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

AUGUST DEKKER, et al., *Plaintiffs*, v. JASON WEIDA, et al., *Defendants*.	Case No. 4:22-cv-00325-RH-MAF

EXPERT REPORT OF JOHANNA OLSON-KENNEDY, M.D., M.S.

I, Johanna Olson-Kennedy, M.D., M.S., hereby declare and state as follows:

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

2. I am over the age of 18. 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.

BAKCGROUND AND QUALIFICATIONS

3. I have been retained by counsel for Plaintiffs in the above-captioned lawsuit to provide an expert opinion on gender identity; the treatment and diagnosis of gender dysphoria; the *Florida Medicaid Generally Accepted*

Pl. Trial Ex. 008

Professional Medical Standards (GAPMS) Determination on the Treatment of Gender Dysphoria published by Florida's Agency for Health Care Administration (AHCA) in June 2022, along with its attachments; and Fla. Admin. Code. R. 59G-1.050(7) which prohibits Medicaid coverage of puberty blockers, hormone and hormone antagonists, "sex reassignment" surgeries, and any other procedures that alter primary or secondary sexual characteristics.

A. Qualifications and Experience

4. I am a Double Board Certified Physician in Pediatrics and Adolescent Medicine. I specialize in the care of transgender youth and gender diverse children. I am a recognized expert in this field.

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

6. I received my Doctor of Medicine (M.D.) degree from the Chicago Medical School in 1997. In 2000, I completed my residency in pediatrics at the Children's Hospital of Orange County, California, and from 2000 to 2003, I was a Fellow in adolescent medicine at the Children's Hospital of Los Angeles.

7. I have been a licensed physician in California since 2000. I am currently the Medical Director of the Center for Transyouth Health and Development, in the Division of Adolescent Medicine at the Children's Hospital in Los Angeles, California. The Center is the largest clinic in the United States for transgender youth and provides gender diverse youth with both medical and mental health services, including consultation for families with gender diverse children and routine use of medications to suppress puberty in peri-pubertal youth (i.e., youth at the onset of puberty), gender-affirming hormone use for masculinization and feminization, as well as surgical referrals. Under my direction, the Center conducts rigorous research aimed at understanding the experience of gender diversity and gender dysphoria from childhood through early adulthood.

8. Over the course of my work with this population during the past 16 years, I have provided services for approximately 1000 young people and their families, and currently have an active panel of around 650 patients of varying ages, up to 25 years old.

9. I have been awarded research grants to examine the impact of early interventions including puberty-delaying medication (commonly known as puberty blockers) and gender-affirming hormones on the physiological and

psychosocial development of gender diverse and transgender youth. I have lectured extensively, across the United States and internationally on the treatment and care of gender diverse children and transgender adolescents, the subjects including pubertal suppression, gender-affirming hormone therapy, transitioning teens and the adolescent experience, age considerations in administering hormones, and the needs, risks, and outcomes of hormonal treatments. I have published numerous articles and chapters, both peer reviewed, and non-peer reviewed, on transgender health-related issues.

10. I am currently the principal investigator on a multisite National Institutes of Health grant to continue, for an additional 5 years, an ongoing study examining the impact of gender-affirming medical care for transgender youth on physiologic and psychological health and well-being. The first five years have already been completed. This is the first study of its kind in the U.S. to determine longitudinal outcomes among this population of vulnerable youth. The study to date has yielded approximately 26 manuscripts.

11. I am an Associate Professor at the Keck School of Medicine at the University of Southern California and attending physician at Children's Hospital of Los Angeles. I have been a member of the World Professional Association for Transgender Health (WPATH) since 2010, and a Board Member of the U.S.

Professional Association for Transgender Health (USPATH) since 2017. I was recently appointed to the Executive Board of the USPATH. I am also a member of the Society for Adolescent Health and Medicine and the American Academy of Pediatrics. In addition, I am a member of the LGBT Special Interest Group of the Society for Adolescent Health and Development.

12. I am the 2014 Recognition Awardee for the Southern California Regional Chapter of the Society for Adolescent Health and Medicine.

13. In 2019, I was invited by the University of Bristol as a Benjamin Meaker visiting professor, the purpose of which is to bring distinguished researchers from overseas to Bristol in order to enhance the research activity of the university.

B. Previous Testimony

14. In the last four years, I have testified as an expert at trial or by deposition in the following cases: *Fain v. Crouch*, No. 3:20-cv-00740 (S.D. W.Va.); *Kadel v. Folwell*, Case No. 1:19-cv-00272-LCB-LPA (M.D.N.C.); *Miller v. Purdue* (Colorado); *In the interest of JA.D.Y. and JU.D.Y., Children*, Case No. DF-15-09887 (255th Jud. District Ct., Dallas Cty., Tex.); and *Paul E. v. Courtney F.*, No. FC2010-051045 (Superior Ct., Maricopa Cty., Ariz.).

C. Compensation

15. I am being compensated for my work on this matter at a rate of $200.00 per hour for preparation of declarations and expert reports, as well as any pre-deposition and/or pre-trial preparation and any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

D. Bases for Opinions

16. 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. *See* **Exhibit A**. It documents my education, training, research, and years of experience in this field and includes a list of publications.

17. I have also reviewed the materials listed in the attached bibliography. *See* **Exhibit B**. The sources cited therein are authoritative, scientific peer-reviewed publications. I generally rely on these materials when I provide expert testimony, and they include the documents specifically cited as supportive examples in particular sections of this declaration.

18. In addition, I have reviewed the Florida Medicaid Generally Accepted Professional Medical Standards (GAPMS) Determination on the Treatment of Gender Dysphoria published by Florida's Agency for Health Care

Administration (AHCA) in June 2022, along with its attachments, including the "assessments" of Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch (Attachment C), Dr. James Cantor (Attachment D), Dr. Quentin Van Meter (Attachment E), Dr. Patrick Lappert (Attachment F), and Dr. G. Kevin Donovan (Attachment G) (hereinafter, "GAPMS Memo"); and Fla. Admin. Code. R. 59G-1.050(7) which prohibits Medicaid coverage of puberty blockers, hormone and hormone antagonists, "sex reassignment" surgeries, and any other procedures that alter primary or secondary sexual characteristics. I may rely on these documents, as well as those cited in my curriculum vitae and the attached bibliography, as additional support for my opinions.

19. 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.

EXPERT OPINIONS

A. Gender Identity

1. The term gender identity was originally coined in 1964 by American psychiatrist Robert J. Stoller, a noted psychoanalyst who studied sexual orientation, gender identity, and differences in sexual development.[1] Gender identity is a distinct characteristic and is defined as one's internal sense of being male or female (or rarely, both or neither). It has a strong biological basis. Every person has a gender identity.

2. The concept of gender identity is contemporaneously understood both colloquially and within the domain of science and medicine to denote someone's gender. It is a concept well-understood and accepted in medicine and science. Indeed, gender identity information is commonly collected and reported on within the context of scientific research.[2]

3. The term cisgender refers to a person whose gender identity matches their sex assigned at birth. The term transgender refers to a person whose gender identity does not match their sex assigned at birth.

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[1] Stoller, R.J. (1964). A Contribution to the Study of Gender Identity, *The International journal of psycho-analysis*, 45, 220–226.

[2] Clayton JA, Tannenbaum C. (2016). Reporting Sex, Gender, or Both in Clinical Research? *JAMA*. 316(18): 1863–1864.

4. Historically, "gender" was equated with a person's sex assigned at birth, which refers to the sex assigned to a person when they are born, generally based on external genitalia. However, a more contemporary understanding of gender shows that one's gender identity may differ from one's sex assigned at birth.

5. While both gender identity and sex are often assumed and treated as binary and oppositional, they are more accurately experienced as along a spectrum. For example, there are multiple sex characteristics, such as genitalia, chromosomal makeup, hormones, and variations in brain structure and function. For some of these characteristics there is significant variance as reflected by the dozens of intersex mechanisms and varying gender identities. Additionally, not all sex characteristics, including gender identity, are always in alignment. Accordingly, the Endocrine Society Guidelines state that, "As these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided."[3]

[3] Hembree, W.C., Cohen-Kettenis, P.T., Gooren, L., et al. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, 102(11): 3869–3903.

6. As early as 1966 it has been understood that gender identity cannot be changed.[4] Efforts to do so have been shown to be unsuccessful and harmful.

B. Gender Dysphoria and its Treatment

7. Gender Dysphoria (GD) is a serious medical condition characterized by distress due to a mismatch between assigned birth sex and a person's internal sense of their gender. GD was formerly categorized as Gender Identity Disorder (GID) but the condition was renamed in May 2013, with the release of the American Psychiatric Association (APA)'s fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).[5] In announcing this change, the APA explained that in addition to the name change, the criteria for the diagnosis were revised "to better characterize the experiences of affected children, adolescents, and adults."[6] The APA further stressed that "gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition."[7]

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[4] Benjamin, H. (1966). The Transsexual Phenomenon. New York: The Julian Press, Inc. Publishers.

[5] A text revision to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition was published in 2022 ("DSM-5-TR").

[6] DSM-5.

[7] *Id.*

8. On May 25, 2019, the World Health Assembly approved International Classification of Diseases (ICD) version 11 that had been published by the World Health Organization in 2018.[8] In this newest version of the ICD, all trans-related diagnostic codes were removed from the chapter "Mental and Behavioral Disorders," and the code "Gender incongruence" was included in a new chapter "Conditions related to sexual health." These codes replaced the outdated "Gender Identity Disorder of childhood" (F64.2), "Gender Identity Disorder not otherwise specified" (F64.9), "transsexualism" (F64.0), and "Dual-role transvestism" (F64.1), which perpetuated the idea that patients seeking and undergoing medical interventions for a medical condition are mentally ill.[9]

9. For a person to be diagnosed with GD, there must be a marked difference between the individual's expressed/experienced gender and the gender others would assign to the individual, present for at least six months. In children, the desire to be of the other gender must be present and verbalized.[10] The

[8] World Health Organization. (2018). Gender Incongruence. In International Classification of Diseases, 11th Revision.

[9] Suess Schwend A. (2020). Trans health care from a depathologization and human rights perspective. *Public health reviews*, *41*, 3.

