Endocrinology and Pediatric Endocrinology, and WPATH, among others (Hembree, et al, 2017).

52. The Endocrine Society Clinical Guidelines were developed through rigorous scientific processes that “followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines.” The guidelines affirm that patients with gender

CONFIDENTIAL

dysphoria often must be treated with “a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person’s genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person’s affirmed gender.” (Hembree, et al., 2017).

53. The AAP is the preeminent professional body of pediatricians in the United States, with over 67,000 members. The AAP endorses a commitment to the optimal physical, mental, and social health and well-being for youth. The 2018 policy statement titled *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents* further lends support to the treatment options outlined in the WPATH Standards of Care and the Endocrine Society’s Clinical Practice Guidelines (Rafferty, et al., 2018).

54. Aside from the AAP, the tenets set forth by the Endocrine Society Clinical Practice Guidelines and the WPATH Standards of Care are supported by the major professional medical and mental health associations in the United States, including the American Medical Association, the American Psychological Association, the American Psychiatric Association, and American Academy of Family Physicians, among others (e.g., AMA, 2019; American Psychological Association, 2015; Drescher, et al., 2018 (American Psychiatric Association); Hembree, et al., 2017 (Endocrine Society); Klein, et al., 2018 (AAFP); National Academies, 2020; WPATH, 2016).

CONFIDENTIAL

55. As a board-certified pediatric endocrinologist, I follow the Endocrine Society Clinical Practice Guidelines and the WPATH Standards of Care when treating my patients.

E. *Treatment Protocols for Gender Dysphoria in Children, Adolescents, and Adults*

56. Central to the guidance from WPATH, the Endocrine Society, and the AAP is the importance of familial love and support. Transgender youth who report high levels of rejection from family have lower self-esteem and higher degrees of isolation. These youth are at very high risk for health and mental health problems when they become young adults. According to the Family Acceptance Project, transgender young people who reported high levels of family rejection are significantly more likely to have attempted suicide, to report high levels of depression, to use illegal drugs, and to be at high risk for HIV and sexually transmitted diseases compared with transgender young people who report no or low levels of rejection by family due to their identity (Ryan, et al., 2010).

57. Undergoing treatment to alleviate gender dysphoria is commonly referred to as a transition. The transition process in adolescence typically includes (i) social transition and/or (ii) medications, including puberty-delaying medication and hormone therapy. The steps that make up a person's transition and their sequence will depend on that individual's medical and mental health needs and decisions made between the patient, family, and multidisciplinary care team.

CONFIDENTIAL

58. There are no medications considered for transition until after the onset of puberty. Puberty is a process of maturation heralded by production of sex hormones—testosterone and estrogen—leading to the development of secondary sex characteristics. Secondary sex characteristics include testosterone-induced effects such as deepening of the voice, muscular changes, facial and body hair, and estrogen-induced effects such as breast development. There is diversity in the age of pubertal onset; however, most adolescents begin puberty between ages 10 and 12 years.

59. Gender exploration in childhood is expected and healthy. The majority of prepubertal children exploring their gender do not develop gender dysphoria and are not expected to become transgender adolescents or adults. In contrast, data and personal experience shows that children whose gender dysphoria persists into adolescence are highly likely to be transgender (van der Loos, et al., 2022). Some individuals in this field misinterpret older studies showing that a large percentage of children diagnosed with gender identity disorder did not grow up to be transgender. Those studies include children who would not fulfill the current diagnostic criteria for gender dysphoria and, in any case, have no relevance to this case because no medications are prescribed to prepubertal children.

60. Puberty-delaying medication and hormone-replacement therapy—both individually and in combination—can significantly improve a transgender young

CONFIDENTIAL

person's mental health. These treatments allow for a physical appearance more closely aligning with gender identity and decreases the likelihood that a transgender young person will be incorrectly identified with their assigned sex, further alleviating their gender dysphoria, and bolstering the effectiveness of their social transition.

61. At the onset of puberty, adolescents begin to experience the onset of secondary sex characteristics. Adolescents with differences in gender identity may have intensification of gender dysphoria during this time due to development of secondary sex characteristics incongruent with gender identity. Persistence or intensification of gender dysphoria as puberty begins is used as a helpful diagnostic tool as it becomes more predictive of gender identity persistence into adolescence and adulthood (de Vries, et al., 2012).

i. Treatment with puberty-delaying medications

62. Adolescents diagnosed with gender dysphoria who have entered puberty (Tanner Stage 2) may be prescribed puberty-delaying medications (GnRHa) to prevent the distress of developing permanent, unwanted physical characteristics that do not align with the adolescent's gender identity. Tanner Stage 2 refers to the stage in puberty whereby the physical effects of testosterone or estrogen production are first apparent on physical exam. Specifically, this is heralded by the onset of breast budding in an individual assigned female at birth, or the onset of testicular

CONFIDENTIAL

enlargement in an individual assigned male at birth. For individuals assigned male at birth, Tanner Stage 2 typically occurs between age 9-14, and for those assigned female at birth between age 8-12.

63. The treatment works by pausing endogenous puberty at whatever stage it is at when the treatment begins, limiting the influence of a person's endogenous hormones on their body. For example, a transgender girl will experience no progression of physical changes caused by testosterone, including facial and body hair, an Adam's apple, or masculinized facial structures. And, in a transgender boy, those medications would prevent progression of breast development, menstruation, and widening of the hips (Coleman, et al., 2022; de Vries, et al., 2012; Deutsch (ed.), 2016; Hembree, et al., 2017; Rosenthal, 2014).

64. GnRHa have been used extensively in pediatrics for several decades. Prior to their use for gender dysphoria, they were used (and still are used) to treat precocious puberty. GnRHa work by suppressing the signal hormones from the pituitary gland (luteinizing hormone [LH] and follicle stimulating hormone [FSH]) that stimulate the testes or ovaries to produce sex hormones. Upon discontinuation of GnRHa, LH and FSH production resume and puberty will also resume.

65. GnRHa have no long-term implications on fertility. In transgender youth, it is most typical to use GnRHa from the onset of puberty (Tanner Stage 2) until mid-adolescence. While treating, the decision to continue treatment will be

CONFIDENTIAL

continually evaluated. Should pubertal suppression no longer be desired, GnRHa would be discontinued, and puberty would re-commence.

66. Prior to initiation of GnRHa, providers counsel patients and their families extensively on potential benefits and risks. The designed benefit of the treatment is to reduce the risk of worsening gender dysphoria and mental health deterioration. Furthermore, development of secondary sex characteristics incongruent with gender identity could result in the future need for surgeries and other body alterations that would not be needed if GnRHa had been used.

67. As an experienced pediatric endocrinologist, I treat patients with these same medications for both precocious puberty and gender dysphoria and in both cases the side effects are comparable and easily managed. And for both patient populations the risks are greatly outweighed by the benefits of treatment.

68. In addition, I regularly prescribe GnRHa for patients who do not meet criteria for precocious puberty but who require pubertal suppression. Examples include patients with disabilities who are unable to tolerate puberty at the typical age due to hygienic concerns; minors with growth hormone deficiency who despite growth hormone treatment will have a very short adult height; and young women with endometriosis. As with gender dysphoria, the prescription of GnRHa to treat these conditions is “off-label,” yet it is widely accepted within the field of endocrinology and not considered experimental. The same holds true for other

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common medications used in pediatric endocrinology: using metformin for weight loss; growth hormone for short stature not caused by growth hormone deficiency; countless medications used to control type 2 diabetes which have an adult indication but whose manufacturers have not applied for a pediatric indication.

ii. Treatment with hormone therapy

69. In mid-adolescence, the patient, their parents, and the patient's care team may discuss the possibility of beginning the use of testosterone or estrogen. In my practice we discuss these treatments for a patient who is currently receiving GnRHa, or patients who have already gone through their endogenous puberty and either did not have access to, desire, or elect for GnRHa treatment.

70. These hormone therapies are used to treat gender dysphoria in adolescents to facilitate development of sex-specific physical changes congruent with their gender identity. For example, a transgender boy prescribed testosterone will develop a lower voice as well as facial and body hair, while a transgender girl prescribed estrogen will experience breast growth, female fat distribution, and softer skin.

71. Under the Endocrine Society Clinical Guidelines and SOC 8, hormone therapy is an appropriate treatment for transgender adolescents with gender dysphoria when the experience of dysphoria is marked and sustained over time, the adolescent demonstrates emotional and cognitive maturity required to provide and

CONFIDENTIAL

informed consent/assent for treatment, other mental health concerns (if any) that may interfere with diagnostic clarity and capacity to consent have been addressed, the adolescent has discussed reproductive options with their provider. SOC 8 also highlights the importance of involving parent(s)/guardian(s) in the assessment and treatment process for minors (Coleman, et al., 2022; Hembree, et al., 2017).

72. Similar to GnRHa, the risks and benefits of hormone treatment are discussed with patients (and families, if the patient is a minor) prior to initiation of testosterone or estrogen. When treated with testosterone or estrogen, the goal is to maintain the patient's hormone levels within the normal range for their gender. Laboratory testing is recommended to ensure proper dosing and hormonal levels. If starting hormonal care after completing puberty, discussion of egg or sperm preservation prior to starting treatment is recommended.

73. Regardless of the treatment plan prescribed, at every encounter with the care team there is a re-evaluation of the patient's gender identity and their transition goals. Should a patient desire to discontinue a medical intervention, the intervention is discontinued. Discontinuation of GnRHa will result in commencement of puberty. Findings from studies in which participants have undergone comprehensive evaluation prior to gender care show low levels of regret (de Vries, et al., 2011; van der Loos, et al., 2022; Wiepjes, et al., 2018).

CONFIDENTIAL

74. Surgical interventions, including but not limited to chest and genital surgery, are indicated in appropriately selected patients. These surgeries are not typically performed in adolescence but rather considered in adulthood. The WPATH SOC 8 outlines the current literature supporting benefits of surgical interventions for patients with gender dysphoria (Coleman, et al., 2022).

F. *Safety and Efficacy of Puberty-Delaying Medications and Hormone Therapy to Treat Gender Dysphoria*

75. GnRHa, prescribed for delaying puberty in transgender adolescents, is both a safe and effective treatment. Patients under consideration for treatment are working within a multidisciplinary team of providers all dedicated to making informed and appropriate decisions with the patient and family in the best interest of the adolescent. Physicians providing this intervention are trained and qualified in gender identity concerns and childhood growth and development and are participating in this care out of a desire to improve the health and wellness of transgender youth and prevent negative outcomes such as depression and suicide.

76. GnRHa, including injectable leuprolide and implantable histrelin, have rare side effects which are discussed with patients and families prior to initiation. Mild negative effects may include pain at the injection or implantation site, sterile abscess formation, weight gain, hot flashes, abdominal pain, and headaches. These effects can be seen in patients receiving GnRHa for gender dysphoria, or for other indications such as precocious puberty. I counsel patients on maintaining a healthy

CONFIDENTIAL

diet and promote physical activity, and regularly document height and weight during treatment. Nutritional support can be provided for patients at risk for obesity.

77. Risk of lower bone mineral density in prolonged use of GnRHa can be mitigated by screening for, and treating, vitamin D deficiency when present, and by limiting the number of years of treatment based on a patient's clinical course (Rosenthal, 2014). An exceptionally rare but significant side effect, increased intracranial pressure, has been reported in six patients (five treated for precocious puberty, one for transgender care), prompting an FDA warning in July 2022 (AAP, 2022). These cases represent an extremely small fraction of the thousands of patients who have been treated with GnRHa over decades. Symptoms of this side effect (headache, vomiting, visual changes) are reviewed with families and if they occur the medication is discontinued.

78. GnRHa do not have long-term implications on fertility. This is clearly proven from decades of use in the treatment of precocious puberty (Guaraldi, et al., 2016; Martinerie, et al, 2021). Progression through natal puberty is required for maturation of egg or sperm. If attempting fertility after previous treatment with GnRHa followed by hormone therapy is desired, an adult patient would withdraw from hormones and allow pubertal progression. Assistive reproduction could be employed if needed (T'Sjoen, et al., 2013).

CONFIDENTIAL

79. Patients who initiate hormones after completing puberty are offered gamete preservation prior to hormonal initiation (Coleman, et al., 2022), but even when not undertaken, withdrawal of hormones in adulthood often is successful in achieving fertility when it is desired (Light, et al., 2014; Knudson, et al., 2017).

80. Discussing the topic of fertility is important, and not specifically unique to treatment of gender dysphoria. Medications used for other medical conditions, such as chemotherapeutics used in cancer treatment, can affect fertility. For all medications with potential impacts on fertility, the potential risks and benefits of both treatment and non-treatment should be reviewed and data regarding risk for infertility clearly articulated prior to the consent or assent of the patient. Risk for fertility changes must be balanced with the risk of withholding treatment.

81. Review of relevant medical literature clearly supports the benefits of GnRHa treatment on both short-term and long-term psychological functioning and quality of life (e.g., Achille, et al., 2020; Carmichael, et al., 2021; Costa, et al., 2015; de Vries, et al., 2014; de Vries, et al., 2011; Kuper, et al., 2020; Turban, et al., 2020b; van der Miesen, et al., 2020). For example, a 2014 long-term follow-up study following patients from early adolescence through young adulthood showed that gender transition treatment allowed transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender with positive outcomes as young adults (de Vries, et al., 2014).

CONFIDENTIAL

82. In my own practice, adolescent patients struggling with significant distress at the onset of puberty routinely have dramatic improvements in mood, school performance, and quality of life with appropriate use of GnRHa. Side effects encountered are similar to those seen in other patients treated with these medications and easily managed.

83. Hormone therapy (testosterone or estrogen) is prescribed to older adolescents with gender dysphoria. As is the case with GnRHa, the need for hormone therapy is not unique to transgender adolescents. Patients with conditions such as delayed puberty, hypogonadism, Turner Syndrome, Klinefelter Syndrome, gonadotropin deficiency, premature ovarian failure, and disorders of sex development all require treatment with these hormones, often starting in adolescence and continuing lifelong. Without testosterone or estrogen treatment, these patients would be unable to progress through puberty normally, which would have serious medical and social consequences. Whether used in adolescents to treat gender dysphoria, or to treat any of these other conditions, testosterone and estrogen are prescribed with a goal to raise the testosterone or estrogen level into the normal male or female range for the patient's age. Careful monitoring of blood levels and clinical progress are required. Side effects are rare, but most often related to overtreatment, which can be minimized with this monitoring. Additionally, side effects are considered,

CONFIDENTIAL

discussed, and easily managed in all individuals needing hormone therapy regardless of the diagnosis necessitating these medications.

84. Venous thromboembolism (blood clotting) is a known side effect of estrogen therapy in all individuals placed on it including transgender women. Risk is increased in old age, in patients with cancer, and in patients who smoke nicotine. This side effect is mitigated by careful and accurate prescribing and monitoring. In my career, no patient has suffered a thromboembolism while on estrogen therapy.

85. Treatment of gender dysphoria with testosterone or estrogen is highly beneficial for both short-term and long-term psychological functioning of adolescents with gender dysphoria and withholding treatment from those who need it is harmful (e.g., Achille, et al., 2020; Allen, et al., 2019; Chen, et al., 2023; de Lara, et al., 2020; de Vries, et al., 2014; Grannis, et al., 2021; Green, et al., 2022; Kaltiala, et al., 2020; Kuper, et al., 2020). To highlight examples, Green et al. (2022) describe that hormone therapy is correlated with reduced rates of depression and suicidality among transgender adolescents. Turban et al. (2022) documented that access to hormone therapy in adolescence is associated with favorable mental health outcomes in adulthood, when compared to individuals who desired but could not access hormonal interventions.

CONFIDENTIAL

86. I treat many patients with gender dysphoria GnRHa, testosterone, and estrogen. Side effects related to these medications are very rare and can be treated with dose adjustment and/or lifestyle changes.

87. In sum, the use of GnRHa and hormones in adolescents for the treatment of gender dysphoria is the current standard of care and certainly not experimental. This is due to robust evidence of safety and efficacy. The sum of the data supports the conclusion that treatment of gender dysphoria with these interventions promotes wellness and helps to prevent negative mental health outcomes, including suicidality in adolescents. The data to support these interventions are so strong that withholding such interventions would be negligent and unethical.

G. *Harms Associated with Prohibiting and Discontinuing Treatment*

88. Prohibition of gender transition care for adolescents is likely to have devastating consequences. I am concerned such a prohibition might lead to a staggering increase in mental health problems including suicidality for transgender children and adolescents in Florida. One study which highlights my concern is a study of over 21,000 patients who report ever desiring hormone care. When comparing those who were able to access this care to those desiring but never accessing care, those able to access care had lower odds of suicidality within the past year. In addition, those individuals where were able to access care in adolescence

CONFIDENTIAL

had lower odds of suicidality compared to those waiting to access until adulthood (Turban, et al., 2022).

89. Even more concerning is a situation where patients currently receiving care and thriving would be forced to discontinue this care.

H. The Boards' Informed Consent Documents Are Medically Inaccurate, Impose Medically Unwarranted and Harmful Requirements, and Undermine Rather Than Facilitate Informed Consent

90. The consent forms created by the Florida Board of Medicine are inappropriate because they provide incorrect information, mandate inappropriate restrictions on care, and create harmful barriers to minor and adult patients getting the care they need.

91. Health care professionals have both a legal and ethical obligation to ensure that patients receive accurate information about medical treatments they are prescribed. This includes a discussion of the medical condition being treated, potential treatment options, and potential risks and benefits of those treatment options. Providers must ensure that patients and the parents of minor patients have the capacity to understand these discussions and that they agree to the treatment plan. Because the forms state inaccurate information, require unnecessary restrictions on care, and falsely describe the risk/benefit ratio, these forms undermine the process of informed consent rather than facilitate it.

CONFIDENTIAL

92. How health care professionals undertake the informed consent process is tailored to the medical context and the individual patient-provider and, in the case of minor patients, the parent-provider relationship. Most medical decision making does not involve signing a consent form. For example, when a patient is diagnosed with diabetes, very few if any endocrinologists utilize an informed consent document prior to starting insulin even though there are significant risks associated with insulin in management of diabetes. That said, physicians may use written consent forms in a situation where they believe the form will facilitate discussion of a complex medical decision, enhance patient understanding of the intervention, or provide formal documentation that the material was reviewed with the patient. There may be, for example, providers in Florida who will decide to employ a written consent form prior to prescribing masculinizing or feminizing hormonal therapy. In so doing, they are using the consent form as a tool to improve patient care.

93. When a regulatory agency interferes with the informed consent process to require doctors to misstate information, impose medically unsupported requirements, and create unnecessary barriers to ongoing care, the process is corrupted and patient autonomy is undermined. Nowhere is this more apparent than in the consent form itself: “The Florida Board of Medicine or the Florida Board of Osteopathic Medicine requires that your prescribing physician provide this form in accordance with section 456.54, F.S. This form contains information required to be

CONFIDENTIAL

disclosed to you by Florida law and does not necessarily reflect the views or opinions of your physician.” The layman’s translation: the Florida legislature wants to let you know that we disagree with the decision you and your doctor are making together.

94. The consent forms are intended for use in patients with gender dysphoria considering a hormonal intervention. The goal of any intervention for gender dysphoria is to reduce dysphoria and improve functioning. Clinical practice guidelines have been published by several long-standing and well-respected medical bodies: the World Professional Association for Transgender Health (WPATH) and the Endocrine Society (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009), as well as the UCSF Center for Excellence in Transgender Health (Deutsch (ed.), 2016). The clinical practice guidelines and standards of care published by these organizations provide a medically sound, evidence-based framework for treatment of gender dysphoria in adults. These resources provide the context for my more specific comments related to the content of the consent forms.

I. *The “Puberty Suppression Treatment” Form*

95. Prior to a line-item discussion, it is important to point out that in several instances this form describes certain requirements which are medically inappropriate, have no utility, and serve only as a barrier to care. I will point these examples out alongside my discussion of other problems. In addition, because the

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forms repeat a number of mistakes and misstatements, there are some redundancies in this Report that reflects that.

96. The statement in the informed consent forms that says when puberty suppression medications are prescribed for gender dysphoria they are not being “used for their intended purpose” is inaccurate, misleading, and is likely to confuse patients. Off-label use is common. The FDA itself has said that once FDA has approved medications, doctors can prescribe such medications if they judge them to be appropriate for their patients. Many medications are prescribed for off-label uses. That does not mean “they are not being used for their intended purposes.”

97. The requirement for an *in person* visit before initiating puberty suppression undermines care where the individual circumstances of a minor patient and their family would be best served by a virtual visit.

98. Page 1, Paragraph 2 (Medical treatment...): This paragraph undermines the ability of parents of minor patients to make an informed decision by giving them incorrect and biased information. Describing medical treatment of gender dysphoria as being based on very limited, poor-quality research is incorrect and misleading. Medical evidence supports the treatment of gender dysphoria with puberty suppression treatment when appropriate. In addition, far from being “purely speculative,” this care is well-established and based on substantial data and decades of clinical experience.

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99. Page 2, Paragraph 3 (Provera is a pill...): There is no medical reason for this document to include a discussion of Provera. Provera is a medication used for menstrual regulation and it is used in the same manner for transgender boys and non-transgender girls. Provera is not used for pubertal suppression.

100. Page 3 (The specific requirements...), Item 6 (Demonstrates knowledge...): It is unnecessary to discuss the risks and benefits associated with surgery during a conversation about puberty suppression because the decision to have surgery is completely separate from decisions about medications for minors.

101. Page 3, Item 7 (Undergoes an in-person...): While it is reasonable to schedule follow-up visits every six months during puberty suppression treatment, it is not reasonable to require those visits to be in person where, depending on the circumstances of the minor patient and their family, virtual visits may better serve their needs.

102. Page 3, Item 8 (Undergoes a suicide risk assessment...): The frequency of mental health assessments for minors being treated with puberty suppression medications must be individualized according to the needs of the minor patient. It is inappropriate to require assessments every three months for all patients.

103. Page 3, Item 9 (Undergoes relevant laboratory...): The frequency of laboratory testing should be based on the individualized needs of the minor patient.

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104. Page 3, Item 10 (X-ray of the hand...): The requirement of a hand X-ray is not medically necessary. If there is no concern about a minor patient's final height, there is no need to obtain a bone age X-ray.

105. Page 3, Item 11 (Annual bone density scan...): Bone density scans (DEXA) should be served only for those individuals who are at risk for low bone density. While some minor patients experience lower bone density while being treated with puberty suppression medication, research has shown that bone density will be normal when the patient ceases puberty suppression medication, whether or not the patient continues with hormone replacement therapy. Research has helped providers to understand which patients would benefit from a DEXA assessment.

106. Page 3, Item 12 (Annual mental health assessment...): The requirement for assessments by a Board-certified Florida-licensed psychiatrist or psychologist undermines care for patients who would receive better treatment from other mental health professionals, such as therapists and social workers who are often competent and better equipped to conduct mental health assessments for transgender minors.

107. Page 4 (Effects...), Item 2 (If a minor stops...): If a minor stops treatment with puberty suppression medication, in a few months their body will restart the changes of puberty at the development stage they were before starting medication. It is false that the effects of these medications could be permanent.

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108. Page 4, Item 3 (It can take...): Puberty suppression medications work very predictably and how they arrest puberty is well understood. It is false to state that it cannot be predicted how quickly or slowly or even if a minor's body will respond to the medication.

109. Page 4, Item 6 (Puberty blockers can interfere...). Puberty suppression medications do not interfere with fertility. The contrary statement is not accurate.

110. Page 4 (Risks...), Item 1 (The adverse effects...): Puberty suppression medications are well understood to be safe and effective for treating minors with gender dysphoria. There is no evidence to support the claim that the effects are not well known.

111. Page 4, Item 2 (Treatment with puberty blockers...): There is substantial evidence that puberty suppression medications for the treatment of gender dysphoria in transgender youth are associated with improved mental health outcomes. Any statement to the contrary is false and not supported by evidence.

112. Page 4-5, Item 3 (Treatment with puberty blockers may cause...): The effects listed here, including crying, irritability, restlessness, anger, and aggression are not common or expected effects of treatment with puberty suppression medications.

113. Page 5, Item 6 (Seizures are a risk...): The association between puberty suppression medications and seizures are not well established as true.

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114. Page 5, Item 13 (Puberty blockers may cause stalling...). The statement that puberty suppression medication may stall cognitive or brain development in minors is false and not supported by evidence.

J. *The “Masculinizing Medications” Forms*

115. Prior to a line-item discussion, it is important to point out that in several instances the “Masculinizing Medications” forms for minors and for adults describe certain requirements which are medically inappropriate, have no utility, and serve only as a barrier to care. I will point these examples out alongside my discussion of other problems. And as set forth above, there are redundancies in my Report as there are in the forms.

116. The forms for minors and the forms for adults include the same inaccuracies. Except where indicated, the discussion below is based on the forms for adults.

117. The statement in the informed consent forms that says when hormone therapies are prescribed for gender dysphoria they are not being “used for their intended purpose” is inaccurate, misleading and is likely to confuse patients. Off-label use is common. The FDA itself has said that once FDA has approved medications, doctors can prescribe such medications if they judge them to be appropriate for their patients. Many medications are prescribed for off-label uses. That does not mean “they are not being used for their intended purposes.”

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118. Page 1, Paragraph 4 (Medical treatment...): This paragraph undermines the patient's ability to make an informed decision by giving the patient incorrect and biased information. Describing medical treatment of gender dysphoria as being based on very limited, poor-quality research is incorrect and misleading. Medical evidence supports the treatment of gender dysphoria with hormonal care when appropriate, as I have testified to extensively before this court in Dekker v. Weida. In addition, far from being "purely speculative," this care is well-established and based on substantial data and decades of clinical experience.

119. Page 3, Paragraph 2 (Before beginning...): The requirement to undergo evaluation by a Florida licensed psychiatrist or psychologist prior to starting hormone replacement therapy (HRT) and every two years after demonstrates a profound lack of understanding of gender identity and dysphoria and of how health care is provided in our country; there is no medical justification for this requirement, which serves only as an unnecessary and potentially insurmountable barrier to care. The health care professional most appropriate to assess a patient's readiness for HRT is one who has clinical expertise and experience working with gender diverse patients. As the WPATH Standards of Care recognize, this may very well be a psychiatrist or psychologist, but may also be a therapist or social worker, a primary care physician, or another health care professional fluent in these topics and

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available to meet with the patient to have detailed discussion of their experience with gender.

120. In Ann Arbor where I practice, for example, I know of no psychiatrist or psychologist that performs these types of assessments. The assessment of gender dysphoria is primarily the role of therapists and social workers. If every transgender adult in Michigan (and I would presume, in Florida) required a visit with a psychiatrist or psychologist every two years, there would be no logistical way for this to occur due to lack of access. It is also not medically necessary. Psychiatrists, since they can prescribe psychotropic medications, are critical for patients with mental health problems requiring psychotropic drugs. I would refer a transgender patient to a psychiatrist, for example, if they needed assessment and management of bipolar disorder. But there is no similar medical justification for requiring a psychiatrist to approve the use of HRT.

121. As outlined above, mandating that a transgender patient be evaluated by a psychiatrist or psychologist before starting HRT is inappropriate, but requiring the patient to undergo such an evaluation every two years, to continue treatment, compounds the harm caused by this unnecessary requirement, which serves no function that advances either patient care or patient informed consent.

122. More generally, the requirement that transgender patients undergo lifelong therapy has no medical basis. While mental health support can be helpful to

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many patients, with and without gender dysphoria, the Standards of Care do not require lifelong therapy, and there is no medical justification for such a requirement. Accordingly, it is far outside the scope of informed consent to require treatment that is not necessary for care of a medical condition and doing so will keep people from getting the essential medical care they need.

123. The additional requirement that the psychiatrist or psychologist must be licensed in Florida adds another irrational, arbitrary, and harmful barrier. There is no reason that a transgender patient who was diagnosed by an appropriate healthcare provider in another state should have to be re-evaluated by a provider licensed in Florida.

124. In short, this provision of the informed consent form has no basis in medicine and does not provide patient information or promote informed consent in any sense. It is a substantive requirement not essential or even related to the informed consent process and serves only as a barrier to care.

125. The additional claim in the analogous provision on the form for minor patients indicates that a licensed mental health care professional “can work with the minor, your family and friends, and your school staff.” While it may be helpful for a mental health provider to discuss a minor’s case with other members of the patient’s life, this form should not be considered a broad release of information. Rather, each individual collateral would require a standard release of information

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form signed by the parent(s)/guardian(s) prior to HIPAA-protected discussions as in any medical context.

126. Page 3, Paragraph 1 (Testosterone is . . .): This paragraph accurately states that testosterone is not typically given as a pill. It then, however, goes on to discuss “fatal liver problems” associated with a medication that the physician is not going to prescribe. This approach of needlessly scaring patients undermines rather than enhances informed consent.

127. Page 1, Paragraph 1 (Before starting...): As outlined above, mandating the use of this form prior to starting therapy is inappropriate, but requiring it over-and-over, to continue treatment, serves no function that advances either patient care or patient informed consent. The effect of having a patient sign a form multiple times that states the information creates an unnecessary barrier to the care.

128. Page 2, Paragraph 2 (Finasteride is...): Finasteride is a drug that can be used by any person with male-pattern baldness. The medical term for this is androgenic alopecia. A transgender man would only be prescribed this drug if he were having baldness and was bothered by it, just as would be true for a non-transgender man. It is not part of the course of treatment for gender dysphoria. There is no medical justification for requiring signed informed consent by a transgender man for a drug prescribed to combat baldness which he may or may not need and which could be prescribed for either transgender or non-transgender men.

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129. Page 4, Paragraph 1 (The following...). There is no medical basis for the list of items included in Page 4, Paragraph 1. Their inclusion serves only to confuse and undermine informed consent and to create unnecessary obstacles to care. Patients receiving care for gender dysphoria are diverse and have different needs. Patients doing very well may need to be seen less frequently than patients who are struggling. Patients with other medical conditions, such as diabetes or hyperlipidemia, may need lab evaluation more frequently than other patients with no medical problems. Dictating visit frequency, frequency of mental health screening, and laboratory and radiology testing is not an appropriate role for a State Medical Board. These are decisions that medical providers make while thinking critically about each individual patient.

130. Page 6, Row 3: This statement is incorrect, “[T]here is no data in the medical literature or controlled research studies that support the timing, dosing, and type of administration of HRT.” In fact, there are well-established published guidelines that include timing, dosing, and type of administration of hormone therapy and that are supported by research data. (Hembree, et al., 2017; Deutsch (ed.), 2016).

131. On the form for minors, the requirement of a hand X-ray is not medically necessary. If there is no concern about a minor patient’s final height, there is no need to obtain a bone age X-ray.

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132. The item in this section that stands out to me as the most egregious is annual bone scans for 5 years. Testosterone does not cause diminution in bone density; it may increase bone density slightly or have no impact. (Rothman and Iwamoto (2019). There is no medical reason to consider DEXA scans for all transmasculine patients starting testosterone. In addition, doing annual DEXA scans for any reason is illogical. DEXA scans measure bone density and the test is primarily used to assess for osteoporosis in older adults. Changes to bone density occur very slowly and therefore doing annual DEXA scans is not helpful; a year is not enough time to see meaningful change. In fact, most insurance plans that I am familiar with refuse to pay for DEXA scan in adults more frequently than every 2 years for this reason—there is no clinical reason to do this even in people with osteoporosis. The statement in the consent forms related to DEXA scans is a clear tell that the form was written by someone without familiarity with the material, that would result in millions of dollars of unnecessary health care utilization, and that creates a hindrance to transgender patients getting essential care for treatment of gender dysphoria.

133. Summary Table: This table provides a good example about why this type of document is problematic. For each patient, there may be particular risks that I want to focus on related to their situation. For example, in the case of a patient already dealing with significant acne, I would discuss a specific acne plan for them

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while starting testosterone, but I would be much less concerned about their risk for an “inflamed liver” as this is something that I have never seen occur in my clinical practice. Presenting a patient with a laundry list of risks and benefits with no information about how to assess their likelihood undermines a patient’s ability to make an informed medical choice.

134. Masculinizing Effects Table, Row 4 (The following changes could be...). This row lists all the non-permanent effects of testosterone. Saying that any of these effects could be permanent is incorrect.

135. Risks of Testosterone and Estrogen Tables. As set forth above, presenting a laundry list of risks with no information about how to assess their likelihood undermines a patient’s ability to make an informed medical choice.

136. In addition, I want to highlight two rows that are inaccurate. Data does not support the assertion that “treatment with testosterone increases the risk of cancer to the uterus, ovaries, or breasts,” and “taking testosterone causes or worsens migraines.” The inclusion of these “risks” has no medical basis.

K. *The “Feminizing Medications” Forms*

137. Because these forms parallel the masculinizing forms and use identical language in many sections, I will only include here items that are unique to these forms.

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138. Page 2, Paragraph 2 (Cyproterone acetate...). Cyproterone acetate is not available in the United States and therefore should not be included in the consent form. Including a medication that is not available only serves to engender confusion and fear. It does not serve any legitimate purpose and deters patients from getting the care they need.

139. Page 2, Paragraphs 3 and 4. The first four paragraphs on page two include paragraphs related to medications that may or may not be prescribed to the patient. A statement in a consent form that says “various forms of progestins may also be used,” provides no meaningful information and serves only to overwhelm and confuse.

140. Page 2, Paragraph 3 (The administration of finasteride ...): The form states that finasteride “is not recommended for routine use in treating populations with gender dysphoria.” While finasteride is not prescribed for treating gender dysphoria in transgender men, finasteride may be prescribed to treat gender dysphoria in transgender women in certain situations when other anti-androgens not effective, and—contrary to the implications of the form’s statement—there is nothing inappropriate or unsafe about such usage.

141. Page 4, related to DEXA scans in transgender women: I know of no medically supported reason to require annual DEXA scans just because a patient is a transgender woman prescribed estrogen.

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142. Page 5, related to risk of breast cancer may significantly increase if a patient takes estrogen: A transgender woman receiving estrogen has a higher risk of breast cancer compared to men but not higher than other women. In fact, this risk is lower than that for non-transgender women. Therefore, transgender women are recommended to follow the same breast cancer mammogram screening guidelines as non-transgender women; they do not require stricter monitoring. (de Block et al. 2019).

L. Other Restrictions Imposed By SB 254 Have No Medical Basis and Will Serve Only to Deter Transgender Patients from Obtaining Needed Medical Care

143. S.B. 254 arbitrarily and needlessly prohibits advanced practice registered nurses (“APRNs”) from prescribing and administering hormone therapy for transgender patients. As the WPATH Standards of Care recognize, there is no medical basis for this restriction, which will serve only to make it difficult or impossible for many transgender patients to receive care.

144. Prescribing and administering hormone therapy to transgender patients to treat gender dysphoria is part of primary care. The education and training that APRNs amply qualifies them to provide this care to transgender patients.

145. S.B. 254 also arbitrarily and needlessly requires that transgender patients may not receive transition-related medical care unless a physician obtains their written consent in an in-person meeting. In addition to the many other problems

CONFIDENTIAL

with the informed consent requirements, which I outline above, this requirement has no medical basis and serves only to erect another arbitrary and harmful barrier to care. There is nothing about discussing the risks and benefits of treatments with transgender patients and obtaining their informed consent that requires this to be done in an in-person visit, as opposed to a video or audio meeting. This requirement is not imposed for any other patients, including those receiving medications that pose far greater risks, as well as those receiving the same medications for other purposes; there is no reason to impose it only upon transgender patients.

III. CONCLUSION

146. In summary, banning care for transgender adolescents runs counter to evidence-based best practices and standards of care for the treatment of gender dysphoria.

147. Gender dysphoria is a challenging condition, but it is treatable through individualized assessment and treatment, which may include social transition, psychotherapy, pubertal suppression, and hormonal therapy. These treatments are not experimental and are supported by all major medical bodies in the field of transgender medicine and pediatrics.

148. Lack of access to these treatments will result in worse outcomes for countless youth in Florida. Furthermore, banning care and access to evidence-based

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treatment for gender dysphoria sends a message that transgender youth are not valid and should be stigmatized.

149. In my own clinical practice in Michigan, I have seen an influx of patients from states banning medically proven treatments for gender dysphoria who report not feeling safe living in the community that they have always called home. Parents who love and support their transgender children have described themselves as “refugees” in their own country, moving to avoid discriminatory laws which they know would clearly harm their health or the health of their child.

150. Banning care and access to effective treatment for gender dysphoria will not eliminate transgender youth, but will, unfortunately, lead to an increase in mental health problems and suicidality in an already vulnerable population.

151. Finally, the informed consent forms required by the State Boards of Medicine and Osteopathic Medicine state misinformation about care for minors and for adults, create unsupported requirements for ongoing treatment, undermine rather than advance informed consent, and create unjustified and harmful barriers to care.

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

Executed this 16th day of August 2023.



Daniel Shumer, M.D.