[10] Notably, the DSM-IV included a separate diagnosis for GID in children, which required the child to display a number of behaviors stereotypical of the non-natal gender. That diagnosis, and its list of behavioral requirements, have been deleted from the DSM-5 and replaced by updated and more precise diagnostic criteria.

condition must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

10. The World Professional Association of Transgender Health (WPATH) has clear recommendations for the health of transsexual, transgender, and gender non-conforming people in what is now the Standards of Care version 8 (SOC 8).[11] The SOC are based on the best available science and expert professional consensus. Importantly, SOC 8 is based on the best available science and expert professional consensus in transgender health; its recommendation statements were developed based on data derived from independent systematic literature reviews, background reviews, and expert opinions; and its grading of recommendations was based on the available evidence supporting interventions, a discussion of risks and harms, as well as the feasibility and acceptability of these. SOC 8 continues to recommend the provision of medical interventions, such as puberty blockers, hormone therapy, and surgery, as treatment for gender dysphoria, based on an individual patient's needs.

11. The WPATH SOC have been endorsed and cited as authoritative by most major medical associations in the United States, including the American

[11] Coleman, et al. (2022) (SOC 8).

Medical Association, the American Psychiatric Association, the American Psychological Association, the Endocrine Society, the Pediatric Endocrine Society, the American College of Physicians, and the American Academy of Family Physicians, among others.

12. The UCSF Center for Excellence in Transgender Care as well as the Endocrine Society have both published comprehensive guidelines for the care of transgender and non-binary individuals that are largely consistent with the WPATH SOC.[12]

13. The GAPMS Memo and some its attached "assessments" discuss a number of approaches to care, though they fail to properly describe them and to discuss their limitations.

14. One of the approaches discussed by Dr. Van Meter is **"reparative" or "corrective"** therapy. *See* Attachment E to GAPMS Memo, at 6 ("Van Meter"). "Conversion" or "reparative" therapy refers to the practice of attempting to change an individual's sexual orientation and attractions from members of the same sex to those of the opposite sex. A similar model of therapy

[12] Deutsch, M.B. (ed.). (2016). Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (2d ed.). San Francisco, CA: UCSF Center of Excellence for Transgender Health, https://transcare.ucsf.edu/guidelines (UCSF Guidelines); Hembree, et al. (2017) (Endocrine Society Guidelines).

for individuals with a transgender identity or experience has historically been an approach promoted by some individuals, notwithstanding its ineffectiveness and harmful effects. Accordingly, 20 states and the District of Columbia have banned reparative therapy for youth, and major medical organizations have issued statements deeming the practice to be unethical.[13]

15. A Williams Institute report published in 2019 estimates that just under 700,000 LGBT individuals in the United States have undergone "conversion therapy" at some point in their lifetime, about half of those during adolescence.[14] Because some psychiatrists and sexologists working in the 1960's and 70's perpetuated the idea that being transgender was likely the result of a pathological early childhood experience, many professionals and lay community members continue to believe that gender is malleable. Tactics have ranged from simple redirection, thought pattern alteration or hypnosis to aversion techniques including induction of vomiting, nausea, paralysis or electric shock, have been employed in order to change the expression, behavior, and assertion of one's

[13] Movement Advancement Proj., *Conversion "Therapy" Laws,* https://www.lgbtmap.org/equality-maps/conversion_therapy (last updated Jan. 30, 2023).

[14] Mallory, C., Brown, T. N.T., Conron, K.J. (2019). Conversion Therapy and LGBT Youth: Update. Los Angeles, CA: The Williams Institute, UCLA School of Law.

authentic gender.[15] However, multiple studies show that gender identity has a strong biological basis and cannot be changed. As such, reparative therapy is both ineffective and harmful for transgender and gender diverse youth.

16. **"Redirection"** – Under this approach, advocated by people like Dr. Van Meter, a mental health therapist would encourage caregivers to use positive reinforcement to try to "redirect" children toward behavior that is more typical of their birth-designated sex or less gender specific. Underlying this approach is the assumption that a child's gender identity is malleable through social interventions. The goal of redirection is thus to eliminate gender-diverse desires and expressions over time, and to try to prevent the transgender child from being transgender. This approach is not recommended because negative reinforcement (e.g., shaming the child for gender diverse expression) has substantial negative mental and social health consequences.[16] It also ignores that gender identity is innate and cannot be changed.

17. **Wait-and-see** – The wait-and-see approach (also called watchful waiting) involves waiting to see if the child's gender identity will change as the

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[15] *Id.*

[16] Turban, J.L., & Ehrensaft, D. (2018). Research Review: Gender identity in youth: treatment paradigms and controversies. *Journal of child psychology and psychiatry, and allied disciplines*, *59*(12), 1228–1243; Ehrensaft, D. (2017). Gender nonconforming youth: current perspectives. *Adolescent health, medicine and therapeutics*, *8*, 57–67.

child gets older. This approach typically recommends that caregivers prohibit a prepubertal social transition but may allow cross-gender play and clothing within the home or support both masculine and feminine activities as the child explores their interests in other social settings. The wait-and-see approach assumes that gender is binary and becomes fixed at a certain age; it pathologizes gender diversity and fluidity. It is distinguished from following the child's lead, an affirming approach that allows the child to present in the gender role that feels correct and moves at a pace that is largely directed by the child. This approach ignores evidence that young children thrive when given permission to live in the gender that is most authentic to them and are at risk for symptomatic behaviors if prevented from doing so.[17]

18. **Affirmation** – The affirmative approach considers no gender identity outcome: transgender, cisgender, or otherwise, to be preferable.[18] It permits a child to explore gender development and self-definition within a safe setting. A fundamental concept of this approach is that gender diversity is not a mental illness. The gender-affirmative model is defined as a method of therapeutic care that includes allowing children to speak for themselves about

[17] Ehrensaft (2017).

[18] Turban and Ehrensaft (2018).

their self-experienced gender identity and expressions and providing support for them to evolve into their authentic gender selves, no matter at what age. Under this model, a child's self-report is embedded within a collaborative model with the child as subject and the collaborative team including the child, parents, and professionals. Support is not characterized by "encouraging" children or youth to be transgender or not, but rather by allowing children who express a desire to undergo a social transition (which may include changing names, pronouns, clothing, hairstyles, etc.) to do so. **For children who have not yet reached puberty, medical intervention is unnecessary and unwarranted.** After the onset of puberty, medical interventions such as puberty blockers, and later hormones and surgery, may be appropriate.

19. While some argue that gender affirmation leads a child or adolescent down a path of inevitable transgender identity, no such evidence exists, either in the scientific or the clinical setting. To the contrary, studies show that gender identification does not meaningfully differ before and after social transition.[19]

[19] Rae, J. R., Gülgöz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science*, 30(5), 669-681.

20. Under both the "wait and see" and affirmative care models, as understood in the scientific literature, medical care is recommended following the onset of puberty.[20]

21. The most effective treatment for adolescents and adults with GD, in terms of both their mental and medical health, contemplates an individualized approach. Medical and surgical treatment interventions are determined by the care team (usually a medical and mental health professional) in collaboration with the patient, and the patient's family, if the patient is a minor. These medical decisions are made by the care team in conjunction with the patient and, if the patient is a minor, the patient's family, and consider the patient's social situation, level of gender dysphoria, developmental stage, existing medical conditions, and other relevant factors. Sometimes treatment begins with puberty delaying medications (also referred to as puberty blockers), later followed by gender-affirming hormones. Most youth, and certainly all adults, accessing treatment are already well into or have completed puberty.

[20] Ehrensaft (2017).

1) Puberty Blockers

22. The beginning signs of puberty in transgender youth (the development of breast buds in assigned birth females and increased testicular volume in assigned birth males) is often a painful and sometimes traumatic experience that brings increased body dysphoria and the potential development of a host of comorbidities including depression, anxiety, substance abuse, self-harming behaviors, social isolation, high-risk sexual behaviors, and increased suicidality.

23. Puberty suppression, which involves the administration of gonadotrophin-releasing hormone analogues (GnRHa), essentially pauses puberty, thereby allowing the young person the opportunity to explore gender without having to experience the anxiety and distress associated with developing the undesired secondary sexual characteristics. In addition, for parents/guardians who are uneducated about gender diversity and/or who have only recently become aware of their child's transgender identity, puberty blockers provide additional time and opportunity to integrate this new information into their own experience and to develop skills to support their child. Puberty suppression also has the benefit of potentially rendering obsolete some gender-affirming surgeries down the line, such as male chest reconstruction, tracheal shave, facial

feminization, and vocal cord alteration, which otherwise would be required to correct the initial "incorrect" puberty.

24. Puberty suppression has been used safely for decades in children with other medical conditions, including precocious puberty, and is a reversible intervention.[21] If the medication is discontinued, the young person continues their endogenous puberty. The "Dutch protocol," developed from a study conducted in the Netherlands and published in 2006, calls for the commencement of puberty blockers for appropriately diagnosed and assessed gender dysphoric youth as early as 12 years of age.[22] Both the Endocrine Society and the WPATH's SOC, however, recommend initiation of puberty suppression at the earliest stages of puberty (usually, Tanner 2) (assuming someone has engaged in services before or around this time), regardless of chronological age, in order to avoid the stress and trauma associated with developing secondary sex characteristics of the natal sex.

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[21] Mul, D. & Hughes, I. (2008). The use of GnRH agonists in precocious puberty. *European journal of endocrinology / European Federation of Endocrine Societies*. 159 Suppl 1. S3-8.

[22] de Vries, A.L.C., McGuire, J. K., Steensma, T. D., Wagenaar, E. C. F., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2014). Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment. *Pediatrics*, *134*(4), 696-704; Biggs M. (2022). The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence. *Journal of sex & marital therapy*, 1–21.

25. A growing body of evidence, including peer-reviewed cross-sectional and longitudinal studies, demonstrates the positive impact of pubertal suppression in youth with GD on psychological functioning including a decrease in behavioral and emotional problems, a decrease in depressive symptoms, and improvement in general functioning.[23]

26. The initial follow-up studies evaluating the use of puberty suppression in relation to psychological well-being in adolescents with GD came from the Netherlands and demonstrated that behavioral and emotional problems and depressive symptoms decreased and general functioning significantly improved during treatment.[24]

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[23] See for example: de Vries, A.L., Steensma, T.D., Doreleijers, T.A., & Cohen-Kettenis, P.T. (2011). Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study. *The Journal of Sexual Medicine*, 8(8), 2276-2283; Turban, J.L., King, D., Carswell, J.M., & Keuroghlian, A.S. (2020). Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*, 145(2):e20191725; van der Miesen, A.I., Steensma, T.D., de Vries, A.L., *et al*. (2020). Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers. *Journal of Adolescent Health*, 66(6), 699-704; Achille, C., Taggart, T., Eaton, N.R., *et al*. (2020). Longitudinal Impact of Gender-Affirming Endocrine Intervention on the Mental Health and Well-Being of Transgender Youths: Preliminary Results. *International Journal of Pediatric Endocrinology*, 2020(8), 1-5; and Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *The journal of sexual medicine*, *12*(11), 2206–2214..

[24] de Vries, et al. (2011); de Vries, et al. (2014).

27. A study from the United Kingdom demonstrated that psychological support and puberty suppression were associated with improved global psychosocial functioning in adolescents with gender dysphoria with a combination of psychological support and puberty suppression, attributing to a greater improvement than psychological support only.[25]

28. A more recent cross-sectional study from the Dutch team demonstrated that transgender youth undergoing pubertal suppression had better psychological functioning than those youth who had not yet begun puberty blockade.[26]

29. Achille et al. demonstrated a positive effect of puberty blockade on mental health in a small, prospective investigation. The study characterized a treatment cohort over progressive interventions moving from puberty blockade to GAH treatment.[27]

30. Overall, this growing body of evidence is consistent with and supports clinical experience demonstrating a significant positive effect of puberty blockade in youth with gender dysphoria.

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[25] Costa, et al. (2015).

[26] Van der Miesen, et al. (2020).

[27] Achille, et al. (2020).

31. Puberty blockers, thus, afford youth the opportunity to undergo a single, congruent pubertal process and avoid many of the surgical interventions previously necessary for assimilation into an authentic gender role. It is a simple reversible intervention that has the capacity to improve health outcomes and save lives. Over the course of my work in the past sixteen years with gender diverse and transgender youth, I have prescribed hormone suppression for over 350 patients. All of those patients have benefitted from putting their endogenous puberty process on pause, even the small handful who discontinued GnRH analogues and went through their endogenous puberty. Many of these young people were able to matriculate back into school environments, begin appropriate peer relationships, and participate meaningfully in therapy and family functions. Children who had contemplated or attempted suicide or self-harm (including cutting and burning) associated with monthly menstruation or the anxiety about their voice dropping were offered respite from those dark places of despair. GnRH analogues for puberty suppression are, in my opinion, a sentinel event in the history of transgender medicine, and have changed the landscape almost as much as the development of synthetic hormones.

2) Gender-Affirming Hormones

32. Cross-gender or gender-affirming hormone therapy involves administering steroids of the experienced sex (i.e., their gender identity) (estrogen for transfeminine individuals and testosterone for transmasculine individuals). The purpose of this treatment is to attain the appropriate masculinization or feminization of the transgender person to achieve a gender phenotype that matches as closely as possible to their gender identity. Gender-affirming hormone therapy is a partially reversible treatment in that some of the effects produced by the hormones are reversible (e.g., changes in body fat composition, decrease in facial and body hair) while others are irreversible (e.g., deepening of the voice, breast tissue development). Eligibility and medical necessity should be determined case-by-case, based on an assessment of the youth's unique cognitive and emotional maturation and ability to provide a knowing and informed consent. The decision would be made only after a careful review with the youth and parents/guardians of the potential risks and benefits of hormone therapy. The youth's primary care provider, therapist, or another experienced mental health professional can help document and confirm the patient's history of GD, the medical necessity of the intervention, and the youth's readiness to transition medically.

33. As with the use of puberty blockers, the data demonstrating the positive effects of gender affirming hormones (GAH) is well established and growing.

34. The Dutch team at The Center of Expertise on Gender Dysphoria at the VU University Medical Center Amsterdam continued to report out the improvement within their cohort of youth with gender dysphoria after GAH. De Vries et al reported in 2014 that their cohort of young adults who began care in adolescence had steadily improving mental health (including depression, anxiety, anger, internalizing and externalizing psychopathologic symptoms) following puberty blockade, GAH and gender affirming surgery.[28]

35. A German observational study reported that among the participants at follow-up, adolescents in the gender-affirming hormone (GAH) and surgery (GAS) group reported emotional and behavioral problems and physical quality of life scores similar to the German norm mean.[29]

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[28] de Vries, et al. (2014).

[29] Becker-Hebly, I., Fahrenkrug, S., Campion, F., Richter-Appelt, H., Schulte-Markwort, M., & Barkmann, C. (2021). Psychosocial health in adolescents and young adults with gender dysphoria before and after gender-affirming medical interventions: A descriptive study from the Hamburg Gender Identity Service. *European Child & Adolescent Psychiatry*, 30(11), 1755–1767.

36. Also from Germany, Neider et al. reported that among a group of 75 adolescents with gender dysphoria satisfaction improved the further along the treatment course had progressed.[30]

37. From the United States, Kuper et al. carried out a prospective study and reported their cohort of transgender and non-binary youth starting either pubertal blockade or GAH demonstrated improvement at follow up (around a year) in depression, anxiety and body esteem.[31]

38. While small, Grannis et al. demonstrated decreased depression and anxiety in a group of transmasculine youth taking testosterone versus an untreated control group.[32]

39. Most recently our team at the Trans Youth Care United States (TYC-US) reported in the New England Journal of Medicine an improvement among

[30] Nieder, T. O., Mayer, T. K., Hinz, S., Fahrenkrug, S., Herrmann, L., & Becker-Hebly, I. (2021). Individual treatment progress predicts satisfaction with transition-related care for youth with gender dysphoria: A prospective clinical cohort study. *The Journal of Sexual Medicine*, 18(3), 632–645.

[31] Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. *Pediatrics*, 145(4).

[32] Grannis, C., Leibowitz, S. F., Gahn, S., Nahata, L., Morningstar, M., Mattson, W. I., Chen, D., Strang, J. F., & Nelson, E. E. (2021). Testosterone treatment, internalizing symptoms, and body image dissatisfaction in transgender boys. *Psychoneuroendocrinology*, 132, 105358, 1-8.

315 youth in positive affect and life satisfaction as well as a decrease in depressive and anxiety symptoms after two years of GAH.[33]

40. The data documenting the efficacy of hormone treatment in transgender adults is as robust and goes back even further. Numerous longitudinal studies document improvement in various mental health parameters including depression, anxiety, self-confidence, body image and self-image, general psychological functioning.[34]

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[33] Chen D, Berona J, Chan YM, Ehrensaft D, Garofalo R, Hidalgo MA, Rosenthal SM, Tishelman AC, Olson-Kennedy J. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Med.* 2023 Jan 19;388(3):240-250.

[34] See for example: Colizzi, M., et al. (2014). Transsexual patients' psychiatric comorbidity and positive effect of cross-sex hormonal treatment on mental health: results from a longitudinal study. *Psychoneuroendocrinology*, *39*, 65–73; Colizzi, M., et al. (2013). Hormonal treatment reduces psychobiological distress in gender identity disorder, independently of the attachment style. *The journal of sexual medicine*, *10*(12), 3049–3058; Corda, E., et al. (2016). Body image and gender role perceived in gender dysphoria: Cross-sex hormone therapy effects. *European Psychiatry*, 33(S1), S589-S589; Fisher, A. D., et al. (2016). Cross-Sex Hormone Treatment and Psychobiological Changes in Transsexual Persons: Two-Year Follow-Up Data. *The Journal of clinical endocrinology and metabolism*, *101*(11), 4260–4269; Heylens, G., et al. (2014). Effects of different steps in gender reassignment therapy on psychopathology: a prospective study of persons with a gender identity disorder. *The journal of sexual medicine*, *11*(1), 119–126; Keo-Meier, C. L., et al. (2015). Testosterone treatment and MMPI-2 improvement in transgender men: a prospective controlled study. *Journal of consulting and clinical psychology*, *83*(1), 143–156; Manieri, C., et al. (2014) Medical Treatment of Subjects with Gender Identity Disorder: The Experience in an Italian Public Health Center, *International Journal of Transgenderism*, 15:2, 53-65; Motta, G., et al. (2018). Does Testosterone Treatment Increase Anger Expression in a Population of Transgender Men?. *The journal of sexual medicine*, *15*(1), 94–101; Oda, H., & Kinoshita, T. (2017). Efficacy of hormonal and mental treatments with MMPI in FtM individuals: cross-sectional and longitudinal studies. *BMC psychiatry*, *17*(1), 256; and Turan, Ş., et al. (2018). Alterations in Body Uneasiness, Eating Attitudes, and Psychopathology Before and After Cross-Sex Hormonal Treatment in Patients with Female-to-Male Gender Dysphoria. *Archives of sexual behavior*, *47*(8), 2349–2361.

41. An established and growing body of evidence combined with decades of clinical evidence demonstrate the positive effect of gender affirming hormones in adolescents and adults with gender dysphoria.

3) Gender-Affirming Surgeries

42. Some transgender individuals need surgical interventions to help bring their phenotype into alignment with their gender. Surgical interventions may include vaginoplasty, tracheal shave, liposuction, breast implants, and orchiectomy for transfeminine individuals and chest reconstruction, hysterectomy, oophorectomy, salpingectomy, construction of a neoscrotum, and metoidioplasty or phalloplasty for transmasculine individuals.