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Exhibit A
Curriculum Vitae

Daniel Shumer, MD MPH

Clinical Associate Professor in Pediatrics - Endocrinology

Email: dshumer@umich.edu

EDUCATION AND TRAINING

Education

08/2000-08/2003 BA, Northwestern University, Evanston, United States

08/2004-05/2008 MD, Northwestern University, Feinberg School of Medicine,
Chicago, United States

07/2013-05/2015 MPH, Harvard T.H. Chan School of Public Health, Boston,
United States

Postdoctoral Training

06/2008-06/2011 Residency, Pediatrics, Vermont Children's Hospital at Fletcher
Allen Health Care, Burlington, VT

07/2011-06/2012 Chief Resident, Chief Resident, Vermont Children's Hospital
at Fletcher Allen Health Care, Burlington, VT

07/2012-06/2015 Clinical Fellow, Pediatric Endocrinology, Boston Children's
Hospital, Boston, MA

CERTIFICATION AND LICENSURE

Certification

10/2011-Present American Board of Pediatrics, General

Licensure

08/2015-Present Michigan, Medical License

09/2015-Present Michigan, DEA Registration

09/2015-Present Michigan, Controlled Substance

WORK EXPERIENCE

Academic Appointment

10/2015-9/2022 Clinical Assistant Professor in Pediatrics - Endocrinology,
University of Michigan - Ann Arbor, Ann Arbor

09/2022-Present Clinical Associate Professor in Pediatrics - Endocrinology,
University of Michigan - Ann Arbor, Ann Arbor

Administrative Appointment

07/2019-Present Fellowship Director - Pediatric Endocrinology, Michigan
Medicine, Department of Pediatrics, Ann Arbor

07/2020-Present Medical Director of the University of Michigan
Comprehensive Gender Services Program, Michigan
Medicine, Ann Arbor

*Oversee the provision of care to transgender and gender non-
conforming patients at Michigan Medicine.*

07/2020-Present Education Lead - Pediatric Endocrinology, University of
Michigan - Department of Pediatrics, Ann Arbor

Clinical Appointments

04/2022-05/2023 Medical Director in UMMG Faculty Benefits Appt.,
University of Michigan - Ann Arbor, Ann Arbor

Private Practice

08/2013-09/2015 Staff Physician, Harvard Vanguard Medical Associates,
Braintree

RESEARCH INTERESTS

- Gender dysphoria
- Prader Willi Syndrome

CLINICAL INTERESTS

- Gender dysphoria
- Disorders of Sex Development
- Prader Willi Syndrome

GRANTS

Past Grants

A Phase 2b/3 study to evaluate the safety, tolerability, and effects of Livoletide (AZP-531), an unacylated ghrelin analog, on food-related behaviors in patients with Prader-Willi syndrome

Millendo Therapeutics
04/2019 - 04/2021

HONORS AND AWARDS

National

2014 Annual Pediatric Endocrine Society Essay Competition:
Ethical Dilemmas in Pediatric Endocrinology: competition
winner - The Role of Assent in the Treatment of Transgender
Adolescents

Institutional

2012 - 2015 Harvard Pediatric Health Services Research Fellowship;
funded my final two years of pediatric endocrine fellowship
and provided tuition support for my public health degree

- 2016 The University of Michigan Distinguished Diversity Leaders Award, awarded by The Office of Diversity, Equity and Inclusion to the Child and Adolescent Gender Services Team under my leadership
- 2019 Lecturer of the Month, Department of Pediatrics, Michigan Medicine

TEACHING MENTORSHIP

Resident

- 07/2020-Present Rebecca Warwick, Michigan Medicine (co-author on publication #22)

Clinical Fellow

- 07/2017-06/2020 Adrian Araya, Michigan Medicine (co-author on publication #22, book chapter #4)
- 12/2020-Present Jessica Jary, Michigan Medicine - Division of Adolescent Medicine

Medical Student

- 09/2017-06/2020 Michael Ho, Michigan Medicine
- 07/2019-Present Hadrian Kinnear, University of Michigan Medical School (co-author on book chapter #3, abstract #3)
- 07/2019-Present Jourdin Batchelor, University of Michigan

TEACHING ACTIVITY

Regional

- 08/2018-Present Pediatric Boards Review Course sponsored by U-M: "Thyroid Disorders and Diabetes". Ann Arbor, MI

Institutional

- 12/2015-12/2015 Pediatric Grand Rounds: “Transgender Medicine - A Field in Transition”. Michigan Medicine, Ann Arbor, MI
- 02/2016-02/2016 Medical Student Education: Panelist for M1 Class Session on LGBT Health, Doctoring Curriculum. Michigan Medicine, Ann Arbor, MI
- 02/2016-02/2016 Psychiatry Grand Rounds: “Transgender Medicine - A Field in Transition”. Michigan Medicine, Ann Arbor, MI
- 03/2016-03/2017 Pharmacy School Education: “LGBT Health”. University of Michigan School of Pharmacy, Ann Arbor, MI
- 04/2016-Present Course Director: Medical Student (M4) Elective in Transgender Medicine. Michigan Medicine, Ann Arbor, MI
- 04/2016-04/2016 Rheumatology Grand Rounds: “Gender Identity”. Michigan Medicine, Ann Arbor, MI
- 05/2016-05/2016 Lecture to Pediatric Rheumatology Division: “Gender Dysphoria”. Michigan Medicine, Ann Arbor, MI
- 07/2016-07/2016 Internal Medicine Resident Education: “Gender Identity”. Michigan Medicine, Ann Arbor, MI
- 09/2016-09/2016 Presentation to ACU Leadership: “Gender Identity Cultural Competencies”. Michigan Medicine, Ann Arbor, MI
- 10/2016-10/2016 Presentation to Department of Dermatology: “The iPledge Program and Transgender Patients”. Michigan Medicine, Ann Arbor, MI
- 02/2017-02/2017 Swartz Rounds Presenter. Michigan Medicine, Ann Arbor, MI
- 02/2017-02/2017 Lecture to Division of General Medicine: “Transgender Health”. Michigan Medicine, Ann Arbor, MI

- 02/2017-02/2017 Presentation at Collaborative Office Rounds: “Transgender Health”. Michigan Medicine, Ann Arbor, MI
- 10/2017-10/2017 Family Medicine Annual Conference: “Transgender Medicine”. Michigan Medicine, Ann Arbor, MI
- 12/2017-12/2017 Presenter at Nursing Unit 12-West Annual Educational Retreat: “Gender Identity at the Children's Hospital”. Michigan Medicine, Ann Arbor, MI
- 02/2018-Present Pediatrics Residency Lecturer: “Puberty”. Michigan Medicine, Ann Arbor, MI
- 02/2019-Present Medical Student (M1) Lecturer: “Pediatric Growth and Development”. Michigan Medicine, Ann Arbor, MI
- 02/2019-Present Doctors of Tomorrow Preceptor: offering shadowing opportunities to students from Cass Technical High School in Detroit. Michigan Medicine, Ann Arbor, MI
- 03/2019-03/2019 Lecture to Division of Orthopedic Surgery: “Transgender Health”. Michigan Medicine, Ann Arbor, MI

MEMBERSHIPS IN PROFESSIONAL SOCIETIES

2012 - Present Pediatric Endocrine Society

COMMITTEE SERVICE

National

- 2014 - 2016 Pediatric Endocrine Society - Ethics Committee, Other, Member
- 2017 - present Pediatric Endocrine Society - Special Interest Group on Gender Identity, Other, Member
- 2018 - present Pediatric Endocrine Society - Program Directors Education Committee, Other, Member

Regional

2013 - 2015 Investigational Review Board - The Fenway Institute, Boston, MA, Other, Voting Member

Institutional

2017 - 2019 Department of Pediatrics at Michigan Medicine; Diversity, Equity, and Inclusion Committee, Other, Fellowship Lead

2017 - 2019 University of Michigan Transgender Research Group, Other, Director

VOLUNTEER SERVICE

2014 Camp Physician, Massachusetts, Served at a camp for youth with Type 1 Diabetes

SCHOLARLY ACTIVITIES

PRESENTATIONS

Extramural Invited Presentation Speaker

1. Grand Rounds, Shumer D, Loyola University School of Medicine, 07/2022, Chicago, Illinois

Other

1. Gender Identity, Groton School, 04/2015, Groton, MA

2. Television Appearance: Gender Identity in Youth, Channel 7 WXYZ Detroit, 04/2016, Southfield, MI

3. It Gets Better: Promoting Safe and Supportive Healthcare Environments for Sexual Minority and Gender Non-Conforming Youth, Adolescent Health Initiative: Conference on Adolescent Health, 05/2016, Ypsilanti, MI

4. Gender Identity, Humanists of Southeast Michigan, 09/2016, Farmington Hills, MI

5. Gender Identity, Pine Rest Christian Mental Health Services, 10/2016, Grand Rapids, MI
6. Pediatric Grand Rounds - Hormonal Management of Transgender Youth, Beaumont Children's Hospital, 11/2016, Royal Oak, MI
7. Transgender Youth: A Field in Transition, Temple Beth Emeth, 11/2016, Ann Arbor, MI
8. Transgender Youth: A Field in Transition, Washtenaw County Medical Society, 11/2016, Ann Arbor, MI
9. Pediatric Grand Rounds: Transgender Youth - A Field in Transition, St. John Hospital, 02/2017, Detroit, MI
10. Transgender Medicine, Veterans Administration - Ann Arbor Healthcare System, 05/2017, Ann Arbor, MI
11. Gender Identity, Hegira Programs, 05/2017, Detroit, MI
12. Care of the Transgender Adolescent, Partners in Pediatric Care, 06/2017, Traverse City, MI
13. Conference planner, host, and presenter: Transgender and Gender Non-Conforming Youth: Best Practices for Mental Health Clinicians, Educators, & School Staff; 200+ attendees from fields of mental health and education from across Michigan, Michigan Medicine, 10/2017, Ypsilanti, MI
14. Endocrinology Grand Rounds: Transgender Medicine, Wayne State University, 11/2017, Detroit, MI
15. Care of the Transgender Adolescent, St. John Hospital Conference: Transgender Patients: Providing Compassionate, Affirmative and Evidence Based Care, 11/2017, Grosse Pointe Farms, MI
16. Hormonal Care in Transgender Adolescents, Michigan State University School of Osteopathic Medicine, 11/2017, East Lansing, MI
17. Working with Transgender and Gender Non-Conforming Youth, Michigan Association of Osteopathic Family Physicians, 01/2018, Bellaire, MI

18. Community Conversations, Lake Orion, 01/2018, Lake Orion, MI
19. “I Am Jazz” Reading and Discussion, St. James Episcopal Church, 03/2019, Dexter, MI
20. Gender Identity, Michigan Organization on Adolescent Sexual Health, 10/2019, Brighton, MI; Port Huron, MI
21. Ask The Expert, Stand With Trans, 05/2020, Farmington Hills, MI (Virtual due to COVID)
22. Transgender Medicine, Michigan Association of Clinical Endocrinologists Annual Symposium, 10/2020, Grand Rapids, MI (Virtual due to COVID)
23. Transgender Youth in Primary Care, Michigan Child Care Collaborative (MC3), 10/2020, Ann Arbor, MI (Virtual due to COVID)
24. Lets Talk About Hormones, Stand With Trans, 10/2020, Farmington Hills, MI (Virtual due to COVID)
25. Gender Identity, Universalist Unitarian Church of East Liberty, 04/2021, Virtual due to COVID
26. Unconscious Bias, Ascension St. John Hospital, 05/2021, Virtual due to COVID

PUBLICATIONS/SCHOLARSHIP

Peer-Reviewed Articles

1. Vengalil N, Shumer D, Wang F: Developing an LGBT curriculum and evaluating its impact on dermatology residents, *Int J Dermatol*.61: 99-102, 01/2022. PM34416015

Chapters

1. Shumer: Coma. In Schwartz MW6, Lippincott Williams & Wilkins, Philadelphia, PA, (2012)
2. Shumer, Spack: Medical Treatment of the Adolescent Transgender Patient. In Dorđević M; Monstrey SJ; Salgado CJ Eds. CRC Press/Taylor & Francis, (2016)

3. Kinnear HA, Shumer DE: Duration of Pubertal Suppression and Initiation of Gender-Affirming Hormone Treatment in Youth. In Finlayson Elsevier, (2018)
4. Araya, Shumer DE: Endocrinology of Transgender Care – Children and Adolescents. In Poretsky; Hembree Ed. Springer, (2019)

Non-Peer Reviewed Articles

1. Shumer D: The Effect of Race and Gender Labels in the Induction of Traits, *Northwestern Journal of Race and Gender Criticism*.NA01/2014
2. Shumer D: A Tribute to Medical Stereotypes, *The Pharos, Journal of the Alpha Omega Alpha Medical Society*.Summer07/2017
3. Mohnach L, Mazzola S, Shumer D, Berman DR: Prenatal diagnosis of 17-hydroxylase/17,20-lyase deficiency (17OHD) in a case of 46,XY sex discordance and low maternal serum estriol, *Case Reports in Perinatal Medicine*.8(1)01/2018
4. Mohnach L, Mazzola S, Shumer D, Berman DR: Prenatal Diagnosis of 17-hydroxylase/17,20-lyase deficiency (17OHD) in a case of 46,XY sex discordance and low maternal serum estriol, *Case Reports in Perinatal Medicine*.8(1)12/2018
5. Kim C, Harrall KK, Glueck DH, Shumer DE, Dabelea D: Childhood adiposity and adolescent sex steroids in the EPOCH (Exploring Perinatal Outcomes among Children) study, *Clin Endocrinol (Oxf)*.91(4): 525-533, 01/2019. PM31278867
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Exhibit B
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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE et al.,

Plaintiffs,

Civil No. 4:23-cv-00114-RH-MAF

v.

JOSEPH A. LADAPO et al.,

Defendants.

**EXPERT REPORT OF LOREN SCHECHTER, M.D.
ON BEHALF OF PLAINTIFFS**

August 16, 2023

Prepared by
Loren Schechter, M.D.

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TABLE OF CONTENTS

	Page
I. INTRODUCTION AND SUMMARY OF OPINIONS	1
A. Qualifications.....	1
B. Prior Testimony.....	4
C. Compensation	4
D. Bases for Opinions.....	4
II. EXPERT OPINIONS.....	5
III. CONCLUSION.....	9

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I. INTRODUCTION AND SUMMARY OF OPINIONS

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

2. In summary, the informed consent forms required by the State Boards of Medicine and Osteopathic Medicine include numerous factual inaccuracies, detailed herein, about the nature and risks of surgical procedures performed to treat gender dysphoria. These misstatements will cause confusion in patients and undermine, rather than strengthen, the informed consent process.

A. *Qualifications*

3. I am a board-certified plastic surgeon. I specialize in gender confirming surgeries, including chest reconstruction, genital reconstruction, and other procedures to feminize or masculinize the face and body, and I am a recognized expert in this field.

4. 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.

5. I previously served as a Clinical Professor of Surgery at the University of Illinois at Chicago. I resigned that position to become the Director of Gender Affirmation Surgery at Rush University Medical Center in April 2022. I am also a Professor of Surgery and Urology at Rush University Medical Center. In addition, I maintain a clinical practice in plastic surgery in Illinois where I treat patients from around the country, as well as from around the world.

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6. I have been performing gender confirming surgeries for over 28 years. For at least the past five years, I have been performing at least 150 gender confirming surgeries each year, and I have performed over 1,500 of these surgeries during my medical career. Currently, approximately 90 percent of patients in my clinical practice are transgender people seeking gender confirming surgery.

7. I was a contributing author to the World Professional Association for Transgender Health's ("WPATH") Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version Seven, which were published in 2012. 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. In September 2022, WPATH published the Standards of Care for the Health of Transgender and Gender Diverse People, Version Eight ("Standards of Care") in the International Journal of Transgender Health. I was the co-lead author of the surgical and postoperative care chapter of Version Eight.

8. In addition, I have written a number of peer-reviewed journal articles and chapters in professional textbooks about gender confirming 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. I am also a co-investigator on a study regarding uterine transplantation for transgender women.

9. 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 Aesthetic Research, and the Journal of Sexual Medicine. I also serve on the editorial board of both Transgender Health and the

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International Journal of Transgender Health. Each of these publications is a peer-reviewed medical journal.

10. 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 Gender Education Institute, 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, and I am the Director for this upcoming live surgery course in 2023. In 2019, I directed the inaugural Gender Affirming Breast, Chest, and Body Master Class for the American Society of Plastic Surgeons.

11. I am also a founding member and president of the Society for Gender Surgeons; a current member of the Executive Committee of the Board of Directors of WPATH, where I serve as treasurer; and a former member of the Board of Governors of the American College of Surgeons. I am a guest examiner for the American Board of Plastic Surgery, which involves administering the plastic surgery oral board exam to surgeons who have completed their plastic surgery training and seek board certification.

12. I am the former Chair of the Patient Safety Committee for the American Society of Plastic Surgeons, and current Patient Safety Officer for the Division of Plastic Surgery at Rush University Medical Center. In 2017, I was an invited discussant at the Pentagon regarding transgender service members. I recently delivered the Bevan 2023 Lecture at the Chicago Surgical Society, which is a lecture that began in 1928 and was established by Arthur Bevan, a former President of the American Medical Association and Founder of the American Board of Surgery.

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13. I serve on the Committee on Sex and Gender Identification and Implications for Disability Evaluation recently convened by the National Academies for Science, Engineering, and Medicine.

14. The information provided regarding my professional background, experiences, publications, and presentations is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as **Exhibit A**.

B. *Prior Testimony*

15. In the past four years, I have testified as an expert and provided testimony in the following matters: *Dekker v. Weida* (deposition and trial); *Kadel v. Folwell*, M.D.N.C. (deposition); *Toomey v. State of Arizona*, D. Ariz. (deposition); *Fain v. Crouch*, S.D.W.V. (deposition); and *C.R. v. Blue Cross Blue Shield*, W.D. Wash. (deposition).

C. *Compensation*

16. I am being compensated at an hourly rate of \$400/hour plus expenses for my time spent preparing this report and subsequent declaration 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.

D. *Bases for Opinions*

17. In preparing this report, I have reviewed the text of documents adopted by the Florida Boards of Medicine and Osteopathic Medicine titled “Surgical Treatments for Adults with Gender Dysphoria (DH5084-MQA (Rev. 06/23)). The opinions contained in this report are based on all of the following: (1) my clinical experience of over 28 years of caring for transgender patients, including my

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experience teaching other surgeons and medical students to care for this population; (2) my review and familiarity with relevant peer-reviewed literature, including my own, regarding gender confirming surgeries, which reflects the clinical advancements in these procedures and the corresponding growth in research related to the safety and effectiveness of these procedures in treating gender dysphoria; and (3) discussions with colleagues and other experts in the field, including attendance and participation in various educational conferences both nationally and internationally.