43. The current WPATH SOC recommend that surgical interventions may occur when appropriate for an individual.

44. Decades of research confirms that gender confirmation surgery is therapeutic and therefore an effective treatment for gender dysphoria.[35] In a 1998

[35] *See*, *e.g.*, Almazan, A. N., & Keuroghlian, A. S. (2021). Association Between Gender-Affirming Surgeries and Mental Health Outcomes. *JAMA surgery*, 156(7), 611–618; Almazan, et al. (2021); Murad, M. H., et al. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology*, 72(2), 214-231; Smith, Y., et al. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine* 35(1): 89-99; and Pfafflin, F., & Junge, A. (1998). Sex reassignment: Thirty years of international follow-up studies after sex reassignment surgery, a comprehensive review, 1961-1991.

meta-analysis, Pfafflin and Junge reviewed data from 80 studies, from 12 countries, spanning 30 years. They concluded that "reassignment procedures were effective in relieving gender dysphoria. There were few negative consequences and all aspects of the reassignment process contributed to overwhelmingly positive outcomes."[36]

45. Subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in the Netherlands concluded that after surgery there was "a virtual absence of gender dysphoria" in the cohort and "results substantiate previous conclusions that sex reassignment is effective."[37] The authors of the study concluded that the surgery "appeared therapeutic and beneficial" across a wide spectrum of factors and "[t]he main symptom for which the patients had requested treatment, gender dysphoria, had decreased to such a degree that it had disappeared." Similarly, a recent systematic review that included data from 1,052 transmasculine patients who obtained chest surgery found that pooled overall postoperative satisfaction was 92%.[38]

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[36] Pfafflin & Junge (1998).

[37] Smith, et al. (2005).

[38] Bustos, V. P., Bustos, S. S., Mascaro, A., Del Corral, G., Forte, A. J., Ciudad, P., Kim, E. A., Langstein, H. N., & Manrique, O. J. (2021). Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. *Plastic and reconstructive surgery. Global open*, *9*(3), e3477.

46. With regards to transgender adolescents, peer-reviewed research has also shown improvements in mental health following gender-affirming chest surgery for transgender males with gender dysphoria where medically indicated.[39]

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47. Recognizing the importance of individualized care, the SOC 8 has this to say about all gender affirming interventions: "The SOC-8 guidelines are intended to be flexible to meet the diverse health care needs of TGD people globally. While adaptable, they offer standards for promoting optimal health care and for guiding treatment of people experiencing gender incongruence. As in all previous versions of the SOC, the criteria put forth in this document for gender-affirming interventions are clinical guidelines; individual health care professionals and programs may modify them in consultation with the TGD person. Clinical departures from the SOC may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health care professional's evolving method of handling a common situation; a research

[39] Mehringer, J. E., et al. (2021). Experience of Chest Dysphoria and Masculinizing Chest Surgery in Transmasculine Youth. *Pediatrics*, *147*(3), e2020013300; Olson-Kennedy, J., et al. (2018). Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA pediatrics*, *172*(5), 431–436.

protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, explained to the patient, and documented for quality patient care and legal protection."

48. Gender-affirming medical interventions are considered medically necessary and are recognized as such by many major professional organizations. The denial of this care results in negative health consequences.

49. There are those (see GAPMS Memo at 12-13) who would make the argument that the recent uptick in youth presenting for services related to GD is the result of "social contagion." But if social contagion theory applied to gender and gender identity, there would be zero transgender people, because of the consistent exposure to an overwhelming majority of cisgender people. The social contagion argument that is posited by some confuses the relationship between one's recognition of their gender and their exposure to gender related information and community, particularly with regard to internet activity, asserting that youth are declaring themselves to be transgender or gender diverse because they were exposed to this online, or they have multiple friends who are also experiencing GD. Adolescent development includes finding like groups of peers, which extends to finding friend groups who are also gender diverse. Finally, attributing

GD to "social contagion" is a simplistic perspective that discounts that the process of doing something about one's gender dysphoria is complex and difficult and involves parental consent for minors.

50. There is no scientific evidence that one develops gender dysphoria from being exposed to people with GD. To the contrary, most evidence shows that gender identity has a biological basis[40] and is affixed by early childhood.[41]

C. Critiques of the GAPMS Memo and the Attached "Assessments"

51. The GAPMS Memo and the attached assessments contain a number of inaccurate assertions or misrepresentations, in addition to those noted above.

Misunderstandings and Misrepresentations of Desistance

52. The GAPMS Memo falsely states that "the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex and that the puberty suppression can have side effects." (GAPMS Memo at 14). This is a blatant misrepresentation of the scientific literature. The studies pertaining to desistance upon which the GAPMS Memo

[redacted]

relies pertain to *pre-pubertal* youth, not adolescents. In fact, contrary to the GAPMS Memo's assertion, studies show that if gender dysphoria is present in adolescence, it usually persists.[42]

[redacted]

who demonstrate an interest or preference for clothing, toys, and games that are stereotypically of interest to members of the "other" gender. Some of these children are transgender and some are not. It is the study of such *pre-pubertal* children that has created confusion about the persistence of gender dysphoria into adolescence and adulthood. Specifically, the *pre-pubertal* children who were the subject of research endeavors in the late 20th century included both children who are transgender and children who are not, i.e., those who would have met current criteria for a diagnosis of "Gender Dysphoria in Children" and those who would be considered "sub-threshold" for this diagnosis.

54. At the time of these studies, the diagnosis of "Gender Dysphoria in Children" did not exist and therefore the study subjects did not need to meet criteria B, which is "the presence of clinically significant distress associated with the condition." In addition, the criteria for the then-used "gender identity disorder

[42] de Vries, et al. (2011).

in children" diagnosis did not require a child to have "a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)," which the current "Gender Dysphoria in Children" diagnosis requires.

55. Thus, given the broader criteria used at the time, it is unsurprising that some of the research undertaken toward the end of the 20th century demonstrated that most children who exhibited gender-nonconforming behavior did not go on to have a transgender identity in adolescence. Yet, notwithstanding its inapplicability and faulty underpinnings, this "evidence" has been used to argue against gender affirmation for children and adolescents.

56. What is more, these arguments about desistance in *pre-pubertal* children are wholly irrelevant to the question of coverage and provision of medical care as treatment for GD. That is because research to date shows that if transgender identification persists into adolescence, then desistance is incredibly rare, and no medical or surgical treatments are recommended for *pre-pubertal* children.

57. Additionally, no studies have ever demonstrated that gender affirmation in childhood "leads to" a child being transgender who otherwise might not have been. Studies have demonstrated that the majority of youth whose

GD and cross-gender identity continue to be present, or those whose GD emerges in adolescence, are highly unlikely to identify and live as cisgender individuals. Youth with GD, particularly those who are unaffirmed and denied care, are at high risk for depression, anxiety, isolation, self-harm and suicidality at the onset of puberty-related changes that feel wrong to them.

The Myth of Social Contagion and Rapid-Onset Gender Dysphoria (ROGD)

58. The GAPMS memo asserts that gender-affirming care should not be provided because the causes of GD are uncertain. It suggests that "exposure to 'social and peer contagion'" accounts for the rise in numbers of adolescents who identify as transgender, pointing to research that has identified so-called "rapid-onset gender dysphoria" (ROGD). (GAPMS Memo at 12-13; see also Cantor ¶ 48-49). However, ROGD is not a diagnosis recognized by any medical or scientific institution, and there is no scientific evidence in support of it.

59. The concept of ROGD originated from a single article authored by Lisa Littman, a researcher who had no experience in the field of gender medicine, transgender issues, or gender dysphoria, prior to the publication of her article.[43]

[43] Littman L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PloS one*, *13*(8), e0202330.

60. Littman's article was heavily criticized for its flawed methodology, potential for bias, and overrepresentation of its findings.[44] For example, Littman's study was based solely on "parent observations and interpretations." But parental reports are not necessarily a reliable basis for understanding a particular youth's experience with their gender, let alone whether the youth has gender dysphoria.[45] Moreover, most of the parents who participated in the study were recruited from websites targeted to parents likely to question their child's gender self-identification and the current best health care approaches. In addition, the study also failed to collect data from the adolescents and young adults (AYAs) or clinicians, which would have been necessary in order to come up with and validate ROGD as a new phenomenon.

[44] *See*, *e.g.*, Brandelli Costa, A. (2019) Formal comment on: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLoS ONE 14(3): e0212578; Restar A. J. (2020). Methodological Critique of Littman's (2018) Parental-Respondents Accounts of "Rapid-Onset Gender Dysphoria". *Archives of sexual behavior*, *49*(1), 61–66.

[45] *See*, *e.g.*, Kennedy, N. (2022) Deferral: the sociology of young trans people's epiphanies and coming out. *Journal of LGBT Youth*, 19:1, 53-75; Brandelli Costa (2019).

61. Following the numerous critiques of the Littman study, the journal that published the study retracted it, ordered a post-publication review, and republished the article with a correction notice,[46] along with an apology.[47]

62. The correction notice acknowledged, among other things, that: [48]

a. "there is some information about the AYAs that the parents would not have access to and the answers might reflect parent perspectives" and that "consideration of what information parents may or may not have access to is an important element of the findings";

b. "the study's output was hypothesis-generating rather than hypothesis-testing";

c. "three of the sites that posted recruitment information expressed cautious or negative views about medical and surgical interventions for gender dysphoric adolescents and young adults

[46] Littman L. (2019) Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE*, 14(3): e0214157.

[47] Heber, J. Correcting the scientific record on gender incongruence – and an apology, PLoS ONE (Mar. 19, 2019), https://everyone.plos.org/2019/03/19/correcting-the-scientific-record-and-anapology/.

[48] Littman (2019).

and cautious or negative views about categorizing gender dysphoric youth as transgender"; and

d. "There is expected variation in how objective parents can be about their own children" and that the "descriptive study was not designed to explore or measure the objectivity of participants."

63. Thus, the correction notice ultimately acknowledged that the study "does not validate the phenomenon" of ROGD and that the term ROGD "should not be used in a way to imply that it explains the experiences of all gender dysphoric youth nor should it be used to stigmatize vulnerable individuals."[49] In the end, aside from the correction notice, the journal that published the study issued an apology "for oversights that occurred during the original assessment of the study."[50]

64. To date, no study has been published that validates or proves the hypothesis of ROGD presented by the Littman study. Indeed, Lisa Littman herself said at the GenSpect 2021 Conference that ROGD was not a new phenomenon, but rather a re-naming of late onset GD.

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[49] *Id.*

[50] Heber (2019).

65. The GAPMS Memo, Dr. Cantor, and Dr. Van Meter incorrectly allege that an increase in numbers of youth presenting for care related to GD provides support for the social contagion theory. (See GAPMS Memo at 12-13; Van Meter at 9-10). For one, varying estimates of prevalence are the result of inconsistent measures of transgender populations. Some studies have assessed the fraction of a population which had received the DSM-IV diagnosis of GID or the ICD 10 diagnosis of transsexualism, both of which were limited to clinical populations who sought a binary transition (male-to-female or female-to-male). For example, the prevalence reported in DSM-5 (0.005–0.014% for birth-assigned males; 0.002–0.003% for birth-assigned females) are based on people who received a diagnosis of GID or transsexualism and were seeking hormone treatment and surgery from gender specialty clinics, and, therefore, do not reflect the number of all individuals with gender dysphoria or who identify as transgender.[51] Other studies have reported on those who self-identified as transgender or gender incongruent and found that measuring self-identity yields much higher numbers. In 2016, data from the Center for Disease Control's Behavioral Risk Factor Surveillance System suggested that 0.6% of U.S. adults

[51] Coleman, et al. (2022).

identify as transgender, double the estimate utilizing data from the previous decade.[52] Ultimately, there is nothing surprising about the fact that more transgender people have begun identifying themselves to others as societal stigma has started to abate, and nothing about that lends support to the "social contagion" theory.

Dr. Cantor's False Assertion of Transition-on-Demand

66. In his "assessment," Dr. Cantor, a psychologist with no clinical experience in treating gender dysphoria in minors and no experience monitoring patients receiving drug treatments for gender dysphoria, states that "transition-on-demand" increases the probability of unnecessary transition and unnecessary medical risks. (Cantor ¶ 21).

67. His claim is wholly divorced from the reality of care for transgender people. First, like all health care, gender-affirming care for every transgender person is individualized. There simply is no one specific route.

68. Second, Dr. Cantor inaccurately assumes that every transgender person wants and receives rapid access to services. For most transgender individuals seeking care, nothing about their process has been rapid, even when

[52] Byne, W., Karasic, D. H., Coleman, E., Eyler, A. E., Kidd, J. D., Meyer-Bahlburg, H. F. L., … Pula, J. (2018). Gender dysphoria in adults: An overview and primer for psychiatrists. *Transgender Health*, *3*(1), 57-70.

they are young. Most individuals with gender dysphoria have engaged in a long, arduous and private process of understanding their gender to be different from the one assumed at birth. Dr. Cantor gives no credibility to transgender patients regarding their right to bodily autonomy nor their capacity to make sound and informed decisions.

69. Finally, Dr. Cantor is wrong to assert that affirmation "increases the probability of unnecessary transition and unnecessary medical risks." (Cantor ¶ 21). There is no evidence to support the notion that affirmation of gender in pre-pubertal children, or at any age, leads to transition. Medical interventions are not recommended and are not appropriate for pre-pubertal children. If one's gender could be impacted by the role of rearing, there would be few transgender people who transition in adulthood, as most were reared in the gender role that corresponded with their sex assigned at birth. It is not logical to think that while we have been epically failing at convincing transgender people to be cisgender, we would be able to make someone who is cisgender into someone who is transgender, a directionality that may correspond with higher rates of discrimination, harassment, and even violence. There is no data to support any such notion that children who are socially transitioned in a pre-pubertal time

period who then go on to embrace their assumed gender at birth are damaged. I know several such young people who are healthy and happy.

The Quality of the Evidence and Lack of Randomized Controlled Trials

70. The care of transgender individuals has a long history. As with all medical care, there is a range of quality in the existing data regarding the treatment of gender dysphoria,[53] and there is certainly a need for additional studies of a longitudinal nature. But again, that is true with most medical care.

71. Between 1963 and 1979, over 20 university-based gender identity clinics opened in the United States.[54] These clinics provided interdisciplinary care that included psychiatrists and other mental health professionals and played an important role in the provision of medical services to transgender people and in promoting research to improve their care. The majority of these clinics closed following a 1981 decision of the U.S. Department of Health and Human Services (HHS) that labeled sex reassignment surgery as experimental, in large part due to advocacy by Dr. Paul McHugh.[55] That decision was overturned by HHS in 2014 in a determination that concluded that the 1981 decision was "not

[53] See Deutsch (ed.) (2016) (UCSF Guidelines).

[54] Byne, et al. (2018).

[55] In this way, Dr. McHugh actively attempted to suppress the research that he complains is lacking in this field of care.

reasonable" and found that gender-affirming surgery is "a safe and effective treatment option."[56]

72. Over the last four decades: research has continued to occur in the United States and internationally; WPATH (formerly the Henry Benjamin International Gender Dysphoria Association) published the first iteration of the Standards of Care in 1979, which is now in its 8th version; the DSM and ICD stopped classifying transgender identification as a mental disorder; the American Psychological Association and Endocrine Society, as well as other medical organizations, adopted clinical guidelines consistent with the WPATH Standards of Care; and dozens of interdisciplinary gender clinics associated with research institutions and teaching hospitals have been providing gender-affirming care for transgender youth and adults across the United States.

73. Drs. Brignardello-Petersen and Wiercioch repeatedly refer to an apparent lack of data comparing treated vs. untreated individuals with gender dysphoria. Their report continually places emphasis on data that they rated as "low certainty" based on GRADE criteria. These observations about the data do not mean that gender-affirming care is experimental or investigational.

[56] U.S. Dep't Health & Hum. Servs., NCD 140.3, Transsexual Surgery 18, 21 (2014); Byne, et al. (2018).

74. One of the intrinsic elements of rating the quality of evidence is the study design. Randomized controlled trials (RCTs) are considered the highest quality in the grading of evidence. Many of the research studies on gender-affirming care get a "low quality" grade due to the lack of RCTs.

75. But it is well-established that utilizing an untreated control group is unethical in this context – gender-affirming medical interventions have been used for decades, resulting in a vast amount of clinical knowledge about their efficacy. That said, we have a large de facto group of untreated individuals with gender dysphoria who experience significant psychiatric symptoms because of widespread barriers to access to care.

76. Clinicians who are competent in the care of transgender individuals practice according to a "first do no harm" ethic which understands that doing nothing is not a neutral option for those with gender dysphoria. Multiple studies have demonstrated the safety of gender-affirming hormones, and a growing body

of evidence does the same with regards to the safety of GnRH analogues.[57] The same is true with regards to surgery.[58]

77. In addition, RCTs are ill-suited to studying the effects of gender-affirming interventions on psychological wellbeing and quality of life of trans people. Adequate masking, adherence, and generalizability are severely impeded in transgender care, thereby negating the superior scientific value of RCTs.

78. Gender-affirming interventions have physiologically evident effects, making it impossible to mask RCTs. The purpose of puberty blockers, hormone therapy, and transition-related surgeries is to inhibit or produce visible bodily changes.

79. In an RCT, adolescents who are on puberty blockers would notice that their endogenous pubertal development had stopped, whereas those not on puberty blockers will notice that they had not. Hormonal suppression is achieved

[57] Kuper, et al. (2020); Chew, D., Anderson, J., Williams, K., May, T., & Pang, K. (2018). Hormonal Treatment in Young People With Gender Dysphoria: A Systematic Review. *Pediatrics*, *141*(4), e20173742; Colton-Meier, S. L., Fitzgerald, K. M., Pardo, S. T., & Babcock, J. (2011). The effects of hormonal gender affirmation treatment on mental health in female-to-male transsexuals. *Journal of Gay & Lesbian Mental Health*, 15(3), 281-299.

[58] Marano, A. A., Louis, M. R., & Coon, D. (2021). Gender-Affirming Surgeries and Improved Psychosocial Health Outcomes. *JAMA surgery*, *156*(7), 685–687; Olson-Kennedy, et al. (2018); Murad, et al. (2010); Smith, et al. (2005); Pfafflin & Junge (1998).

around four weeks after treatment is initiated, but it may take multiple months before participants notice that pubertal development has ceased.

80. Similarly, transgender people given hormone therapy would notice bodily changes from taking estrogen or testosterone, whereas transgender people in the control arm would notice no such changes. The onset of visible effects from hormone therapy varies from person-to-person. The first changes typically appear between one and six months of initiation, whereas other desired changes may not begin for up to a year.

81. Although it may take some time before participants are able to ascertain which treatment they were allocated to due to the delayed effect of puberty blockers and the progressive effect of and hormone therapy, large-scale unmasking is inevitable. Because the physiological changes are the primary purpose of gender-affirming care, meaningful effects on psychological wellbeing and quality of life are not expected until unmasking occurs. As such, while RCTs can be utilized to examine the effects of gender-affirming care on physiology, using RCTs to measure the effect of gender-affirming care on psychological wellbeing and quality of life would be inappropriate.

82. Unmasking an RCT of gender-affirming care would lead to non-compliance, cross-over, and response bias in the control arm of the study.

Transgender people with gender dysphoria who pursue gender-affirming care are typically insistent and persistent in seeking the interventions. They are not ambivalent as to whether they are assigned to the intervention or control arm of the study. Upon realizing that they are in the control arm due to physiological effects or lack thereof, a large proportion of the study participants would likely withdraw from the study or pursue alternative sources of gender-affirming interventions.

83. Withdrawing from the study and noncompliance with the study protocol is most likely among people who have alternative means of securing gender-affirming care and who experience more severe bodily gender dysphoria, raising grave concerns of systematic bias. Gender-affirming interventions can be obtained from parents, peers, illicit or unauthorized sources, other providers within or outside of the health care system, and through medication-sharing with participants from the active arm of the study. Some of these options are associated with elevated safety risks, giving rise to additional ethical concerns about the use of RCTs. Intentional withdrawal with the goal of forcing the study to end is also possible. Resentment towards researchers for not allowing all participants to receive gender-affirming interventions may also increase the risk of response bias compared to observational studies, and the experimental design

may motivate youths to engage in self-harm or suicidal behavior to influence the study results, aggravating scientific and ethical concerns.