II. EXPERT OPINIONS

18. In my expert opinion, the forms are riddled with misstatements and written in a way that will cause more confusion than clarity in a patient preparing to undergo a surgical procedure to treat gender dysphoria. This is true for a number of reasons.

19. Page 1 (“What are the types of surgery to treat gender dysphoria?”). As an initial matter, the forms address a wide range of surgeries, many, and likely most, of which will be wholly inapplicable to an individual patient. As just one example, the form includes descriptions for both a vaginoplasty and a phalloplasty. Setting aside the inaccuracies in each description, which I detail below, no patient will undergo both a phalloplasty and a vaginoplasty. A phalloplasty is a surgical procedure performed on transgender men. A vaginoplasty is a surgical procedure performed on transgender women. There is no purpose for describing a vaginoplasty in an informed consent form to be reviewed and signed by a transgender man. The inclusion of a description of a surgical procedure a patient is not and would never undergo is confusing, disrupts the patient-surgeon relationship, and undermines informed consent.

20. Page 1, Paragraph 3 (“Medical treatment of people with gender dysphoria...”). The form also begins with a misstatement of the evidence that

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supports the efficacy of surgeries for gender dysphoria. It is incorrect to state that the “practice is purely speculative.” It is also wrong to say that the “treatment of people with gender dysphoria is based on very limited, poor- quality research with only subtle improvements seen in some patient’s psychological functioning in some, but not all, research studies.” There are decades of research demonstrating the efficacy of gender confirming surgeries to treat patients with gender dysphoria, and there have been many studies that show very positive results in ameliorating the effects of gender dysphoria. While the quality of the evidence for much of the research is characterized as “low” because of the hierarchy of evaluation of study designs, the language in the forms is inaccurate and conveys misinformation to a patient.

21. Page 1, Paragraph 3 (“ . . . in many cases, the need for lifelong medical treatments.”). It is also misleading to say that surgeries will result in the need for lifelong treatment. As an initial matter, all patients—transgender or not—have a need for lifelong treatment. That is, generally speaking, healthy medical practice. But there is no correlation between gender confirming surgeries and an increased need for lifelong treatment. In fact, some procedures reduce the need for certain follow-up care. For example, a transgender man who gets male chest reconstruction along with breast removal will have lowered his risk of breast cancer and, therefore, minimized a need for regular mammograms. A transgender woman who receives a vaginoplasty will require annual speculum exams, but the same patient would still have required an annual prostate exam, notwithstanding the vaginoplasty. The statement about a need for life-long treatment is a distortion because, gender confirming surgery may impact the *type* of routine medical care required, it does not create a need for routine medical care. This distortion undermines rather than enhances informed consent. While it is true that the WPATH Standards of Care

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recommend annual visits for follow-up, that is not the same as stating that gender confirming surgical procedures create the need for life-long treatment.

22. In addition, there are misstatements about many of the surgical procedures themselves. These include the following:

23. Page 1, Orchiectomy: An orchiectomy is not only performed by a urologist. Plastic surgeons, general surgeons, and gynecologists specializing in gender confirming care also routinely perform this surgical procedure. Further, the description of orchiectomy includes only one surgical approach (scrotal incision), but there are other effective surgical approaches for this procedure, including an inguinal approach.

24. Page 2, Vaginoplasty: The description of vaginoplasty states that “[f]or those patients treated with puberty blockers as a minor, such treatment may lead to insufficient penile tissue that could necessitate the use [of] other tissues, such as the colon, to create a vagina.” This statement is relevant to the informed consent discussion when *initiating* blockers, but not when a provider is seeking informed consent for a vaginoplasty. Further, a patient may have insufficient penile *and* scrotal tissue for a number of reasons other than the use of puberty blockers, including, but not limited to, congenital factors, normal anatomic variation, obesity, and previous circumcision. Additionally, tissue, other than that from the colon, may be used to line the vagina, including, but not limited to, skin, small intestine, peritoneum, and tissue substitutes (i.e. allograft, xenograft).

25. Page 2, Phalloplasty: The description of phalloplasty excludes the full range of surgical options for the procedure which may be performed in a number of ways and stages depending on the patient’s clinical needs and desired outcomes. For example, a patient can have a shaft only phalloplasty without the construction of a urethral channel. The procedure may also be performed in a manner that maintains the vaginal canal and uterus. The description purports to

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comprehensively describe the procedure but describes just one method of surgical procedure while disregarding other routine methods. The techniques used in staging these procedures also vary. For example, we currently perform hysterectomy and vaginectomy at the first stage of a phalloplasty which may also include lengthening of the perineal urethra. The second stage is then construction of the shaft, typically with either forearm, thigh, abdomen, groin, or back tissue. The description of prosthetics is limited and underinclusive. There are both malleable and inflatable penile prosthesis, each with its own advantages and disadvantages.

26. Page 2, Metoidioplasty: The description of metoidioplasty indicates that “[a] urethra is also reconstructed using either local skin tissue or a graft from the mouth” However, this procedure may also be performed without urethral reconstruction. Also, typically, testicular prostheses are not placed at the same time that urethral reconstruction is performed. Prostheses are typically placed at a later date.

27. Page 2, Hysterectomy: The description of hysterectomy is also underinclusive in that it excludes other surgical approaches, notably the option of robotic or traditional ‘open’ techniques.

28. Page 3 (“What happens after surgery to treat gender dysphoria?”). This section underestimates the length of swelling for most procedures. Part of providing informed consent in a shared decision-making process, is discussing, understanding, and ‘managing’ expectations. It is not reasonable to assume that swelling will last for only two to four weeks following cheek and nose surgery. The return to activity following ‘bottom surgery,’ a non-specific term for a range of surgical procedures which may include transfeminine and/or transmasculine procedures, likely underestimates the period of recovery, especially following phalloplasty.

29. Page 3 (“When should I see my surgeon?”). This section omits

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important risks involved in any surgical procedure performed under general anesthesia such as difficulty breathing, chest pain, shortness of breath (i.e., warning signs of Deep Vein Thrombosis/Venous Thromboembolism/Pulmonary embolus).

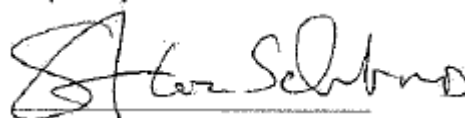
30. Page 3 (“What are some potential complications of surgery to treat gender dysphoria?”). The list of surgical risks is confusing because it lists surgical risks that many patients will not face because of the nature of their surgery. For example, a patient undergoing facial feminizing surgery does not have a risk of problems with urination or diminishment of bladder function.

III. CONCLUSION

The informed consent forms required by the State Boards of Medicine and Osteopathic Medicine include factual inaccuracies about the nature and risks of surgical procedures performed to treat gender dysphoria. These misstatements will result in patient confusion and serve to subvert, rather than strengthen, the informed consent process.

I declare under penalty of perjury that the foregoing is true and correct.
Executed this 16th day of August 2023.

Respectfully submitted.

A handwritten signature in black ink, appearing to read "Loren Schechter", written over a horizontal line.

Loren Schechter, M.D.

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Exhibit A
Curriculum Vitae

Curriculum Vitae

NAME: LOREN SLONE SCHECHTER, MD, FACS

OFFICE: Rush University Medical Center
1725 W. Harrison St
Suite 758
Chicago, Il 60712
312.942.3640

E-MAIL: loren_schechter@rush.edu
lorenschechter1@gmail.com

MARITAL STATUS: Married (Rebecca Brown Schechter, MD)

CERTIFICATION: The American Board of Plastic Surgery 2001
Certificate Number 6271
Date Issued: September 2001
Maintenance of Certification: 2011
Maintenance of Certification: 2021

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 Coordinated Training Program in Plastic and Reconstructive Surgery	1994-1999
Chief Resident:	The University of Chicago Hospitals Section of Plastic and Reconstructive Surgery	1998-1999
Fellowship:	Reconstructive Microsurgery The University of Chicago Hospitals Section of Plastic and Reconstructive Surgery	1999-2000

TEACHING APPOINTMENT and CURRENT PRACTICE LOCATION:

Professor of Surgery (Department of Surgery, Division of Plastic Surgery with joint appointment in the Department of Urology), Chief Section of Gender-Affirmation Surgery, Rush University Medical Center
Director, Gender Affirmation Surgery-Rush University Medical Center

LICENSURE: Illinois
Illinois Controlled Substance
DEA
Georgia

STAFF APPOINTMENTS:

Rush University Medical Center
 Advocate Lutheran General Hospital
 Louis A. Weiss Memorial Hospital

HONORS AND AWARDS:

2022	WPATH award for Courage and Bravery
2022	Chicago Magazine Top Doctor
2021	Chicago Magazine Top Doctor-Surgery
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 48 th 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:

2023-	Society of Gender Surgeons
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:

Patient Safety and Quality Officer, Division of Plastic Surgery, Rush University Medical Center

PROFESSIONAL SOCIETY COMMITTEES:

Committee on Sex and Gender Identification and Implications for Disability Evaluation, The National Academies for Science, Engineering, and Medicine

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

Contractor Advisory Committee, National Government Services Inc

OTHER:

American Board of Plastic Surgery-Oral Board Guest Examiner (2020, 2021)

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:

Clinical Professor of Surgery, The University of
Illinois at Chicago

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, Physician Assistant Program,
College of Health Professionals, Rosalind Franklin
University

Associate Professor of Surgery, The College of Health
Professionals, Rosalind Franklin University

Clinical Associate in Surgery, The University of
Chicago

PREVIOUS HOSPITAL COMMITTEES:

Director, Center for Gender Confirmation Surgery,
Louis A. Weiss Memorial Hospital

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
9. Georgetown University, Department of Plastic Surgery, July 21, 2022
10. Galilee Medical Center, Nahariya, Israel, Department of Obstetrics and Gynecology, July 1-11, 2023

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."

Honorary Lecture:

1. 2023 Arthur D. Bevan Lectureship, The Chicago Surgical Society, February 2, 2023, Chicago, IL

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 ASPS 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 Smotrich, 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

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10. Lawrence J. Gottlieb, Alex Kaplan, Kirstin Stenson, **Loren Schechter**: The Thoracoacromial Trunk as a Recipient Vessels: A Lifeboat in Head and Neck Reconstruction, The Journal of Reconstructive Microsurgery, 18(6):563, 2002.
11. Liza C. Wu M.D., **Loren S. Schechter, M.D.**, Robert F. Lohman M.D., Robin Wall, P.A., Mieczyslawa Franczyk, P.T., Ph.D.: Defining the Role for Negative Pressure Therapy in the Treatment Algorithm of Extremity Wounds, Plastic Surgical Forum, Vol. XXV, p.245 2002.
12. Liza C. Wu, **Loren S. Schechter**, Robert F. Lohman, Somchai Limsrichamren, Charles G. Winans, J. Michael Millis, and David C. Cronin: Implantable Doppler Probe for Continuous Monitoring of Hepatic Artery and

Portal Vein Blood Flow in Pediatric Liver Transplantation, The Journal of Reconstructive Microsurgery, 19(7): 517, 2003.

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
15. **Loren S. Schechter, MD, FACS**, James Boffa, MD, Randi Ettner, Ph.D., and Frederic Ettner, MD: Revision Vaginoplasty With Sigmoid Interposition: A Reliable Solution for a Difficult Problem, The World Professional Association for Transgender Health (WPATH) 2007 XX Biennial Symposium P. 31-32
16. Jacob M.P. Bloom, MS, Alvin B. Cohn, MD, Benjamin Schlechter, MD, Nancy Davis, MA, **Loren S. Schechter, MD**, Abdominoplasty and Intra-Abdominal Surgery: Safety First, Plastic Surgery Abstract Supplement vol. 120, no 4, p. 99
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
18. Michael Salvino, MD and **Loren S. Schechter, MD**, Microvascular Reconstruction of Iatrogenic Femoral Artery Injury in a Neonate, The Midwestern Association of Plastic Surgeons Book of Abstracts, April 18-19, 2009, p.65
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
20. Iris A. Seitz, MD, PhD, Sarah Friedewald, MD, Jonathon Rimler, BS, **Loren Schechter, MD, FACS**, Breast MRI Helps to Define the Blood Supply to the Nipple-Areolar Complex, Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, p.26
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
22. Iris A. Seitz, MD, PhD, Craig Williams, MD, **Loren Schechter, MD, FACS**, Facilitating Harvest of the Serratus Fascial Flap with Ultrasonic Dissection, Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, p. 29

23. Michelle Roughton, MD, **Loren Schechter, MD, FACS**, Patient Safety: Abdominoplasty and Intra-Abdominal Procedures, Advocate Research Forum, Research and Case Report Presentation Abstracts, Advocate Lutheran General Hospital, May 5, 2010, p. 20
24. Iris A. Seitz, MD, PhD., Sarah M. Friedewald, MD, Jonathon Rimler, BS, **Loren S. Schechter, MD, FACS**, Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, Abstract, P. 44.
25. Loren S. Schechter, MD, FACS, Gender Confirmation Surgery in the Male-to-Female Individual: A Single Surgeon's Fourteen Year Experience, Annals of Plastic Surgery, Vol. 74, Suppl. 3, June 2015, p. s187.
26. 25th WPATH Symposium, Surgeons Only, November 1, 2018, Buenos Aires, Argentina, A Novel Approach for Neovagina Configuration During Vaginoplasty for Gender Confirmation Surgery
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
30. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Gender Surgeons Experience with Detransition and Regret

PRESENTATIONS:

1. Student Summer Research Poster Forum-The University of Chicago, Jan. 21, 1992: "A Comparison of Dynamic Energy Expenditure Versus Resting Energy Expenditure in Burn Patients Using The Doubly Labeled Water Method"
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-Distracton: 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 (DGPREAC), 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
118. "Uterine Transplantation and Donation in Transgender Individuals; Proof of Concept," World Professional Association for Transgender Health 27th Scientific Symposium, September 16-20, 2022, Montreal, Canada
119. Differences and Similarities of Vaginoplasty Techniques Throughout the World: Is There a Consensus?, World Professional Association for Transgender Health 27th Scientific Symposium, September 16-20, 2022, Montreal, Canada
120. Sigmoid Vaginoplasty for Primary Gender Affirming Vaginoplasty, Brielle Weinstein, Brendan O'Donnell, Henry Govekar, Loren Schechter, Chicago Surgical Society Colorectal Symposium Poster Session, March 18, 2023, Chicago, IL

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) ASPSP/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
80. WPATH GEI, Online GEI Foundations Course, Moderator, August 31, 2021.
81. WPATH Health Plan Provider (HPP) Training, Q&A Panel, September 13, 14, 21 2021, via Zoom
82. WPATH, GEI Advanced Medical Course, Upper and Lower Surgery (via zoom), December 9, 2021
83. I want to be a gender surgeon: where do I even start, American Society for Reconstructive Microsurgery, Annual Meeting, January 17, 2022, Carlsbad, CA
84. Faculty Instructor, Upper Extremity Flaps and Lower Extremity Trauma, 1st Annual Rush University – University of Chicago Cadaver Lab, June 11, 2022
85. WPATH Health Plan Provider (HPP) Training, Q&A Panel, July 12, 2022, via Zoom
86. Nonbinary Workshop, WPATH GEI, July 23, 2022, via Zoom
87. WPATH GEI Advanced Ethics workshop (2022-2023), September 17-18, 2022, Montreal, Canada
88. Course Director: 3rd Live Surgery Conference for Gender Affirmation Procedures presented by MT. Sinai and WPATH May 11-13, 2023, New York, New York

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)

26. WPATH Journal Club #3, Uterine Transplantation and Donation in Transgender Individuals; Proof of Concept, December 13, 2021 (Zoom)

27. Program Coordinator and Moderator, Surgeon's Only Course, WPATH 27th Scientific Symposium, September 16-17, 2022, Montreal, Canada

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, Northwestern 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, 2020

17. Natalia Whitney, Randi Ettner, **Loren Schechter**, Sexual Function Expectations, Outcomes, and Discussions for Patients Undergoing Gender-Affirming Surgery, 2022 Trainee Research Day, Rush University Medical Center, The Irwin Press Patient Experience Research Poster Award

18. Natalia Whitney, Randi Ettner, **Loren Schechter**, Sexual Function Expectations, Outcomes, and Discussions for Patients Undergoing Gender-Affirming Surgery, 2022 Trainee Research Day, Rush University Medical Center, Peoples Choice-Third Place Poster Presentation

19. Adam Steur, Christy Ciesla, Clarion Mendes, Loren Schechter, The Need for a Comprehensive Interprofessional Postsurgical Rehabilitation Pathway: Initial Recommendations and Future Visions, The World Professional Association for Transgender Health, 27th Scientific Symposium, Surgeon's Only Program September 16-17, 2022, Montreal, Canada

20. Brielle Weinstein, MD, Kristin Jacobs, MD, Edward Cherullo, MD and Loren Schechter, MD, Illinois Surgical Society, Interesting Case Competition: Revision Vaginoplasty, April 22, 2023, Chicago, IL

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 Sugery, 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)
220. Gender Confirmation Surgery, Grand Rounds, Rush University, Section of Urology, June 8, 2021.
221. Genitourinary introduction lecture, M2, Rush University School of Medicine, September 2, 2021 (by Zoom)
222. Demystifying Gender: Fostering Gender Friendly Healthcare, Gender Affirmative Care in Adults, Querencia (Lady Hardinge Medical College, WHO Collaborating Center for Adolescent Health, Dept of Paediatrics, JSCH & LHMC, New Delhi, WPATH September 5, 2021 (by zoom)
223. Gender Confirmation Surgery, The University of Chicago Pritzker School of Medicine, MS-1, Anatomy lecture, September, 14, 2021, Chicago IL.
224. Gender Confirmation Surgery, A Single Surgeon's 22 Year Experience: Where are We Now?, Research Seminar, Section of Endocrinology, The University of Chicago, Chicago, IL, October 4, 2021 (by Zoom)
225. Chest Surgery, The Illinois Dept. of Corrections (by zoom), October 13, 2021.
226. Vaginoplasty, The Illinois Dept. of Corrections (by zoom), October 15, 2021.

227. International Continence Society, 20th Physioforum, Pelvic Floor Physical Therapy and Gender-Affirming Surgery, October 16, 2021, Melbourne, Australia (by Zoom)
228. Rush University Division of Plastic Surgery, Gender Affirmation Surgery: Where Are We Now?, educational conference, November 23, 2021, Chicago, IL
229. 51 Congreso Argentino de Cirugia Plastica, Microsurgery Symposium, SACPER-FILACP, 3 Step Approach to Lower Extremity Trauma, November 29, 2021, Mar del Plata, Argentina
230. 51 Congreso Argentino de Cirugia Plastica, Genital Aesthetics and Gender Confirmation Surgery I, "Gestión Quirúrgica de la Disforia de Género: Descripción general del manejo quirúrgico y los estándares de atención," December 1, 2021, Mar del Plata, Argentina
231. 51 Congreso Argentino de Cirugia Plastica, Genital Aesthetics and Gender Confirmation Surgery II, Cirugía Genital Masculinizante (Metoidioplastia y Faloplastia), December 2, 2021, Mar del Plata, Argentina
232. 51 Congreso Argentino de Cirugia Plastica, Genital Aesthetics and Gender Confirmation Surgery III, Faloplastia: optimización de resultados y reducción de complicaciones, December 2, 2021, Mar del Plata, Argentina
233. Government of India, Ministry of Health and Welfare, National AIDS Control Organization, Meeting with AIIMS on Gender Affirmation Care (GAC) Clinic Pilot Intervention, December 21, 2021, New Delhi (virtual)
234. Affirming Care for Gender Diverse Patients, Rosalind Franklin University, January 5, 2022, North Chicago, IL (Virtual by Zoom)
235. Sub-Unit Transplantation, Penile Transplant, WSRM/ASRT Mini-Symposium VCA Transplant, World Society for Reconstructive Microsurgery/American Society for Reconstructive Transplantation/American Society for Reconstructive Microsurgery Annual Meeting, January 14, 2022, Carlsbad, CA
236. Strategies for Penile Transplantation, American Society for Reconstructive Microsurgery, Annual Meeting, January 16, 2022, Carlsbad, CA
237. ASRM/WSRM/ASRT Battle of the Frontiers: To Transplant or Not? Conventional Reconstruction (Phalloplasty), American Society for Reconstructive Microsurgery, Annual Meeting, January 16, 2022, Carlsbad, CA
238. Strategies for Penile Innervation, American Society for Gender Surgeons, Annual Meeting, January 18, 2022, Carlsbad, CA
239. Pathway To Informed Consent: Vaginoplasty, Illinois Dept. of Corrections (virtual), February 10, 2022
240. Gender Confirmation Surgery From Top to Bottom: A Single Surgeon's 22 Year Experience, Where are We Now, Grand Rounds (virtual), Department of Plastic Surgery, University of South Florida, February 14, 2022

241. Vaginoplasty: Dissection of the vaginal canal and selection of technique, International Confederation of Plastic Surgery Societies (ICOPLAST), First World Congress, Lima Peru May 19-21, 2022 (President of the session: Genital/Transgender Session 1)
242. Phalloplasty: Strategies to reduce complications and optimize outcomes, International Confederation of Plastic Surgery Societies (ICOPLAST), First World Congress, Lima Peru May 19-21, 2022
243. Chest Surgery in Transgender Men, International Confederation of Plastic Surgery Societies (ICOPLAST), First World Congress, Lima Peru May 19-21, 2022
244. Gender-Affirming Surgery: A 23 Year Experience Where are we now, 65th Annual Scientific Meeting, Southeastern Society of Plastic and Reconstructive Surgeons (Finding The Solutions Now and The Future), Orlando, Fl, June 11-15, 2022
245. Top Tips for Safety: The Culture of Safety, 65th Annual Scientific Meeting, Southeastern Society of Plastic and Reconstructive Surgeons (Finding The Solutions Now and The Future), Orlando, Fl, June 11-15, 2022
246. Uterine Transplantation, GAPS (Ghent Academy of Plastic Surgery) 2022: Bridging the Gap Between Reconstructive and Aesthetic Surgery, June 17-18, 2022, Ghent, Belgium
247. In Honor of Professor Stan Monstrey, GAPS (Ghent Academy of Plastic Surgery) 2022: Bridging the Gap Between Reconstructive and Aesthetic Surgery, June 17-18, 2022 Ghent, Belgium
248. "TRANS" Grand Rounds Panel Discussion (panel discussants: Loren S. Schechter, MD, Michaela West, MD, PhD, Courtney Cripps, MD, Ervin Kocjancic, MD), University of Chicago, Department of Surgery, July 6, 2022, Chicago, Il
249. Gender Affirming Surgery, Grand Rounds, July 12, 2022, Department of Urology, Rush University Medical Center, Chicago, Il
250. Gender Affirming Surgery, Gender Affirmation Lecture Series, Rush University Medical Center, July 15, 2022, Chicago, Il
251. Anatomy of A Lawsuit, Rush PRS Weekly Didactic Conference, Rush University Medical Center, Plastic and Reconstructive Surgery, July 20, 2022, Chicago, Il
252. Gender Affirmation Surgery: Where are We Now? The University of Chicago, Section of Plastic Surgery, Grand Rounds, August 10, 2022, Chicago, Il
253. Thriving in Sexual & Gender Diversity, The Transgender Patient, August 10, Virtual CME Event (broadcast from Dr. Shino Bay Aguilera's office in Miami, Fl)
254. Gender Affirming Medical and Surgical Therapies, Illinois College of Emergency Physicians Webinar, August 17, 2022

255. Gender Affirming Surgery Panel, Liebert Publishing, Webinar, August 26, 2022, Moderator: Jeffrey Spiegel, MD
256. Gender Confirmation Surgery, The University of Chicago Pritzker School of Medicine, MS-1, Anatomy lecture, September, 14, 2022, Chicago IL
257. Gender Affirmation Surgery: Where We Have Been and Where We are Going: GURS-WPATH Invited Lecture, Society of Genitourinary Reconstructive Surgeons, Academic Congress, Montreal, Canada, September 15, 2022
258. Phalloplasty: Optimizing Outcomes and Reducing Complications, North Carolina Society of Plastic Surgeons 2022 Annual Scientific Meeting, Pinehurst, North Carolina, October 7-9, 2022
259. Special Guest Lecture: Gender Affirmation Surgery: Where We've Been and Where We're Going, North Carolina Society of Plastic Surgeons 2022 Annual Scientific Meeting, Pinehurst, North Carolina, October 7-9, 2022
260. Diversity in Practice, North Carolina Society of Plastic Surgeons 2022 Annual Scientific Meeting, Pinehurst, North Carolina, October 7-9, 2022
261. Gender Affirming Surgery, Fenway/HMS Advances in Transgender Care, October 15, 2022
262. Genitourinary introduction lecture, M2, Rush University School of Medicine, October 26, 2022, Chicago, IL
263. Optimizing Aesthetics and Sensation in Vaginoplasty and Phalloplasty, The American Society of Plastic Surgeons 91st Annual Meeting (PSTM), Boston, MA, October 30, 2022
264. Gender-Affirming Surgery: From Top to Bottom, The Rush University Medical Center Departments of Emergency Medicine and Internal Medicine for the Emergency Medicine Grand Rounds Lecture, Chicago, IL, November 16, 2022
265. Dueling Perspectives in Transgender Surgery, New York Regional Society of Plastic Surgeons, New York, New York, November 19, 2022
266. Gender-Affirming Surgery: From Top to Bottom, Rush University Medical Center Department of Anesthesia Grand Rounds, November 30, 2022, Chicago, IL.
267. Gender-Affirming Surgery: Where We Have Been and Where We are Going, Mass General Brigham Center For Transgender Health, Grand Rounds, December 13, 2022 Boston, MA (lecture delivered virtually)
268. An Intro to Providing Gender Affirming Care to Gender Diverse Patients, Rosalind Franklin University, Chicago Medical School, December 21, 2022, North Chicago, IL (virtual by Zoom)
269. Surgical Techniques and Outcomes in Penile Reconstruction, WSRM/ ASRT Symposium on VCA in the Transgender Patient, Annual Meeting of The American Society for Reconstructive Microsurgery, January 20, 2023, Aventura, FL

270. Argument for Transgender Transplantation, WSRM/ ASRT Symposium on VCA in the Transgender Patient, Annual Meeting of The American Society for Reconstructive Microsurgery, January 20, 2023, Aventura, Fl
271. Moderator: Gender Surgery Symposium, Society of Gender Surgeons, January 24, 2023, Aventura, Fl
272. Trans female top surgery, 38th Annual Atlanta Breast Surgery Symposium, January 27-29-2023, Atlanta, GA
273. Trans male top surgery, 38th Annual Atlanta Breast Surgery Symposium, January 27-29-2023, Atlanta, GA
274. Top Surgery for Transgender Women, What Implant I use and Why, American Society of Plastic Surgeons Spring Meeting, March 4, 2023 (virtual)
275. Over The Top Surgery, The Aesthetic Meeting 2023, The American Society of Aesthetic Plastic Surgery, Miami Beach, Fl, April 22, 2023
276. Panel: Gender Affirming Surgery: Beyond the Knife, The American Association of Plastic Surgeons 101st Annual Meeting, April 29-May 2, 2023, Chicago, Il
277. SOC 8 Panel-What's New and How We Use It: 3rd Live Surgery Conference for Gender Affirmation Procedures presented by MT. Sinai and WPATH May 11-13, 2023, New York, New York
278. Meet the Professor, Long Term Outcomes After Gender Affirming Surgeries, Endo 2023, The Annual Meeting of The Endocrine Society, June 15-18, 2023, Chicago, IL
279. Gender-Affirming Surgery, Forensic Friday, Populations with Unique Needs, The Illinois Association of Forensic Nurses, June 16, 2023, Chicago, Il
280. Gender Affirmation Surgery, Galilee Medical Center, Nahariya, Israel, July 5, 2023
281. Gender Affirmation Surgery, Grand Rounds, Department of Obstetrics and Gynecology, Rabin Medical Center, Tel Aviv, Israel, July 6, 2023
282. Gender Affirmation Surgery: Where We've Been and Where We're Going, Midwestern Association of Plastic Surgeons (MAPS), Safety in Gender Affirmation Surgery Session, Grand Geneva Resort, Lake Geneva, Wisconsin, July 15, 2023

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE et al.,

Civil No. 4:23-cv-00114-RH-MAF

Plaintiffs,

v.

JOSEPH A. LADAPO et al.,

Defendants.

**EXPERT REPORT OF VERNON LANGFORD, DNP, APRN-CNP, FNP-C
ON BEHALF OF PLAINTIFFS**

August 16, 2023

Prepared by
Vernon Langford, DNP, APRN-CNP, FNP-C

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TABLE OF CONTENTS

	PAGE
I. INTRODUCTION AND SUMMARY OF OPINIONS	1
A. Background and Qualifications.....	2
B. Bases for Opinions.....	4
C. Prior Testimony.....	5
D. Compensation	5
II. EXPERT OPINIONS	5
A. SB 254’s Prohibition on Provision of Care by Highly Qualified and Skilled Medical Providers	5
B. Scope of Practice for Advanced Practice Registered Nurses and Nurse Practitioners.....	7
C. Nurse Practitioners Are Well Equipped to Provide Gender Transition Care.....	9
III. CONCLUSION.....	15

I. INTRODUCTION AND SUMMARY OF OPINIONS

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

2. Florida SB 254, creating Florida Statute 456.52(3), prohibits qualified medical providers, including but not limited to Autonomous Practice Registered Nurse (APRN) Nurse Practitioners (NPs) (hereinafter “APRN-NPs”), from prescribing evidence-based medical care to their transgender patients without justification.

3. Florida law has explicitly established the capacity of APRN-NPs to engage in autonomous practice, including providing the full scope of primary care. Florida’s autonomous practice statute is grounded in strong evidence, science, and decades of clinical practice experience. The treatment of gender dysphoria for transgender adults is part of the provision of ordinary primary care. Nurse practitioners routinely prescribe the full range of medications for the treatment of gender dysphoria.

4. SB 254 excludes from the scope of practice authority solely the prescribing of treatment for transgender patients while allowing the prescribing of treatments for non-transgender patients with no medical justification. This

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unnecessary restriction is causing significant harm to transgender individuals, including the thousands of transgender adults in Florida who have long received their healthcare from APRN-NPs and are now displaced and without access to needed medical care.

A. Background and Qualifications

5. I am a family nurse practitioner (NP), an advance practice registered nurse (APRN) licensed in both Florida and Texas, and a Registered Nurse (RN) licensed in both Florida and Texas. I have National Board Certification with the American Association of Nurse Practitioners (AANP), and Autonomous Practice (AP-APRN) registration on my APRN license in Florida.

6. I am a primary care provider with United HealthGroup's Landmark Health and also Citrus State Healthcare Consultants where I provide primary care and health policy consulting. I am speaking on behalf of myself as a subject matter expert and not as a representative of my employer(s).

7. I graduated with a Bachelor's of Science degree in Nursing (RN, BSN) from Bowling Green State University, where I received a Nursing Excellence Scholarship. I graduated with a Master's of Science in Nursing (MSN, FNP-C) from the University of Toledo, where I received a Dean's Scholarship. I graduated with a Doctorate in Nursing Practice (DNP) from the University of North Florida, where I received the Med Nexus Scholarship and the Allen Meek Nursing Scholarship.

8. I have worked as the lead nurse at the University of Toledo Medical Center, within the orthopedic and medical surgery PCU, as well as the urology and renal transplant PCU. I worked as a travel staff nurse in the hematology and oncology PCU at the Florida Hospital Orlando. And I worked as the Director of Clinical Evaluation in neurology and neuropathic interventions at the Florida Neuropathy and Pain Center.

9. As a certified Nurse Practitioner, I have extensive experience in the provision of primary care to adults in the state of Florida.

10. I am the President of the Florida Association of Nurse Practitioners, and I have been a leading member of the Association since 2015. I am the past co-chair of the Florida Coalition of Advanced Practice Nurses, and have been a member of the Coalition since 2017. I serve as the legislative Chair and Past President of the Central Florida Advanced Nursing Practice Council, which I have been a member of since 2012. I am a member of the Legislative Team of the Florida Nurses Association, and have been a member of the Association since 2012. I am the Florida State Advocacy Representative of the UnitedHealth Group Center for Clinician Advancement, I have been a member of the American Association of Nurse Practitioners since 2008, a member of the Sigma Theta Tau Nursing Honor Society since 2009, a member of the Florida Nurse Practitioner Network since 2015, and a member of the American Association of Men in Nursing since 2020. I have also

served as the Organization Delegate for the Quality and Unity in Nursing Organization since 2021, and an Organization Delegate of the National Action Coalition of Florida since 2021.

11. I have received numerous awards throughout my career, including the following awards from UnitedHealth Group / Optum Clinical Services: The Values in Action Award, the Sages of Clinical Services Award, and the Optum SuperHero Award. I have also received the Distinguished Service Award from the Central Florida Advanced Nursing Practice Council, the Nurse of the Year Award from the American Association for Men in Nursing, the Luther Christman Fellow award from the American Association of Men in Nursing, the Icon in Nursing Award from the Florida Nurses Association, and the recognition/award of America's Top NP for the specialty of Primary Care by the Point of Care Network (POCN).

12. The information provided regarding my professional background, experiences, awards, and professional memberships is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as Exhibit A.

B. *Bases for Opinions*

13. In preparing this report, I have relied upon my training and clinical experience, as set out in my curriculum vitae, and on the materials listed therein. I have also reviewed the materials listed in the attached bibliography, Exhibit B. 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.

14. In addition, I have reviewed the language of SB 254, which, among other things, unfairly and unjustifiably restricts the ability of Nurse Practitioners to provide evidence-based treatments for gender dysphoria to transgender individuals in the state of Florida.

C. *Prior Testimony*

15. I have not testified as an expert at trial or by deposition in the past four years.

D. *Compensation*

16. I am being compensated for my work on this matter at an hourly rate of \$350.00 for preparation of declarations and expert reports, and deposition and 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. *SB 254's Prohibition on Provision of Care by Highly Qualified and Skilled Medical Providers*

17. SB 254 limits those who can prescribe or administer essential transgender healthcare to physicians licensed to practice allopathic or osteopathic medicine, even though the State of Florida otherwise permits other qualified

providers, including APRN-NPs, to prescribe similar types of medication and administer similar forms of medical care to non-transgender persons.

18. SB 254 created Fla. Stat. § 456.52(3), which states that “[s]ex-reassignment prescriptions or procedures may not be prescribed, administered, or performed except by a physician.” The law defines the term “physician” as “a physician licensed under chapter 458 or chapter 459 or a physician practicing medicine or osteopathic medicine in the employment of the Federal Government.”

19. SB 254 provides that a medical provider who violates this provision commits, and may be prosecuted for, a misdemeanor in the first degree. Fla. Stat. § 456.52(5).

20. Restrictive laws like SB 254 interfere with the trust and confidentiality between patients and clinicians in the delivery of evidence-based, critical medical care. These laws also conflict with the obligations of every APRN-NP to promote, advocate, and protect the rights, health, and safety of their patients.

21. Florida SB 254 significantly limits access to gender transition care for transgender individuals in the state of Florida.

22. There is no medical justification for the state to arbitrarily carve out the healthcare needs of *only* transgender patients from the allowable scope of practice for APRN-NPs in Florida. The very same providers who are now banned from prescribing treatments to transgender patients are still free to prescribe the exact

same medications, including controlled substances like testosterone, to any other non-transgender patient for any other reason.

23. Supported by a growing body of evidence supporting the provision of care by APRNs, there has been a national effort to remove needless barriers to full practice authority from organizations such as the Institute of Medicine (IOM), the National Governors Association (NGA), the Federal Trade Commission (FTC), the Bipartisan Policy Center, and the Veteran’s Health Administration (VHA), among others. Shortages in primary care providers affect 1 in 5 Americans.¹ APRN-NPs are trained and able to help meet the significant unmet healthcare needs of Florida’s transgender population, but under SB 254 they are not permitted to do so with no medical basis.

B. *Scope of Practice for Advanced Practice Registered Nurses and Nurse Practitioners*

24. An autonomous-practice certified Advanced Practice Registered Nurse who is a nurse practitioner (“APRN-NP”) in Florida is an advanced practice nurse who is authorized to practice autonomously in the field of primary care practice, which is defined by administrative regulation as “physical or mental health promotion, assessment, evaluation, disease prevention, health maintenance,

¹ Vanfleet, A., Paradise, J. (2015). Tapping Nurse Practitioners to Meet Rising Demand for Primary Care. Kaiser Family Foundation. <https://files.kff.org/attachment/issue-brief-tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care>.

counseling, patient education, diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions.” Fla. Admin. Code Ann. 64B9-4.001(12) (2021).

25. APRN-NPs are qualified to properly diagnose gender dysphoria and recommend and prescribe appropriate medical treatment, such as puberty blockers and hormones.

26. Florida APRN-NPs have been diagnosing and prescribing hormone therapy for transgender patients for many years, including controlled substances (e.g. testosterone) since January 1, 2017.