84. Given that withdrawal rates could be high enough for studies to be terminated before they are concluded, RCTs may prove impossible to conduct altogether. The likelihood of withdrawal, non-adherence, and response bias in the context of transgender care undermines RCTs' ability to detect true associations and avoid specious associations between the intervention and the outcomes.

85. Many disciplines and areas of research rely on observational studies because RCTs are considered impracticable or unethical. This is especially common when studying the mental health outcomes of physiologically evident interventions due to the impossibility of masking, and when studying the outcomes of highly desired interventions due to the risks of de-randomization. Psychological and psychosocial interventions are most commonly studied using observational methodologies, and many research questions remain unstudied with RCTs.

86. Thus, while the GAPMS Memo correctly notes that "[p]resently, no RCTs that evaluate puberty suppression as a method to treat gender dysphoria are available," the lack of RCTs is easily understood considering the above

observations about RCTs in this context. (See GAPMS Memo at 15). And, the GAPMS Memo fails to mention that "[d]espite GnRH analogue treatment being used in precocious puberty for more than 20 years, there are no randomized controlled trials to evaluate the effect of GnRHa on a final height compared with untreated controls."[59]

87. In addition, the GAPMS Memo's focus on RCTs reveals AHCA's fundamental misunderstanding of "evidence-based medicine." (GAPMS Memo at 9).

88. Evidence-based medicine, which originated in the second half of the 19th Century, means the conscientious, explicit, judicious, and reasonable use of current best evidence in making decisions about the care of individual patients. Since its inception, evidence-based medicine has included an element of clinician expertise. Indeed, the modern understanding of evidence-based medicine is a systematic approach to clinical problem solving which allows the integration of the best available research evidence with *clinical expertise and patient values*.[60]

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[59] Mul & Hughes (2008).

[60] Masic, I., Miokovic, M., & Muhamedagic, B. (2008). Evidence based medicine - new approaches and challenges. *Acta informatica medica : AIM : journal of the Society for Medical Informatics of Bosnia & Herzegovina : casopis Drustva za medicinsku informatiku BiH*, *16*(4), 219–225.

89. Contemporaneous evidence-based medicine is defined by the *integration of clinical knowledge and skills* with the best critically-appraised-evidence available *as well as patient values and preferences in order to make a clinical decision*. The research literature is continually growing as new discoveries unravel.

90. The GAPMS Memo assigns no value to clinician expertise, experience, and skill, nor to the desires of the individual seeking services. In fact, the GAPMS Memo repeatedly and broadly asserts that recommendations for treatment of GD by well-established professional associations do not rely on evidence-based medicine, but rather on the recommendations outlined by WPATH, the Endocrine Society or others. But these two organizations not only examine best available evidence, but the guidelines and standards of care are updated by clinicians and scientists at the top of the field.

The Use of "Off-Label" Medications

91. Both the GAPMS Memo and Dr. Van Meter repeatedly express concern that the U.S. Food and Drug Administration (FDA) has not approved puberty blockers or hormone therapy for the treatment of GD. (See, e.g., GAPMS Memo at 8, 19; Van Meter at 8). Indeed, Dr. Van Meter asserts that the mere use of these medications "off-label" amounts to "uncontrolled, non-consentable

experimentation on children." (Van Meter at 8). These concerns are misleading and false.

92. The use of "off-label" medications is extremely common across all fields in medicine and there are many medications that are used "off-label" in the pediatric population. Most of the therapies prescribed to children are on an off-label or unlicensed basis.[61] Common medications that are used "off-label" in pediatrics include antibiotics, antihistamines, and antidepressants. That is because the majority of drugs prescribed have not been tested in children and safety and efficacy of children's medicines are frequently supported by low quality evidence. This is explained by the lack of clinical research in this population, caused by ethical, scientific, and technical issues, as well as commercial priorities.

93. "From the FDA perspective, once the FDA approves a drug, healthcare providers generally may prescribe the drug for an unapproved use when they judge that it is medically appropriate for their patient."[62] Indeed, for

[61] Allen, H.C., Garbe, M.C., Lees, J., Aziz, N., Chaaban, H., Miller, J.L., Johnson, P., & DeLeon, S. (2018). Off-Label Medication use in Children, More Common than We Think: A Systematic Review of the Literature. *The Journal of the Oklahoma State Medical Association*, *111*(8), 776–783.

[62] U.S. Food and Drug Admin. Understanding Unapproved Use of Approved Drugs "Off Label" (Feb. 5, 2018), https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatmentoptions/understanding-unapproved-use-approved-drugs-label.

over 40 years, the FDA has informed the medical community that "once a [drug] product has been approved …, a physician may prescribe it for uses or in treatment regimens of patient populations that are not included in approved labeling."[63] Accordingly, the American Academy of Pediatrics has stated that "off-label use of medications is neither experimentation nor research."[64] Thus, "[t]he administration of an approved drug for a use that is not approved by the FDA is not considered research and does not warrant special consent or review if it is deemed to be in the individual patient's best interests."

Concerns about the Diagnosis of Gender Dysphoria and the Use of Self-Reports

94. The GAPMS Memo and Dr. Cantor criticize that the diagnosis of gender dysphoria is based, at least in part, on a patient's self-report. (GAPMS Memo at 19, 24, 28; Cantor ¶¶ 42, 49). This critique demonstrates a fundamental misunderstanding of how gender-affirming care is provided.

95. While we have continued to attain a greater understanding about the etiology of gender incongruence, patients do not self-diagnose, as Dr. Cantor

[63] U.S. Food and Drug Admin, "Citizen Petition Regarding the Food and Drug Administration's Policy on Promotion of Unapproved Uses of Approved Drugs and Devices; Request for Comments," 59 Fed. Reg. 59,820 (Nov. 18, 1994).

[64] Frattarelli, D. A., Galinkin, J. L., Green, T. P., Johnson, T. D., Neville, K. A., Paul, I. M., Van Den Anker, J. N., & American Academy of Pediatrics Committee on Drugs (2014). Off-label use of drugs in children. *Pediatrics*, *133*(3), 563–567.

suggests. (Cantor ¶¶ 42, 49). However, it is not unusual or extraordinary in medicine for a provider to consider patients' reports of their symptoms as part of the medical assessment. Much like the diagnosis of many clinical conditions, providers rely on self-report to ascertain accurate diagnoses. Consider the diagnosis of chronic fatigue. The diagnostic criteria for this diagnosis include the following: fatigue so severe that it interferes with the ability to engage in pre-illness activities; of new or definite onset (not lifelong); not substantially alleviated by rest; worsened by physical, mental or emotional exertion. Like gender dysphoria, these diagnostic criteria are a subjective telling of an individual's personal experience. It is incumbent upon providers of gender-affirming care to acquire skills that help them ascertain many details about their patient's gender experience including but not limited to the history, developmental trajectory, and expectations regarding treatment options.

96. The provision of gender-affirming care occurs in multi-disciplinary settings, and indeed, the WPATH SOC recommend such an approach.[65] The

[65] Chen, D., Hidalgo, M. A., Leibowitz, S., Leininger, J., Simons, L., Finlayson, C., & Garofalo, R. (2016). Multidisciplinary Care for Gender-Diverse Youth: A Narrative Review and Unique Model of Gender-Affirming Care. *Transgender health*, *1*(1), 117–123; Coleman, et al. (2022); Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gendernonconforming people, version 7. *International Journal of Transgenderism*, 13(4), 165-232.

multiple health providers involved, from various fields, are well trained to conduct clinical interviews and to assess a patient's report to determine whether they meet the diagnostic criteria for GD.

Particular Concerns about the Use of Puberty Delaying Medications

97. The GAPMS Memo and Dr. Cantor allege that the provision of puberty delaying medications for the treatment of GD is not effective. This is not true.

98. A substantial body of evidence shows that gender-affirming medical interventions improve mental health outcomes for transgender persons with GD, who, without treatment, experience higher levels of depression, anxiety, and suicidality. Each of these studies—as with all studies in medicine—has strengths and limitations, and no one study design can answer all questions regarding an intervention. But taken together, these studies indicate that gender-affirming medical care improves mental health for adolescents who require such care.

99. Keeping this in mind, peer-reviewed cross-sectional and longitudinal studies have found that pubertal suppression is associated with a range of improved mental health outcomes for transgender adolescents, including statistically significant improvements in internalizing psychopathology (*e.g.*,

anxiety and depression), externalizing psychopathology (*e.g.*, disruptive behaviors), global functioning, and suicidality.[66]

100. For example, in the realm of cross-sectional studies, Turban et al. *Pediatrics* 2020 found that, after controlling for a range of other variables, those who accessed pubertal suppression had lower odds of lifetime suicidal ideation than those who desired but were unable to access this intervention during adolescence. A similar study by van der Miesen et al. in the *Journal of Adolescent Health*, noted above, compared 272 adolescents who had not yet received pubertal suppression with 178 adolescents who had been treated with pubertal suppression. Those who had received pubertal suppression had statistically significant lower "internalizing psychopathology" scores (a measure of anxiety and depression).[67]

101. Longitudinal studies have yielded similar results. For example, de Vries et al. in the *Journal of Sexual Medicine* (discussed above) found statistically significant improvements in symptoms of depression and general

[66] *See*, *e.g.*, Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA network open*, *5*(2), e220978; Turban, et al. (2020); van der Miesen, et al. (2020); Achille, et al. (2020); de Vries, et al. (2014); de Vries, et al. (2011). *See also* paragraphs 25-30, *supra*.

[67] van der Miesen, et al. (2020).

functioning following pubertal suppression for adolescents with gender dysphoria.[68]

102. The GAPMS Memo, as well as the "assessments" by Dr. Brignardello-Petersen and Dr. Wiercioch and by Dr. Cantor, emphasize the possible risks and side effects associated with the provision of gender-affirming care. Every single medication, however, has potential negative side effects, in addition to the possibility of new side effects that have not been historically documented. This is one of the reasons that evidence-based medicine relies heavily on experienced clinicians to exercise their expertise and judgement.

103. The risks associated with the provision of GnRH analogues are comparable when used for transgender and non-transgender patients alike. For example, many of the side effects and risks associated with the provision of GnRH analogues have been well-studied with regards to the use of these medications for the treatment of central precocious puberty (CPP).[69]

104. Given than puberty blockers are reversible, permanent sterility is not a side effect. There is no data to support that patients who have been treated with

[68] de Vries, et al. (2011).

[69] Eugster E. A. (2019). Treatment of Central Precocious Puberty. *Journal of the Endocrine Society*, *3*(5), 965–972.

blockers for central precocious puberty are "sterilized" following its use. To the contrary, information regarding long-term outcomes of patients treated with GnRH analogues with respect to gonadal function are reassuring. In fact, some studies have shown that assigned males had normal sperm function following treatment and cisgender women treated as children did not need assisted reproductive techniques.

105. In addition, while during the course of treatment with pubertal delaying medication, there is some loss in bone density, which is a side effect that we discuss with all patients and their families, studies show that with removal of the blocking agent or addition of gender affirming hormone therapy, bone mineral density begins to improve.[70] Studies regarding the use of GnRH analogues for the treatment of CPP document that following cessation of therapy with puberty delaying medications bone mineral accrual appears to be within the normal range compared with population norms. Indeed, patients treated with pubertal suppression for CPP are on pubertal blockades without affirming

[70] Vlot, M. C., et al. (2017). Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone*, *95*, 11–19; Klink, D., et al. (2015). Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria. *The Journal of clinical endocrinology and metabolism*, *100*(2), E270–E275.

hormones for longer periods of time than patients treated with puberty blockers for the treatment of gender dysphoria and the same risks are present.[71]

Particular Concerns about the Use of Cross-Sex Hormones

106. The claim that treating gender dysphoria with medically supervised and recommended hormone treatment is particularly risky or causes serious mental health effects is not supported by data.

107. Peer-reviewed research studies have found improved mental health outcomes following gender-affirming hormone treatment (*e.g.*, estrogen or testosterone) for individuals with gender dysphoria, including adolescents.[72] These include statistically significant improvements in internalizing psychopathology (*e.g.*, anxiety and depression), general well-being, and suicidality. For example, Allen et al. followed a cohort of 47 adolescents with gender dysphoria, and found statistically significant improvements in general well-being and suicidality, as measured by the National Institutes of Health "Ask Suicide Screening Questions" instrument.[73]

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[71] Eugster (2019).

[72] *See*, *e.g.*, Achille, et al. (2020); de Lara, D.L., Rodríguez, O.P., Flores, I.C., *et al*. (2020). Psychosocial Assessment in Transgender Adolescents. *Anales de Pediatría (English Edition)*, 93(1), 41-48; Grannis, et al. (2021); Allen, L.R., Watson, L.B., Egan, A.M., & Moser, C.N. (2019). Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311.

[73] Allen, et al. (2019).

108. What is more, the side effects and risks associated with these treatments are not unique to transgender individuals placed on these therapies.

109. The WPATH SOC require that fertility preservation is offered to all transgender patients prior to the initiation of gender affirming hormones. However, data shows that treatment with testosterone is not sterilizing.[74] And many transgender men become pregnant on their own.

110. It is also important to note that when these risks are reported, they are rare risks. While starting a transgender individual with GD on gender affirming hormones can raise their risk, their risk profile remains similar to their cisgender counterparts. Many times, the lipid profiles, hematologic profiles, and findings are equivalent to that of the gender these individuals identify with, as opposed to that of their sex assigned at birth.

The Misconceived Notion that Psychotherapy Alone Is Sufficient for the Treatment of Gender Dysphoria

111. Dr. Cantor describes several studies and claims that because the study subjects who were recipients of both gender-affirming hormones or puberty blockers, on the one hand, and psychotherapy, on the other hand, demonstrated

[74] Yaish, I., et al. (2021). Functional ovarian reserve in transgender men receiving testosterone therapy: evidence for preserved anti-Müllerian hormone and antral follicle count under prolonged treatment. *Human reproduction (Oxford, England)*, *36*(10), 2753–2760.

improvements in mental health, that the medical interventions could not be differentiated as responsible for the improvement. (Cantor ¶¶ 40-41).

112. Historically the psychotherapy professional world advocated for a "therapy only" model to address gender dysphoria. As early as the 1920's and 1930's it became evident to the preeminent scholars in the field that gender dysphoria (named something else at that time) was refractory to psychotherapy. As noted in 1966 in Harry Benjamin's The Transsexual Phenomenon, "Allegedly, transsexualism, although basically a psychiatric condition, is paradoxically resistant to psychiatric help."[75] In this statement, Harry Benjamin acknowledges that psychiatric intervention cannot alter people's gender, nor does it lead to a diminishing of the distress that arises from gender incongruence. There has been an abundance of opportunity to demonstrate unequivocally that gender dysphoria is best treated with psychotherapy alone, and yet it never has been. To suggest this is now an appropriate approach simply because transgender people are coming out at younger ages is illogical.

[75] Benjamin (1966).

Dr. Lappert's Critique of My Published Work

113. In his "assessment," Dr. Lappert criticizes a 2018 article I co-wrote that was published in JAMA Pediatrics, which he acknowledges to be a "leading journal." He refers to the article as "reckless" and using "low-quality data." (Lappert, p. 7).

114. Dr. Lappert takes issue with the claim in this article that regret for surgery is "rare." (Lappert p. 7). The manuscript describes that no individual who had undergone chest reconstruction in this cohort regretted this decision. While no single study can capture all experiences, the data reported in this study and clinical experience support the claim that regret after chest surgery is rare.

115. Dr. Lappert additionally calls surgery on minors a "reckless, experimental practice" and, without citing any evidence to support his claims, states that it has "apparently been abandoned as unethical" in England, Sweden, and Finland. (Lappert p. 7). Chest surgery for transmasculine youth younger than the age of majority is not experimental. While the scientific study of the care of transgender youth is still ongoing and growing, this does not make such care experimental. By its very nature, science is ever growing and ongoing. Moreover, Dr. Lappert's claim completely discounts the clinical experiences of both community members and providers of such care.

116. Dr. Lappert seems to take issue with the methods my study used to recruit participants, which he terms "convenience sampling" and suggests constitutes "self-selection" and confirmation bias. (Lappert p. 7). While it is true that the participants were recruited from our practice, individuals seeking such a surgical intervention will also be enrolled in care at clinics familiar with gender affirming care, therefore, they are "self-selecting" to become patients. As noted in my manuscript, we made an attempt to reach all patients in our clinic who had been referred for chest surgery.

117. Dr. Lappert emphasizes that 26% of study participants who had undergone surgery could not be reached during follow-up phone calls. (Lappert p. 7). He further highlights that of the individuals we were able to reach by phone, 72% completed our survey. Again Dr. Lappert bemoans these facts as demonstrating self-selection and confirmation bias. Our Center provides services for youth and young adults up to the age of 25. Some participants who were unable to be reached had aged out of services, moved, changed their phone numbers, or simply didn't answer a phone call. This is common among all research.

118. Dr. Lappert additionally criticizes our paper for using a novel measure of gender dysphoria, which he claims is "entirely unvalidated" and "junk

science." (Lappert p. 8). When no measures exist to gain understanding about an experience, measures need to be created. Chest dysphoria is a latent construct, and as such needs to be captured through a collective of questions. The chest dysphoria scale components were developed through both content and face validity. The scale was not validated, as I clearly reported in the manuscript. In a manuscript by Sood et al., Chest Dysphoria, as measured by the scale I created, among 156 transmasculine youth, showed a significant, positive association with anxiety and depression.[76]

119. Dr. Lappert suggests that our findings, which looked at satisfaction with gender-affirming surgery for patients who had undergone surgery between less than 1 to 5 years prior to the survey, are "misleading" and "deceptive" because they are not completely consistent with other long-term longitudinal population studies. (Lappert p. 8). I have not seen any longitudinal studies looking at chest surgery that dispute the findings laid out in my manuscript. In a meta-analysis related to satisfaction following masculinizing chest surgery,

[76] Sood, R., Chen, D., Muldoon, A. L., Chen, L., Kwasny, M. J., Simons, L. K., Gangopadhyay, N., Corcoran, J. F., & Jordan, S. W. (2021). Association of Chest Dysphoria With Anxiety and Depression in Transmasculine and Nonbinary Adolescents Seeking Gender-Affirming Care. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*, *68*(6), 1135–1141.

Bustos et al. found that among 1,052 transmasculine patients, the overall satisfaction rate was 92%.[77]

120. Based on his review of my study, Dr. Lappert concludes that it "is essentially useless in making any clinical decisions regarding who should be offered surgery, what is the likelihood they will benefit from it, and what is the likelihood they will regret their decision." (Lappert p. 8). There have been at least two studies since my manuscript that have duplicated the findings laid out in my manuscript in addition to the meta-analysis conducted by Bustos et al. described above.

CONCLUSION

121. Gender-affirming medical and surgical care is effective, beneficial, and necessary for transgender people suffering with gender dysphoria, including transgender youth after the onset of puberty. It is well documented and studied, through years of clinical experience, observational scientific studies, and even some longitudinal studies. It is also the accepted standard of care by all major medical organizations in the United States.

[77] Bustos, et al. (2021).

122. The denial of gender-affirming care, on the other hand, is harmful to transgender people. It exacerbates their dysphoria and may cause anxiety, depression, and suicidality, among other harms.

123. The GAPMS memo is misguided and informed by individuals with no experience or knowledge base regarding the provision of gender-affirming care, not to mention well-documented biases against transgender people and/or the provision of gender-affirming care. The report leans heavily on manuscripts that are not contemporaneous with our modern understanding of gender identity and gender dysphoria, demonstrated by outdated and incorrect terminology.

124. While data may be described as weak due to the lack of randomized controlled trials, many disciplines and areas of research rely on observational studies because RCTs are considered impractical or unethical. This is especially common when studying the mental health outcomes of physiologically evident interventions due to the impossibility of masking, and when studying the outcomes of highly desired interventions due to the risks of de-randomization. Psychological and psychosocial interventions are most commonly studied using observational methodologies, and many research questions remain unstudied with RCTs.