27. In 2016, Florida APRN-NPs were granted full authority to prescribe DEA schedule II – V (controlled substance) medications on equal terms with licensed physicians within the framework of a supervisory protocol. This brought Florida into alignment with every other state in the country, each of which provide DEA licensure to APRN-NPs allowing them to prescribe controlled substances.

28. In 2020, recognizing APRN-NPs’ competence to provide care and Florida’s imminent shortfall of 18,000 practicing physicians by 2035, Florida passed Fla. Stat. § 464.0123 (the “Autonomous Practice Act”), that grants APRN-NPs who obtain autonomous practice certification under the law full authority to independently operate primary care practices in Florida without a supervising physician, upon meeting certain requirements.

29. Numerous studies demonstrate that NPs administer such services safely, achieve high quality results, and that patient satisfaction with NPs and their willingness to be seen by NPs is high.²

30. Data also demonstrates that without the provision of care by autonomous practice certified APRN-NPs, there would be a dramatic gap in access to medical care in Florida.³

C. Nurse Practitioners Are Well Equipped to Provide Gender Transition Care

31. APRN-NPs receive advanced education and numerous hours of specialized clinical training, providing them medical expertise comparable to primary care physicians. *Stucky et al.*, 2021.

32. APRN-NPs undergo rigorous education and training programs that prepare them to provide comprehensive and evidence-based care. They must hold either a master's or doctoral degree in nursing and have completed advanced clinical

² Barnes H, Richards MR, McHugh MD, Martsolf G. *Rural and Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners*. Health Aff (Millwood). 2018 Jun;37(6):908-914. doi: 10.1377/hlthaff.2017.1158. PMID: 29863933; PMCID: PMC6080248.

³ Florida HB 607, Health Quality Subcommittee Bill Analysis (March 27, 2020) (providing support for the necessity of the Florida Autonomous Practice Act, explaining “In 2018, Florida had a ratio of 86.8 primary care physicians providing direct patient care per 100,000 population,” and “[i]n its 2019 Physician Workforce Annual Report, the Department of Health (DOH) indicated that 12.5 percent of Florida’s physicians reported that they were planning to retire within the next five years, which will exacerbate Florida’s shortage of physicians.” The legislative analysis found that “not only does Florida have a shortage of physicians, but also there is a maldistribution of physicians and they are generally concentrated in urban areas.”)

training in their specialty area. NPs are trained to assess, diagnose, treat, and manage acute and chronic illnesses, as well as promote health and provide preventive care.

33. Most NP programs require between 500-1,000 hours of practicum training prior to graduating, in addition to the thousands of contact hours of clinical training in RN school and the subsequent work as an RN.

34. By way of example, I am an APRN-NP with an Autonomous Practice license in Florida, and I have completed more than 38,220 hours of clinical practice. Through my educational programs, I completed more than 1,700 total clinical hours (BSN-RN program (600 hours minimum); MSN-NP program (600 hours minimum); DNP-NP program (500 hours minimum)). As a full-time RN, I completed approximately 7,270 clinical hours, and as a full time NP, I have completed approximately 29,250 clinical hours.

35. One practice in Florida that serves about 2,500 transgender patients who are now without access to care was founded by a nurse practitioner who is an Autonomous Practice APRN-NP. He founded the practice in response to the desperate need for competent, qualified medical providers who could meet the needs of Florida's LGBTQ+ community, with the mission to provide top quality comprehensive primary healthcare options for LGBTQ+ individuals. Without access to APRN-NPs for the provision of their primary care, many among this patient population will not be able to obtain gender transition healthcare.

36. The founder of that practice, prior to receiving an Autonomous Practice license, completed an estimated 22,800 clinical hours (with 1,000 clinical hours in NP school, 500 clinical hours in RN school, and 500 clinical hours in LPN school, in addition to 2,080 hours of full-time nursing work over the course of the ten-year period).

37. Planned Parenthood of South, East and North Florida has more than 2,000 transgender patients who were seeing APRN-NPs, and whose access to treatment is now threatened. The predicted shortfall of 17,924 physicians in Florida by 2035 will further exacerbate transgender persons' ability to obtain care.⁴

38. Throughout the state, many transgender patients receive transition-related healthcare from APRN-NPs. According to data made available by the Florida Board of Nursing, there are approximately 51,989 APRNs licensed by the state of Florida, and approximately 44,556 of those are licensed nurse practitioners. The prohibition in SB 254 against transgender adult patients seeing anyone qualified to care and treat them other than a licensed physician results in many transgender patients unable to receive care.

⁴ IHS Markit. (2021, December). *Florida Statewide and Regional Physician Workforce Analysis: 2019 to 2035*. The Safety Net Hospital Alliance of Florida and the Florida Hospital Association. <http://safetynetsflorida.org/wp-content/uploads/Florida-Physician-Workforce-Analysis.pdf>.

39. Numerous studies demonstrate that APRN-NPs administer such services safely, achieve high quality results, and that patient satisfaction with APRN-NPs and their willingness to be seen by APRN-NPs is high.⁵

40. The WPATH Standards of Care, version 8, permits the provision of gender-affirming care by licensed and qualified healthcare providers, which include nurse practitioners. WPATH, Statement 5.1(a), at S33 (“We recommend health care professional assessing transgender and gender diverse adults for gender-affirming treatments: (a) Are licensed by their statutory body and hold, at a minimum, a master’s degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution[,]” going on to list “general medical practitioner” and “nurse” among potentially qualified health care providers who could meet the criteria if they have, “at a minimum a masters-level qualification in a clinical field related to transgender health or equivalent further clinical training and [are] statutorily regulated; examples include a mental health professional (MHP), general medical practitioner, nurse, or other qualified HCP.”); *id.* at S34 (“The need to include an HCP with some expertise in mental health does not require the inclusion of a psychologist, psychiatrist, or social worker in each assessment.

⁵ Hilary Barnes, et al., *Physician Practices Increasingly Rely On Nurse Practitioners*, 37(6) Health Aff. 908 (2018).

Instead, a general medical practitioner, nurse, or other qualified HCP could also fulfill this requirement[.]”).⁶

41. The WPATH Standards of Care also state that transgender healthcare can be provided in the course of ordinary primary care as long as the qualified provider has the necessary competency in caring for transgender patients, and that primary care providers include, among others, “nurse practitioners, advanced practice nurses, [and] physician associates/assistants[.]”. *Id.*, WPATH SOC v. 8, at S143.

42. The diagnosis of gender dysphoria in adults can be made by a health care provider with relevant expertise and training in identifying and making mental health care diagnoses. This may include a primary care provider, autonomous practice certified advanced practice registered nurse, psychiatrist, psychologist, or licensed social worker or therapist.

43. APRN-NPs can help address the primary care provider shortage by providing essential healthcare services, particularly in underserved areas. According to a study published in Health Affairs, states with greater NP practice autonomy have a higher likelihood of improved access to care for vulnerable populations.⁷

⁶ Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health*. 2022 Sep 6;23(Suppl 1):S1-S259.

⁷ Ortiz J, Hofler R, Bushy A, Lin YL, Khanijahani A, Bitney A. *Impact of Nurse Practitioner Practice Regulations on Rural Population Health Outcomes*. Healthcare (Basel). 2018 Jun 15;6(2):65. doi: 10.3390/healthcare6020065. PMID: 29914051; PMCID: PMC6023304.

44. Numerous studies have shown that NPs provide safe and effective care comparable to physicians, leading to positive patient outcomes. A systematic review published in the Journal of the American Medical Association (JAMA) found that NPs deliver high-quality care and achieve equivalent or better patient outcomes compared to physicians.⁸ Another study published in the New England Journal of Medicine reported similar patient outcomes for NPs and physicians in managing chronic conditions such as diabetes and hypertension.⁹

45. A study published in the Journal of Nursing Economics found that expanded NP practice authority led to reduced hospitalization rates and lower healthcare costs. *Fairman et al.*, 2011.

46. The American Association of Nurse Practitioners (AANP) reports that NPs provide cost-effective care, with each primary care NP capable of generating an average of \$1.02 million in cost savings annually. American Association of Nurse Practitioners, 2022.

⁸ Mundinger MO, Kane RL, Lenz ER, et al. Primary care outcomes in patients treated by nurse practitioners or physicians: a randomized trial. JAMA. 2000 Jan 5;283(1):59–68.

⁹ Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. *Substitution of doctors by nurses in primary care*. The Cochrane database of systematic reviews. 2005;(2) CD001271.

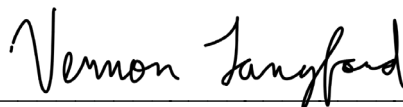
47. A study published in the Journal for Nurse Practitioners found that patients who received care from NPs were highly satisfied and valued the autonomy and accessibility of NPs.¹⁰

III. CONCLUSION

48. The restrictions contained in SB 254 prohibit highly qualified medical providers from prescribing treatments for transgender patients with no medical justification. This unnecessary restriction is causing significant harm to the thousands of transgender individuals in Florida who have long received their healthcare from APRN-NPs. SB 254 creates unjustifiable, harmful barriers to care for transgender Floridians.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 16th day of August, 2023.



Vernon Langford, DNP, APRN-CNP, FNP-C

¹⁰ Carthon JMB, Brom H, Poghosyan L, Daus M, Todd B, Aiken L. *Supportive Clinical Practice Environments Associated With Patient-Centered Care*. J Nurse Pract. 2020 Apr;16(4):294-298. doi: 10.1016/j.nurpra.2020.01.019. Epub 2020 Mar 11. PMID: 32863798; PMCID: PMC7454202.

Exhibit A

Curriculum Vitae

Vernon Matthew Langford DNP, APRN-CNP, FNP-C

1411 Crocus Court ♦ Longwood, FL 32750 ♦ 313-522-9468

VernonLangford@gmail.com

CREDENTIALS

AANP National Board Certification	F0711499	July 2011 – July 2026
RN License, State of Florida	RN9322191	April 2011 – June 2024
APRN License, State of Florida (Autonomous)	APRN9322191	October 2011 – June 2024
National Provider Identifier (NPI)	1609153824	November 2011 – Current
RN License, State of Texas	RN908531	September 2016 – August 2022
APRN License, State of Texas	AP132336	October 2016 – August 2022
Medicare Provider PTAN	FT1982	January 2012 – Current

EDUCATION

Doctorate in Nursing Practice (DNP)	August 2022
University of North Florida, Jacksonville, Florida	
Med Nexus Scholarship, Allen Meek Nursing Scholarship	
Master of Science in Nursing (MSN, FNP-C)	May 2011
University of Toledo, Toledo, Ohio	
Dean's Scholarship	
Bachelor of Science in Nursing (RN, BSN)	August 2008
Bowling Green State University, Bowling Green, Ohio	
Ruth Kelly Scholarship, Nursing Excellence Scholarship	
Associate in Science in Business Administration (AS)	December 2014
Valencia College, Orlando, Florida	
President's List	
Technical Certificate: Business Management	December 2014
Technical Certificate: Business Operations	
Technical Certificate: Business Specialist	
Valencia College, Orlando, Florida	

CERTIFICATIONS

CPR With AED	2008-Current
BLS CPR Healthcare Provider	2008-Current
Notary Public	STATE OF FLORIDA 2014-2024

PROFESSIONAL EXPERIENCE

Orthopedic / Med-Surg PCU (Staff / Charge Nurse)	August 2008 - May 2010
University of Toledo Medical Center (Level 1 Trauma Center)	

Hematology/Oncology PCU (Travel Staff Nurse) October 2011-January 2012
 Florida Hospital Orlando (Level 3 Trauma Center)

Neurology/Neuropathic Interventions (APRN/ Director of Clinical Evaluation) December 2011-May 2015 Florida
 Neuropathy and Pain Centers Inc. (Specialty Clinic Practice)

- Provide medical evaluations with medication and co-morbidity counseling based on acuity
- Dual administrative and clinical roles to set healthcare policies and procedures while treating advancing neurological deficits with cardiac complications
- Perform comprehensive initial and routine assessments while collaborating with multidisciplinary team to facilitate optimal outcomes in cases of life limiting illnesses involving diagnosis and appropriate prescribing
- Hire and train clinical staff, facilitate annual performance reviews, provide plans to improve operational efficiency, coach and terminate providers if indicated

Primary Care Provider/Healthcare Policy Consultant (Medical Director / CEO) June 2013-Current
 Citrus State Healthcare Consultants (Health Policy and Insurance Appeals Consultation)

- Provide subject matter expertise in care plan analysis, solution development, risk management, performance improvement, and quality improvement
- Oversee the development of policy to Medicare Approved Contractor Local Coverage Determination adherence and the Medicare Claim Appeals process
- Manage staff development and monitor provider engagement to meet and exceed performance goals
- Optimize utilization of resources for patient care with compliance to healthcare statutory regulations
- Develop business development strategies for specific clinical populations to optimize office revenue

Primary Care Home Health (APRN – Florida Statewide Traveler) May 2015-Current
 UnitedHealth Group / Optum HouseCalls (Home Health Assessment)

- Completion of in-home medical assessments to include the PMH, physical exam, ROS, prescription and supplement review and psychosocial/psychiatric screening
- Medication education to improve comprehension and adherence based on member-specific disease processes
- Documentation compliance to national preventative care standards with HIPAA guidance, HEDIS, and STAR quality measures
- Communication with the members multidisciplinary care team to improve health outcomes relevant to their future treatment and screenings while diagnosing current disease processes

PROFESSIONAL AFFILIATIONS

American Association of Nurse Practitioners (Student / Professional)	2008-Current
Sigma Theta Tau Nursing Honor Society	2009-Current
Central Florida Advanced Nursing Practice Council (Legislative Chair/Past-President)	2012-Current
Florida Nurses Association (Legislative Team / Health Policy SIG)	2013-Current
Florida Association of Nurse Practitioners (President)	2015-Current
Florida Nurse Practitioner Network (Leadership Think Tank)	2015-Current
Florida Coalition of Advanced Practice Nurses (Past Co-Chair)	2017-Current
American Association of Men in Nursing (UHG Chapter President)	2020-Current
UnitedHealth Group Center for Clinician Advancement (Florida State Advocacy Rep)	2021-Current
Quality and Unity in Nursing (Organization Delegate)	2021-Current
National Action Coalition of Florida (Organization Delegate)	2021-Current

AWARDS

Values in Action Award	UnitedHealth Group / Optum Clinical Services	2017
Distinguished Service Award	Central Florida Advanced Nursing Practice Council	2018-2019
Nurse of the Year Award (UHG)	American Association for Men in Nursing	2019
Sages of Clinical Services Award	UHG / Optum Center for Clinician Advancement	2019
Optum SuperHero Award	UHG / Optum Center or Clinician Advancement	2021
Luther Christman Fellow	American Association of Men in Nursing	2021
Icon in Nursing Award (Advocacy)	Florida Nurses Association	2021

SPECIAL SKILLS / PROFICIENCIES

Clinical Preceptor for Health Assessment - South University and University of South Florida

Highly Proficient with: eHouseCalls Medical Software Application

SharePoint Team Collaborative Software

Microsoft Teams Video Conferencing Platform

Microsoft Office Suite (Word, Excel, Outlook, PowerPoint, Publisher)

Clinical Experience / Competency in: Healthcare Management, Clinical Leadership, Team Management,

Cultural Competency, Utilization Management, Diversity and Inclusion Fluency, Wound Care, Suturing,

Diabetes Education, Health Promotion, EKG's, Phlebotomy, Primary Care, Nutritional Counseling, Quality

Improvement, and Diagnosis and Treatment of multi-system disorders

Exhibit B

Bibliography

BIBLIOGRAPHY

2022 *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-V), Text Revision.

Barnes H, Richards MR, McHugh MD, Martsolf G. *Rural and Nonrural Primary Care Physician Practices Increasingly Rely On Nurse Practitioners*. *Health Aff (Millwood)*. 2018 Jun;37(6):908-914. doi: 10.1377/hlthaff.2017.1158. PMID: 29863933; PMCID: PMC6080248.

Carthon JMB, Brom H, Poghosyan L, Daus M, Todd B, Aiken L. *Supportive Clinical Practice Environments Associated With Patient-Centered Care*. *J Nurse Pract*. 2020 Apr;16(4):294-298. doi: 10.1016/j.nurpra.2020.01.019. Epub 2020 Mar 11. PMID: 32863798; PMCID: PMC7454202.

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Mundinger MO, Kane RL, Lenz ER, et al. Primary care outcomes in patients treated by nurse practitioners or physicians: a randomized trial. *JAMA*. 2000 Jan 5;283(1):59–68.

Ortiz J, Hofler R, Bushy A, Lin YL, Khanijahani A, Bitney A. *Impact of Nurse Practitioner Practice Regulations on Rural Population Health Outcomes*. *Healthcare (Basel)*. 2018 Jun 15;6(2):65. doi: 10.3390/healthcare6020065. PMID: 29914051; PMCID: PMC6023304.

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Vanfleet, A., Paradise, J. (2015). *Tapping Nurse Practitioners to Meet Rising Demand for Primary Care.* Kaiser Family Foundation. <https://files.kff.org/attachment/issue-brief-tapping-nurse-practitioners-to-meet-rising-demand-for-primary-care>.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE et al.,

Plaintiffs,

Civil No. 4:23-cv-00114-RH-MAF

v.

JOSEPH A. LADAPO et al.,

Defendants.

**EXPERT REPORT OF KENNETH W. GOODMAN, PhD, FACMI, FACE
ON BEHALF OF PLAINTIFFS**

August 16, 2023

Prepared by
Kenneth W. Goodman, PhD, FACMI, FACE

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TABLE OF CONTENTS

	Page
I. INTRODUCTION AND SUMMARY OF OPINIONS.....	1
A. Background and Qualifications.....	2
B. Bases For Opinions	3
C. Compensation.....	4
D. Prior Testimony.....	4
II. EXPERT OPINIONS.....	5
A. The GAPMS Report Erroneously Concludes That There is Little or No Evidence For The Benefits of Medical Care for Gender Dysphoria	5
B. The Board’s Informed Consent Requirements Depart from Well- Established Principles of Medical Ethics	11

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I. INTRODUCTION AND SUMMARY OF OPINIONS

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

2. The Florida Board of Medicine and Osteopathic Medicine Rules (64B8-9.019, Fla. Admin. Code (effective March 16, 2023) and 64B15-14.014, Fla. Admin. Code (effective March 28, 2023)) and Senate Bill 254 (“SB 254” effective May 17, 2023) (collectively the “Bans”) prohibit doctors in Florida from providing transition medications to minors. Further, SB 254 and the Boards’ Emergency Rules (64B8ER23-7; 64B8ER23-9, Fla. Admin Code (effective July 7, 2023) (collectively, the “Informed Consent Requirements”)) limit access to gender transition care for minors and adults in Florida by, among other things, establishing rigid mandatory prerequisites for physicians to obtain lawful consent. I understand a violation of the Boards’ rules is a basis for disciplinary action, and a violation of SB 254 may subject a medical provider to criminal and civil liability.

3. There is no valid basis for the State to disregard the robust clinical research studies demonstrating the safety and efficacy of gender transition medication, and, in the absence of dispositive evidence demonstrating that such treatments pose significant safety risks and/or lack of efficacy, it is unprecedented

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for the Boards to intrude in the doctor-patient relationship to override the professional judgment of clinicians who adhere to established professional guidelines and standards of care. When parents consent to care for their transgender adolescents, they are consenting to established care supported by the same level and quality of evidence as many other widely accepted treatments for adolescents.

4. Also, there is no ethical or public-interest justification for legislative and/or regulatory stipulations regarding the exact setting or content for valid consent, such as the Requirements' rigid mandate that the consent be obtained in person (as opposed to, for example, via telemedicine or telephone), by the attending physician (as opposed to another qualified healthcare professional), in the presence of a witness, and on a form prescribed by the Boards.

A. *Background and Qualifications*

5. I am the founder and director of the University of Miami Miller School of Medicine's Institute for Bioethics and Health Policy and the co-founder and director of the University's Ethics Programs. I also direct the Florida Bioethics Network and chair the UHealth/University of Miami Hospital Ethics Committee as well as the Adult Ethics Committee for Jackson Memorial Health System.

6. I am a full Professor of Medicine with tenure at the University of Miami, with additional appointments in the Department of Philosophy, the Department of Public Health Sciences, and the School of Nursing and Health

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Studies. My responsibilities include teaching ethics to medical students and trainees and providing continuing education in medical ethics to health professionals at the University of Miami and elsewhere.

7. I received my PhD in Philosophy in 1991 from the University of Miami. I submit this report as an expert in the field of bioethics and the issue of informed consent. A full list of my credentials, experience and publications authored appears in my *curriculum vitae*, which is attached to my declaration (ECF 158-1). All institutional affiliations and positions listed here and in my *curriculum vitae* are purely and exclusively for the sake of identification and to demonstrate expertise. The views expressed herein are mine alone.

8. I have extensive experience as a bioethicist. Bioethicists examine the ethical issues that arise in medicine and life sciences. In addition to my research and publication as outlined in my *curriculum vitae*, I am responsible for providing clinical consultative services to providers across the Jackson and UHealth Systems and on a consulting basis to other institutions. The purpose of these consultations is to help clinicians make decisions concerning patient care in cases that presents unique or challenging ethical issues.

B. *Bases For Opinions*

9. I have actual knowledge of matters stated in this report. My expert opinions are based upon my education, training, research, and years of experience

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as a teacher and medical ethicist, as well as my attendance at and participation in conferences relating to bioethics, and my ongoing review of the relevant professional literature on the subject.

10. In preparing this report, I reviewed the Florida Medicaid: Generally Accepted Professional Medical Standards on the Treatment of Gender Dysphoria (“GAPMS Report”),¹ the Endocrine Society Clinical Practice Guidelines,² the World Professional Association for Transgender Health Standards of Care,³ the Boards’ Rules, and Mandatory Consent forms. I also relied on my years of research and publication in the field of medical ethics, as set forth in my *curriculum vitae*, and the materials therein.

C. Compensation

11. I am not being compensated for offering these opinions, except for the reimbursement of expenses incurred in connection with the submission of this report.

D. Prior Testimony

12. I previously testified as an expert at trial or by deposition in the following cases: *Adams & Boyle, P.C., et. al. v. Herbert H. Slattery, III, et. al.*, Case

¹ Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria, Florida Agency for Health Care Administration, <https://ahca.myflorida.com/let-kids-be-kids>.

² Endocrine Society, Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (September 2017), available at <https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence>.

³ World Prof’l Ass’n for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People (8th ver. 2023), <https://www.wpath.org/publications/soc>.

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No. 3:15-cv-00705 (Middle Dist. TN), *Gainesville Woman Care, LLC, et. al. v. State of Florida, et. al.*, Case No. 37 2105 CA 001323 (Circuit Court, Leon County).

II. EXPERT OPINIONS

A. *The GAPMS Report Erroneously Concludes That There is Little or No Evidence For The Benefits of Medical Care for Gender Dysphoria*

13. The clinical practice guidelines established by the Endocrine Society were developed using the Grading of Recommendations Assessment, Development, and Evaluations (GRADE) guidelines. In this process, guidelines and recommendations are subjected to rigorous internal and external review, including public comment, and undergo peer review prior to publication. Guidelines are reviewed periodically and may be revised and republished based on new evidence.

14. GRADE is a widely accepted framework for developing and presenting summaries of medical evidence and establishing clinical recommendations and guidelines based thereon.⁴ The framework considers the population in question – here, transgender adolescents experiencing gender dysphoria, and the outcomes desired from clinical intervention – and the alleviation of clinically significant distress associated with such dysphoria. The framework is then used to rank the quality of evidence as applied to the desired outcome to assess the strength of the correlation between the intervention and the desired outcome. The GRADE

⁴ GRADE: Welcome to the GRADE working group. Accessed May 17, 2023. Available at <https://www.gradeworkinggroup.org/#pub>.

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approach uses four categories to rate the quality of evidence: “high,” “moderate,” “low,” and “very low.” These rankings reflect the extent of confidence that the estimates of an effect are adequate to support a particular clinical decision or recommendation.⁵

15. In the rating of evidence, randomized control trials are initially rated as “high quality” and observational studies as “low quality.” A randomized controlled trial (“RCT”) is a study that divides patients randomly into a control group (no treatment) and a treatment group. In contrast, an observational study records information about patients in a real-world setting, *e.g.*, a cohort of patients seen at a clinic. The term “low quality” in this context does not reflect a condemnation of evidence but rather reflects that the body of peer-reviewed literature in this area is composed primarily of observational studies.

16. The determination of evidence as low quality does not imply the strength of a particular clinical recommendation. In fact, low quality studies regularly guide important aspects of clinical practice, and the GRADE framework specifically notes that GRADE should not be used to dismiss observational studies or to give absolute priority to RCTs, as it appears the Boards have done here.⁶ Put another way, technically “low quality” evidence can, and often does, support strong

⁵ Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol.* 2011;64(4):403.

⁶ Balshem et al., *supra* note 5, at 402.

CONFIDENTIAL

clinical recommendations. Further, it is incoherent to suggest that, in the absence of “best-grade” evidence, clinicians should provide no clinical intervention or treatment at all, especially where there is solid evidence that all points in the same direction with respect to showing efficacy of treatment. From a practical perspective, if the standard were that clinical practice guidelines could only issue when there was evidence characterized under the GRADE system as “high quality,” many well-established and effective medical treatments would be barred from use. Indeed, under current ethical standards, doing so would likely constitute medical malpractice.

17. The WPATH SOC and Endocrine Society Guidelines are parallel to countless other practice guidelines and, indeed, enjoy reliance on a robust and evolving literature. The GAPMS report mysteriously departs from the GRADE framework by excluding available evidence as of “low quality.” This appears a calumny more than a reasoned critique. It is, moreover, noteworthy that though the GAPMS document purports to rely on standards for evidence-based medicine, it neglects to recognize a key aspect of its foundations: “Evidence-based medicine ... is the integration of best research evidence with clinical expertise and patient values.”⁷ Leading scholars of evidence-based medicine have long and consistently

⁷ Sackett, D.L., Straus, S.E., Richardson, W.S., Rosenberg, W., Haynes, R.B. *Evidence-Based Medicine: How to Practice and Teach EBM*. (2d ed. 2000).

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made clear the essential role of patient values and clinical judgment in evidence-based medical practice. The role of legislatures in regulating that judgment and practice was, until recently, unthinkable. It is and remains, however, scientifically and ethically illicit. In normal circumstances, the measure in question would seem to compel physicians to commit medical neglect or abandonment and, sadly, do so based on ideology and not evidence.

18. In the context of medical treatment for gender dysphoria in adolescents, the use of an RCT would present serious ethical concerns. The medical care at issue here has been demonstrated, by reliable scientific methods, to be effective in alleviating the distress associated with gender dysphoria and improve mental health outcomes in adolescents. Given that there is broad medical consensus, based on solid, peer-reviewed research that these medical treatments are safe and effective, it would likely be unethical to conduct a randomized, placebo-controlled trial, which would entail the withholding of standard-of-care treatment from a control group of adolescents experiencing gender dysphoria.

19. The clinical practice guidelines for treatment of gender dysphoria in adolescents are consistent with guidelines developed in other areas of pediatric care where many interventions are supported solely or primarily by evidence regarded as less than high quality. Much pediatric practice would be utterly undone and out of bounds if the stance revealed in the GAPMS Report were applied to many conditions

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afflicting adolescents. In pediatric oncology, for instance, numerous interventions are both the only options available and are, as such, embraced by the medical community. The same is true in many other specialties; indeed, the lack of RCT evidence has long been a challenge to the pediatrics community (where one analysis found that “43% [of pediatric practice guidelines] were based on experimental studies, 30% on observational studies, and 27% on expert opinion or no reference).”⁸ The GAPMS report would, similarly, enjoin the use of most if not all off-label medication prescriptions. To be sure, observational and case-control studies “may be the only available or practical information in support of a therapeutic strategy.”⁹ Indeed, this is the case with all rare diseases, for which observational and real-world data are all that is available.¹⁰ It would be medically and ethically impermissible to deny or delay treatment for millions of pediatric patients with a wide range of maladies because state legislatures found fault with the evidentiary bases of available treatments. Similarly, in Florida, minors frequently receive cosmetic procedures, including breast augmentation, ear surgery, liposuction, and rhinoplasty

⁸ Isaac, Andre et. al., Quality of Reporting and Evidence in American Academy of Pediatrics Guidelines. *Pediatrics*. April 2013;131(4):732–738. Available at <https://publications.aap.org/pediatrics/article-abstract/131/4/732/31887/Quality-of-Reporting-and-Evidence-in-American?redirectedFrom=fulltext>.

⁹ PDQ Adult Treatment Editorial Board. Levels of Evidence for Adult and Pediatric Cancer Treatment Studies: Health Professional Version. *PDQ Cancer Summaries [Internet]*. October 2022. Available at <https://www.ncbi.nlm.nih.gov/books/NBK65748/>.

¹⁰ Liu, Jing et. al., Natural History and Real-World Data in Rare Diseases: Applications, Limitations, and Future Perspectives. *J Clin Pharmacology*. December 2022;62(S2):S38-S55. Available at <https://accp1.onlinelibrary.wiley.com/doi/10.1002/jcph.2134>.

CONFIDENTIAL

– with a less-than-optimal evidence base. These procedures are intended to treat no malady and cure no disease.

20. It is worthy of note that an effort to establish a registry that would have improved gender dysphoria evidence was rejected by Florida’s Boards of Medicine and Osteopathic Medicine. It is difficult to understand how and why those who are newly concerned about the evidence for gender dysphoria treatment would disdain existing evidence *and* impede efforts to acquire more and better evidence.

21. To my knowledge, the actions of the Florida Boards of Medicine and Osteopathic Medicine in prohibiting health care providers from following clinical practice guidelines or standards of care for the treatment of a particular patient population are unprecedented. No other pediatric clinical guidelines or standards of care have been rejected by the Florida Boards of Medicine and Osteopathic Medicine because the quality of the evidence supporting them is determined to be less than “high quality.” Permitting these Boards to bar health care providers from following clinical practice guidelines or standards of care that are based on less than high quality evidence would subject many pediatric patients to serious harm.

22. To be clear, there are no other recommended pediatric clinical guidelines or standards of care subjected to the same degree of scrutiny as the Boards have applied here in an attempt to justify the prohibition on medical treatment for gender dysphoria.

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B. *The Board's Informed Consent Requirements Depart from Well-Established Principles of Medical Ethics*

23. The Restrictions reflect a critical misunderstanding of the role of informed consent (more appropriately called “valid consent”) for medical procedures. Rather than serving an interest in protecting the health and well-being of an individual seeking necessary gender transition care, the Restrictions subvert that interest.

24. “Informed consent” names the ethical and legal obligation of health care professionals to ensure that certain fundamental conditions are met before patients undergo medical procedures. Those conditions may be straightforwardly itemized as follows:

- The patient must receive adequate information about the procedure, including its risks, likely benefits and accepted alternatives;
- The patient must have the mental capacity to understand and appreciate the information as provided; and
- The patient’s agreement to receive the treatment must be voluntary—that is, free of coercion or undue influence.

25. All three components apply, meaning that the term “valid consent” is more accurate than “informed consent” because, for instance, a patient might be adequately informed but lack the mental capacity to consent. Although there is disagreement and controversy on some subjects within the field of bioethics, these

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standards for valid consent are not subject to dispute: they are universally accepted as core components of medical practice and research. The fundamental idea is that every mature person who is capable of making decisions should have the right to decide what should be done to her or his body.

26. This is at the foundation of uncontested national and international recognition of rights to self-determination and personal autonomy. The medical ethics literature is unequivocal about this.¹¹ There are two critical reasons why the Informed Consent Requirements run afoul of these standards.

27. First, valid consent is context-specific: physicians, allied health professionals, patients, and the precise medical services under consideration will all vary greatly and, together, for each patient, form an individualized pattern—a kind of “clinical fingerprint.” There is wide variety in, for instance, physicians’ and their allied health professionals’ communication styles; patients’ health histories, medical needs, previous experience in medical settings, and ability to travel to a health clinic; and the nature and risks of the procedures themselves. Thus, it is impractical and inappropriate to impose a blanket requirement that legal consent be obtained: (1) in-

¹¹ See, e.g., Gert, B., Culver, C.M., and Clouser, K.D. 2006. *Bioethics: A Systematic Approach*. New York: Oxford University Press, esp. Ch. 9, pp. 213 ff.; Beauchamp, T.L, Faden, R.R. Informed Consent, I. History of informed consent, and II. Meaning and elements, in Jennings, B., ed., *Bioethics*, 4th Edition. Farmington Hills, MI: Macmillan Reference USA, 2014, Vol. 3, pp. 1673-1687; Berg, Jessica W., Paul S. Appelbaum, Charles W. Lidz, and Alan Meisel. 2001. *Informed Consent: Legal Theory and Clinical Practice*. 2nd ed. New York: Oxford University Press; Dworkin, Gerald. 1988. *The Theory and Practice of Autonomy*. Cambridge: Cambridge University Press. Faden, Ruth R., and Tom L. Beauchamp. 1986. *A History and Theory of Informed Consent*. New York: Oxford University Press; Goodman KW. *Ethics and Evidence-Based Medicine: Fallibility and Responsibility in Clinical Science*, Cambridge: Cambridge University Press, 2003.

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person as opposed to other equally effective modes of communication), (2) by the physician prescribing the medication or performing the procedure as opposed to a competent allied health professional, (3) in the presence of a third-party witness, and (4) on a form prescribed by a regulatory agency. The context-specific nature of consent applies to every medical procedure— appendectomy, breast reduction or augmentation, tooth extraction, brain surgery, and so on; there is nothing medically unique about gender transition care in this regard.

28. To be sure, many specialized procedures and surgeries do employ procedure-specific consent forms, but these are crafted by experts in the procedure or surgery who are not trying to discourage their patients; such forms are based on the specific and likely risks of the procedure, and not compelled by law or regulation. With the exception of gender transition care and abortion, no such form or process has, to my knowledge, ever been compulsory or required under threat of prosecution.

29. It is also unprecedented for a consent document to contain falsehoods such as those in the Boards' consent forms: "Medical treatment of people with gender dysphoria is based on very limited, poor-quality research with only subtle improvements seen in some patient's psychological functioning in some, but not all, research studies. This practice is purely speculative, and the possible psychological benefits may not outweigh the substantial risks of medical treatments and, in many cases, the need for lifelong medical treatments."

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30. The consent forms approved by the Boards are utterly unlike any others in standard use. They require that each putative risk be initialed by the patient and parent; one such form requires 38 placements of initials. Many of the risks, cast as “statements,” include material that has nothing to do with the standard consent process, e.g., “Compliance with the requirements explained above is a prerequisite for you to receive treatment with feminizing medications.” It is highly unusual for a consent document to feature content clearly intended to discourage the treatment. (The “requirements” alluded to in that form comprise a list of 13 stipulations related to the practice of medicine or psychology, not to the valid consent process.) Moreover, demands for such things as ongoing medical monitoring and a specified number of follow-up visits and their periodicity are with few exceptions wholly outside the scope of the valid consent process.

31. It is particularly unusual to list risks of procedures a patient will not receive. Doing so undermines any suggestion that the forms are customized, which is a direct impediment to the valid consent process. Including these “statements” impairs the consent process and erodes the patient-doctor relationship. It is inconsistent with goals of valid consent to include mention of treatments a patient will not receive.

32. Such an unusual and highly granular list of warnings, threats, and risks, in conjunction with the requirement that patients initial all of them, has resulted in

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documents that read like legal contracts. It is also well established that no promise or guarantee should ever be made in conjunction with a medical procedure, and it is extremely peculiar for a clinical consent document actively to discourage a particular intervention or imply its likely failure. The Boards of Medicine forms compel a departure from longstanding best practice in medicine.

33. Stated differently, a one-size-fits-all mandate for legal consent – particularly one that disregards the importance of patient-desired outcomes, originates outside the clinical relationship, and applies to all cases inflexibly – cannot, by definition, be adequate for every consent process. Rather, after the patient and health care provider have discussed the patient’s preferences and unique medical history, as well as the specifics of the contemplated prescription or procedure, they are best equipped to determine together—without legislative interference—whether the patient is ready to provide valid consent.

34. The second reason the Informed Consent Requirements run afoul of consent standards is the common and widespread agreement that the doctor-patient relationship is of fundamental importance and therefore should be free from legislative or regulatory interference that does not serve a medical justification. A law such as the Informed Consent Requirements—which specifies the manner, form, and setting in which information must be delivered and the particular health

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professional who must deliver the information—undermines the physician’s judgment about how to serve a patient’s best interests.

35. In order to advance the goals of valid consent, forms that list items for doctors to review with their patients should be accurate and clear. Having multiple statements that are not guided by evidence-based medicine and practice or that address procedures that a patient will not receive undermines patients’ ability to make for themselves medical decisions that accurately take risks and benefits into account.

36. These principles apply as a matter of professional ethics notwithstanding any individual’s personal viewpoint on gender identity or whether gender transition care should be legally accessible. A practitioner’s duty is to provide the patient with the necessary information to allow the patient to make the most appropriate personal health decision, and then to respect the patients’ autonomy. There is no medical or ethical justification for the Requirements as a tool of valid consent.

37. The mandates contained in the Informed Consent Requirements constitute an intrusion into universally accepted medical and ethical standards. These state-mandated Requirements override the clinical team’s professional judgment to the potential detriment of the patient’s health, undermine the physician-

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patient relationship, and subvert fundamental tenets of medical ethics and universal standards for valid consent.

Executed on this 16th of August, 2023.

A handwritten signature in black ink, appearing to read "K. Goodman", is positioned above a horizontal line.

Kenneth W. Goodman, PhD

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE et al.,

Plaintiffs,

Civil No. 4:23-cv-00114-RH-MAF

v.

JOSEPH A. LADAPO et al.,

Defendants.

**REBUTTAL EXPERT REPORT OF ARON JANSSEN, M.D.
ON BEHALF OF PLAINTIFFS**

September 5, 2023

Prepared by
Aron Janssen, M.D.

PL000930

TABLE OF CONTENTS

	PAGE
I. INTRODUCTION	1
A. Qualifications.....	1
B. Compensation	1
C. Prior Testimony.....	1
D. Bases for Opinions.....	2
II. REBUTTAL EXPERT OPINIONS.....	2
A. Dr. Román Does Not Appear to Have the Necessary Training or Clinical Experience to Opine on the Standard of Care for Gender Dysphoria in Adolescents	2
B. There Is No Scientific Evidence to Support Dr. Román’s Speculation that an Increase in Gender Dysphoria Diagnoses in Adolescents Is Attributable to “Social Contagion”.....	4
C. The Existence of Co-Occurring Mental Health Diagnoses Does Not Provide a Medical Justification for Withholding Treatment for Gender Dysphoria.....	5

I. INTRODUCTION

1. I am a board-certified child and adolescent psychiatrist specializing in the treatment of gender dysphoria in children and adolescents. I have been retained by counsel for Plaintiffs in the above-captioned lawsuit to provide an expert opinion on the standards of care for treating individuals diagnosed with gender dysphoria. I submit this report in rebuttal to the expert report submitted on behalf of the Defendants in this case by Dr. Sven Román.

A. *Qualifications*

2. My professional background, experiences, publications, and presentations are detailed in my curriculum vitae and in my earlier expert reports submitted in this case and the companion case of *Dekker v. Weida*. I incorporate all of those materials into this rebuttal report by reference.

B. *Compensation*

3. I am being compensated at an hourly rate of \$450/hour plus expenses for my time spent in connection with this case. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

C. *Prior Testimony*

4. In the previous four years, I have provided expert testimony by deposition or at trial in *Dekker v. Weida*, No. 4:22-cv-00325-RH-MAF (N.D. Fla.), *B.P.J. v. West Virginia State Board of Education et al.*, No. 2:21-cv-00316 (S.D.W.V.), *L.E. v. Lee et al.*, No. 3:21-cv-00835 (M.D. Tenn), and *Loe v. Texas*, No. D-1-GN-23-003616 (District Court of Texas, Travis County).

D. *Bases for Opinions*

5. In preparing this rebuttal report, I have relied on my training and years of research and clinical experience as detailed in my CV and my previous expert reports in this action and *Dekker*, the materials cited in text or listed in the bibliographies attached to my previous reports in this action and *Dekker*, and any additional materials cited in this rebuttal report. The sources cited in each of these are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject, which include authoritative, scientific peer-reviewed publications. I reserve the right to revise and supplement the opinions expressed in this declaration 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. I may also further supplement these opinions in response to information produced by Defendants in discovery and in response to additional information from Defendants' designated experts.

II. REBUTTAL EXPERT OPINIONS

A. *Dr. Román Does Not Appear to Have the Necessary Training or Clinical Experience to Opine on the Standard of Care for Gender Dysphoria in Adolescents*

6. Much of Dr. Román's report consists of quoting from various news articles and policy documents and offering his description of the history of certain events and policy developments relating to the treatment of gender dysphoria in adolescents taking place in Sweden and other European countries. To the extent Dr. Román's report includes his opinions concerning the standards for diagnosis and treatment of gender dysphoria in adolescents, however, he appears to lack sufficient training or clinical experience to offer an expert opinion on those subjects. Additionally, his report relies on media accounts, websites, and similar sources that

are not peer-reviewed research studies or other materials of the type that an expert in the field would rely upon in forming opinions on these subjects.

7. Based on his report and curriculum vitae, Dr. Román does not appear to have sufficient training or experience to offer expert opinions regarding the standard of care for treatment of gender dysphoria in children and adolescents. Dr. Román states that he has “met with” approximately 35 children who have been diagnosed with gender dysphoria. He does not describe the ages of these children or in what capacity he met with them. He also states that he has not referred patients for medical treatment for gender dysphoria, which suggests that he has never monitored or supervised minor patients during their treatment with medication for gender dysphoria. In my view, this reflects insufficient clinical experience to offer an opinion concerning the diagnosis and medical treatment of gender dysphoria in adolescents.

8. Much of Dr. Román’s experience with treatment of gender dysphoria in adolescents appears to relate to his involvement with the Gender Identity Challenge (GENID) association, which he describes as a group of parents who were “concern[ed]” or “distressed” that their minor or young adult children had received medical treatment for gender dysphoria. (Expert Decl. of Dr. Sven Román, dated Aug. 16, 2023 (“Report”), ¶¶ 9, 13.) In my view, involvement with a group of this type, without meaningful research or clinical experience treating transgender adolescents, is not a sufficient basis for offering expert opinions on medical treatment of gender dysphoria.

9. Additionally, the sources cited in Dr. Román’s report include many that are not peer-reviewed scientific research articles, but instead are popular news publications, television programs, and books written for a general audience rather than medical professionals. Some of the cited materials are opinion pieces (a term that Dr. Román himself uses) that apparently appeared in general interest

publications and were intended to influence policymakers or the public to support restrictions on medical treatment for transgender adolescents. While not commenting on the quality of these publications as news sources, they are not references from which psychiatrists should make assertions about their clinical practice. These sources are not scientific research, and they are not materials on which an expert in the field would rely in forming an opinion on the medical treatment of gender dysphoria in adolescents.

B. *There Is No Scientific Evidence to Support Dr. Román’s Speculation that an Increase in Gender Dysphoria Diagnoses in Adolescents Is Attributable to “Social Contagion”*

10. Like many of Defendants’ other experts, Dr. Román advances a theory that an increasing number of people who are assigned female at birth are suddenly identifying as males in mid-to- late adolescence as a result of peer pressure and social contagion. For this opinion he relies primarily on media accounts and publications by opponents of medical treatment for transgender adolescents. None of Dr. Román’s speculation is supported by actual medical evidence.

11. The theory that some adolescents experience “Rapid Onset Gender Dysphoria” as a result of social influences is based almost exclusively on one highly controversial study (Littman, 2018). This study was based on an anonymous survey, allegedly of parents, about the etiology of their child’s gender dysphoria. Participants were recruited from websites promoting this social contagion theory, and the children were not surveyed or assessed by a clinician. Those serious methodological flaws render the study meaningless. The only conclusion that can be drawn from that study is that a self-selected sample of anonymous people recruited through websites that predisposed participants to believe transgender identity can be influenced by social factors do, in fact, believe those social factors influence children to identify as transgender.

12. The opinions of Dr. Román and many of Defendants’ other experts reflect the same speculation that more people are identifying as transgender because of social influences. Whether it is attributed to social media, peer pressure, or, in Dr. Román’s view, the introduction of the iPhone in 2007 (Report, ¶ 14), there is no medical research to suggest that any of these factors have led to an increase in youth identifying as transgender.

13. It is a normal developmental process for adolescents to seek out peers with shared experiences. This is not unique to transgender and gender-diverse young people. All types of minoritized youth tend to seek out affinity groups with those that share their experiences. In my experience, transgender youth also seek out those social connections. It is not the social connections that leads to the identity, but it is the identity that leads to seeking out these social connections.

C. The Existence of Co-Occurring Mental Health Diagnoses Does Not Provide a Medical Justification for Withholding Treatment for Gender Dysphoria

14. Dr. Román states that he does not refer adolescent patients for medical treatment for gender dysphoria because in his experience, all such patients “have other psychiatric conditions in addition to their professed gender dysphoria.” (Report, ¶ 2.) Whatever Dr. Román’s experience may be, the available research shows that many transgender adolescents with gender dysphoria do not have other co-occurring mental health diagnoses. In one study, for example, 67.6% of patients had no concurrent psychiatric disorder.¹

15. Dr. Román also states that “parents report that children often relinquish their gender dysphoria when receiving psychotherapy or other interventions to

¹ de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T., *Psychiatric Comorbidity in Gender Dysphoric Adolescents*, 52 J. of Child Psychol. and Psychiatry 1195, 1195-1202. (2011).

address psychiatric comorbidities.”² There is no medical evidence to support the speculation that an adolescent’s gender dysphoria will spontaneously disappear if other co-occurring conditions are treated.

16. Research and clinical experience repeatedly reaffirm that gender transition significantly improves the mental and physical health of transgender young people and is the only treatment that has been demonstrably effective for gender dysphoria.

17. I have extensive clinical and research experience working with transgender youth who have co-occurring mental health diagnoses. The WPATH Standards of Care specifically recommend that providers who assess adolescents for gender-affirming care should have experience and training to distinguish between gender dysphoria and other mental health conditions or developmental anxieties. But the existence of a co-occurring mental health diagnosis is not—by itself—a reason to withhold care for gender dysphoria. It is important that co-occurring conditions are treated. And if co-occurring conditions impair the individual’s capacity to understand the interventions in question, we have to treat those conditions before any medical care for gender dysphoria would be initiated. But there is no evidence that treating co-occurring mental health conditions resolves gender dysphoria. In the same way that we would not expect that treating anxiety is going to get rid of ADHD, treating anxiety, for example, is not going to get rid of gender dysphoria.

18. I hold each of the opinions expressed in this report with a reasonable degree of scientific certainty, based on the materials I have reviewed and on my education, experience, and knowledge. I reserve the right to supplement, amend, or modify my opinions upon review of further information, including, but not limited to, testimony, documents, and reports I receive after the date of this report.

² *Id.*

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

Executed this 5th day of September 2023.

A handwritten signature in black ink, appearing to read 'A. Janssen', is positioned above a horizontal line.

Aron Janssen, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
Tallahassee Division

JANE DOE et al.,

Plaintiffs,

Civil No. 4:23-cv-00114-RH-MAF

v.

JOSEPH A. LADAPO et al.,

Defendants.

**REBUTTAL EXPERT REPORT OF DAN H. KARASIC, M.D.
ON BEHALF OF PLAINTIFFS**

September 5, 2023

Prepared by
Dan H. Karasic, M.D.

PL000939

TABLE OF CONTENTS

	PAGE
I. INTRODUCTION	1
A. Qualifications.....	1
B. Compensation	1
C. Prior Testimony.....	1
D. Bases for Opinions.....	2
II. REBUTTAL EXPERT OPINION.....	2
A. The material cited in Dr. Román’s report is unreliable, outdated, and incomplete; his report does not provide an accurate picture of the care provided to transgender adolescents in Sweden or other European countries, which is consistent with the WPATH Standards of Care and the Endocrine Society’s Clinical Practice Guidelines for the Treatment of Gender Dysphoria.....	2

I. INTRODUCTION

1. I have been retained by counsel for Plaintiffs in the above-captioned litigation. I submit this report in rebuttal to the expert report submitted on behalf of the Defendants in this case by Dr. Sven Román. 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.

A. *Qualifications*

2. I am a Professor Emeritus of Psychiatry at the University of California – San Francisco (UCSF). I have been on faculty at UCSF since 1991. I have also had a telepsychiatry private practice since 2020.

3. My professional background, experiences, publications, and presentations are detailed in my curriculum vitae and in my earlier expert reports submitted in this case and the companion case of *Dekker v. Weida*. I incorporate those materials into this rebuttal report by reference.

B. *Compensation*

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

C. *Prior Testimony*

5. Over the past four years, I have given expert testimony at trial or by deposition in the following cases: *C.P. v. Blue Cross Blue Shield of Illinois*, No. 3:20-cv-06145-RJB (W.D. Wash.); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C.); *Fain v. Crouch*, 3:20-cv-00740 (S.D.W. Va.); *Brandt v. Rutledge*, No. 4:21-cv-00450 (E.D. Ark.); *K.C. et al. vs Individual Members of the Indiana*

Licensing Board, et al, and *Dekker, et al. v. Weida, et al.*, No. 4:22-cv-00325-RH-MAF. 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.

D. *Bases for Opinions*

6. In preparing this report, I have relied on my training and years of research and clinical experience, as set out in my curriculum vitae, my previous declarations and reports in this matter and *Dekker v. Weida*, the materials listed and sources cited in bibliographies attached to those reports, and additional sources cited in this rebuttal report.

7. 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.

8. I may also further supplement these opinions in response to information produced by Defendants in discovery and in response to additional information from Defendants' designated experts.

II. REBUTTAL EXPERT OPINION

A. *The material cited in Dr. Román's report is unreliable, outdated, and incomplete; his report does not provide an accurate picture of the care provided to transgender adolescents in Sweden or other European countries, which is consistent with the WPATH Standards of Care and the Endocrine Society's Clinical Practice Guidelines for the Treatment of Gender Dysphoria*

9. Dr. Román's report relies heavily on news articles, television programs, and other media sources. As a general matter, these are not the types of peer-

reviewed research studies and materials upon which an expert in this field would rely to inform opinions on these subjects.

10. Dr. Roman's report also relies on material that is unavailable in official English translations. For example, Dr. Roman cites to a database maintained by the Swedish National Board of Health and Welfare (Socialstyrelsen), but the link provided is exclusively in Swedish. Similarly, Dr. Roman's report cites to a December 2019 by the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU),¹ but the full report is available only in Swedish.

11. The report indicates that Dr. Román's opinions are based, in part, on his "review of the literature both in Sweden and the rest of the world" with a "focus on the Swedish experience and the resulting systematic review of the Swedish National Health Service." (Expert Decl. of Dr. Sven Román, dated Aug. 16, 2023 ("Report"), ¶ 6.) In fact, however, Dr. Roman's report does not include a comprehensive review of current international or European policies relating to the treatment of gender dysphoria and misstates those policies.

12. Dr. Roman cites to an April 2021 policy change at Astrid Lindgren's Children's Hospital which is described in a document on a webpage of the Society for Evidence Based Gender Medicine (SEGM). (Report, ¶ 23, footnote 10.) The SEGM is an advocacy organization that does not appear to be affiliated with the Children's Hospital or the Karolinska University Hospital² where the Children's Hospital is housed. Dr. Roman is affiliated with SEGM but has no work experience or affiliation with any of the six Swedish gender clinics. (Report, ¶ 24.)

¹ The link to this systematic inventory included in Dr. Roman's report resulted in a 404 error when I attempted to access the page on August 31, 2023. The page does include three suggested links, at least one of which appears to be the review to which Dr. Roman is referring.

² Society for Evidence Based Gender Medicine, About Us. Available at https://segm.org/about_us. Accessed on August 31, 2023.

13. The Astrid Lundgren Children’s Hospital paused new intakes for adolescents for gender affirming care from April 2021 until December 2022. During that time, it continued to provide ongoing treatment with puberty blockers and hormones for those on whom medications had been initiated. In December 2022, after new national guidelines were published by the Swedish National Board of Health and Welfare, Astrid Lundgren Children’s Hospital resumed initiation of care with puberty blockers and hormones for adolescents, and care continues to be available at the other five gender clinics in Sweden.

14. The National Guidelines state that “young people suffering from gender dysphoria need to be promptly assessed and offered appropriate treatment measures...” and “[g]ender affirming treatments need to be offered when these are deemed indicated.”³ The guidelines further state that individual treatment decisions should be made using criteria that include “the existence of the incongruence since childhood, the stability of gender identity over time, clear distress caused by the onset of puberty, and the absence of factors that complicate the diagnosis.”

15. The report also mischaracterizes and incompletely reports policy changes in gender transition care in Finland, the Netherlands, and the United Kingdom.

16. Dr. Roman references June 2020 guidelines issued by the Finnish Ministry of Health but fails to note that they provide for both pubertal suppression and hormonal intervention on a case-by-case basis “after careful consideration and appropriate diagnostic examinations if the medical indications for the treatment are

³ The National Board of Health and Welfare, Care of children and adolescents with gender dysphoria: Summary of National Guidelines (December 2022). Available at <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf>. Accessed August 31, 2023.

present and there are no contraindications.⁴” This approach is consistent with the WPATH Standards of Care Version 8 and the Endocrine Society guidelines.⁵

17. Dr. Roman’s descriptions of care in the United Kingdom are similarly inaccurate and incomplete. Dr. Roman’s report indicates that a petitioner, Keira Bell, “won a Supreme Court case against Tavistock Clinic in London [and] as a result, no children under 16 can receive gender reassignment treatment at that clinic without judicial approval.” (Report, ¶ 21.). This is inaccurate. That preliminary decision was overturned on appeal. Adolescents remain able to receive gender transition medications in the United Kingdom.

18. Dr. Roman further asserts that the Tavistock clinic has “subsequently been closed as a result of an interim review by Dr. Hilary Cass.” (Report, ¶ 22). In fact, the UK is moving from a single specialist provider model to regional centers in part to expand the number of providers and reduce the significantly long waiting periods and other barriers to accessing care⁶. The Tavistock clinic remains open until the new regional centers are in operation.

19. In sum, the current guidelines for gender transition care in adolescents in Sweden provide for the treatment of gender dysphoria in adolescents with gender transition medications on a case-by-case basis in accordance with criteria that are consistent with the WPATH Standards of Care and Endocrine Society Clinical Practice Guidelines.

⁴ Medical treatment methods for dysphoria associated with variations in gender identity in minors: summary of recommendations by COHERE (Council for Choices in Healthcare in Finland). Available at [https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+\(1\).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+\(1\).pdf?t=1631773838474](https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474). Accessed on September 5, 2023.

⁵ Notably Dr. Roman’s report does not include a citation to the Finnish guidelines themselves, but rather a 2015 article published in an online, open access medical journal which examines the adolescent applicants for legal and medical sex reassignment at two Finnish gender identity services clinics over the period of 2013-2015.

⁶ The Cass Review. Independent review of gender identity services for children and young people: Interim report at p. 20. February 2022. Available at <https://cass.independent-review.uk/publications/interim-report/>. Accessed August 31, 2023.

20. I reserve the right to supplement, amend, or modify my opinions upon review of further information, including, but not limited to, testimony, documents, and reports I receive after the date of this report.

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

Executed this 5th day of September 2023.



Dan H. Karasic, M.D.