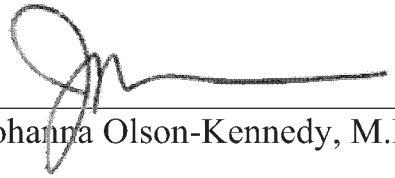
125. Finally, the reports completely overlook bodily autonomy. Given the repeated conflation of children and adolescents, it is not surprising that the "assessments" relied upon by the GAPMS Memo and the GAPMS Memo itself view adolescents as too immature to understand their own gender. However, many studies have demonstrated that cisgender children as young as age 2 know their gender. Denying medical care to adolescent youth with gender dysphoria is an act of acquiescence to the fear of what is not understood.

126. I do not disagree that, as with every field of medicine, there is more to learn in the field of transgender youth care. That is why I became an investigator. However, there is room to provide gender-affirming medical interventions in a thoughtful manner that extrapolates from relevant fields of science and medicine, existing data and clinical expertise while simultaneously carrying out necessary investigations.

127. The denial of much needed care only serves to harm transgender people.

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

Executed this 16 day of February, 2023.



Johanna Olson-Kennedy, M.D., M.S.

Exhibit A

Curriculum Vitae

CURRICULUM VITAE
JOHANNA OLSON-KENNEDY MS, MD
FEBRUARY 14, 2023

PERSONAL INFORMATION:

Work
4650 Sunset Blvd. MS 2 Los Angeles, CA 90027
Phone: 323-361-3128
Fax: 323-953-8116
Work Email: jolson@chla.usc.edu

EDUCATION AND PROFESSIONAL APPOINTMENTS

EDUCATION:

Year	*Degree, Field, Institution, City*
1992	BA, Mammalian Physiology, UC San Diego, San Diego
1993	MS, Animal Physiology, The Chicago Medical School, Chicago
1997	MD, Medical Doctor, The Chicago Medical Shool, Chicago
2015	MS, Clinical and Biomedical Investigations in Translational Science, USC, Los Angeles

POST-GRADUATE TRAINING:

Year-Year	*Training Type, Field, Mentor, Department, Institution, City*
1997 - 1998	Internship, Pediatrics, Children's Hospital Orange County, Orange
1998 - 2000	Residency, Pediatrics, Antonio Arrieta, Children's Hosptial Orange County, Orange
2000 - 2003	Fellowship, Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles
2012 - 2015	Master's Degree, Clinical and Biomedical Investigations in Translational Science, USC

ACADEMIC APPOINTMENTS:

Year-Year	*Appointment*	*Department, Institution, City, Country*
2006 - 2016	Assistant Professor of Clinical Pediatrics	Division of Adolescent Medicine, Children's Hospital Los Angeles/USC Keck School of Medicine, Los Angeles, USA
2016 - Present	Associate Professor of Clinical Pediatrics	Division of Adolescent Medicine, Children's Hospital Los Angeles/USC Keck School of Medicine, Los Angeles, USA

CLINICAL/ADMINISTRATIVE APPOINTMENTS:

2008 - 2012	Fellowship Director	Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, USA
2012 - present	Medical Director	The Center for Transyouth Health and Development, Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, USA

2021 - present	Clinical consultant	Santa Barbara Neighborhood Clinics

LICENSURE, CERTIFICATIONS

LICENSURE:

Year	*License number, State, Status*
2000	A-67352, California, Active

BOARD CERTIFICATION OR ELIGIBILITY:

Year	*Board, State, Status*
2001, 2009, 2015	Pediatrics, California, active

SPECIALTY CERTIFICATION:

Year	*Specialty Certification, Status*
2003, 2013	Adolescent Medicine, California, active

HONORS, AWARDS:

Year	*Description*	*Awarding agency, address, city*
2009	Health Care Advocacy Champion	Democratic Advocates for Disability Issues, Los Angeles
2010	Clinical Research Academic Career Development Award	Saban Research Center TSRI Program: Community Health Outcomes and Intervention, Los Angeles
2012	Extraordinary Service Award	Equality California, 202 W 1st St., Suite 3-0130, Los Angeles
2013	Top Doctor	Castle Connolly
2014	Anne Marie Staas Ally Award	Stonewall Democratic Club; 1049 Havenhurst Drive #325, West Hollywood
2014	Top Doctor	Castle Connolly
2014	Recognition Award for Outstanding, Compassionate and Innovative Service	SoCal Society for Adolescent Health and Medicine Regional Chapter, Los Angeles
2015	The Champion Award	The Division of Adolescent Medicine; CHAMPION FUND 5000 Sunset Blvd. Los Angeles
2016	America's Most Honored Professional's – Top 10%	America's Most Honored Professional's
2016	Regional Top Doctor	Castle Connolly
2017	Exceptional Women in Medicine	Castle Connolly
2017	Regional Top Doctor	Castle Connolly
2017	America's Most Honored Professional's – Top 5%	America's Most Honored Professional's
2018	Regional Top Doctor	Castle Connolly
2019	Benjamin Meaker Visiting Professorship	University of Bristol, Bristol UK
2019	Regional Top Doctor	Castle Connolly
2019	L.A's Top Docs	Los Angeles Magazine
2019	Top Docs	Pasadena Health
2019	America's Most Honored Professional's – Top 1%	America's Most Honored Professional's
2020	Regional Top Doctor	Castle Connolly
2020	Southern California Top Doc	Castle Connolly

2020	Southern California Top Doctors	
2020	L.A's Top Docs	Los Angeles Magazine
2020	America's Most Honored Professional's – Top 1%	America's Most Honored
2021	Southern California Top Doc	Castle Connolly
2021	America's Most Honored Doctors – Top 1%	America's Most Honored
2021	Top Doctors	Castle Connolly
2022	America's Most Honored Doctors – Top 1%	America's Most Honored
2022	Top Doctors	Castle Connolly

TEACHING

DIDACTIC TEACHING:

Keck School of Medicine at USC

Year-Year	*Course Name*	*Units/Hrs*	*Role*
2019	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth	One hour	Curriculum development and delivery
2020, 2021, 2022	Approach to the Care of Gender Non-conforming Children and Transgender Youth	One hour	Curriculum development and delivery
2023	Transgender and Non-binary Youth and Young Adults 101	One hour	Curriculum development and delivery

CalState Fullerton

Year-Year	*Course Name*	*Units/Hrs*	*Role*
2017	Gender Nonconforming and Transgender Youth	One hour	Curriculum development and delivery

UNDERADUATE, GRADUATE AND MEDICAL STUDENT (OR OTHER) MENTORSHIP:

Year-Year	*Trainee Name*	*Trainee Type*	*Dissertation/Thesis/Project Title*
2015 - 2016	David Lyons	MD	Transgender Youth Clinical Clerkship
2016 - 2019	Jonathan Warus	MD	Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts
2019 - 2021	Laer Streeter	MD	Comparison of Histrelin Implants
2020 - Present	Richard Mateo Mora	MD	Fertility Preservation Among Transgender Women
2022	Avery Everhart	PhD	Incomplete Data & Insufficient Methods: Transgender Population Health Research in the US

GRADUATE STUDENT THESIS, EXAM AND DISSERTATION COMMITTEES:

Year-Year	*Trainee Name*	*Committee Type*	*Student Department*
2022	Avery Everhart	Dissertation	Social Work

POSTGRADUATE MENTORSHIP:

Year-Year	*Trainee Name*	*If past trainee, current position and location*
2012-2013	Lisa Simons, MD	Clinical Instructor – Lurie Children's Hospital
2013	Shelley Aggarwal, MD	Clinical Instructor – Stanford University School of Medicine
2014	Julie Spencer, MD	Adolescent Medicine Provider Kaiser Hospital
2014-2015	Michael Haymer, MD	Program Director, Psychiatry Department UCLA
2015-2017	Patrick Shepherd, MD	CHLA Endocrinology Fellow
2015-2018	Jonathan Warus, MD	Faculty, CHLA/USC Keck School of Medicine
2015-2020	Shannon Dunlap, PhD	Postdoctoral Scholar - Research Associate, University of Southern California, Suzanne Dworak-Peck School of Social Work
2020-Present	Marianela Gomez-Rincon, MD	Adolescent Medicine Fellow
2020-Present	Jonathan Warus, MD	CHLA, Assistant Professor of Clinical Pediatrics
2022	Emmett Henderson, PhD, MS	USC Suzanne Dworak-Peck School of Social Work Senior mentor K99; USC

MENTORSHIP OF FACULTY:

Year-Year	*Mentee Name*	*Mentee Department*
2021 - present	Jonathan Warus, MD	Division of Adolescent Medicine, CHLA
2022	Brigid Conn, PhD	Clinical Psychologist, CHLA

SERVICE

DEPARTMENT SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
2010-2015	Secretary, The CHAMPION Fund Executive Board	The Division of Adolescent Medicine, Children's Hospital Los Angeles

HOSPITAL OR MEDICAL GROUP SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
2021 - present	Committee Member	SOGI work group, CHLA

PROFESSIONAL SERVICE:

Year-Year	*Position, Committee*	*Organization/Institution*
2012-present	Member, LGBT Special Interest Group	Society for Adolescent Health and Medicine
2022	Secretary, Executive Board of Directors	US Professional Association of Transgender Health

CONSULTANTSHIPS AND ADVISORY BOARDS:

Year	*Position, Board*	*Organization/Hospital/School, Institution*
2010-2017	Member, Advisory Board	Transyouth Family Allies
2017-present	Member, National Medical Committee	Planned Parenthood
2017 - Present	Board Member	US Professional Association of Transgender Health
2021	Expert Panelist	Robert Wood Johnson Foundation - National Commission on Data Transformation for Health Equity
2021	Member, Advisory Board	The National LGBTQIA+ Health Education Center

PROFESSIONAL SOCIETY MEMBERSHIPS:

Year- Year	*Society*
2003 - present	Society for Adolescent Health and Medicine
2005 - present	American Academy of Pediatrics
2006 - 2011	Los Angeles Pediatric Society (Past president 2010)
2010 - present	Professional Association for Transgender Health
2014 - present	Society for Pediatric Research
2017 - present	US Professional Association for Transgender Health

MAJOR LEADERSHIP POSITIONS: (E.G., DEAN, CHAIR, INSTITUTE DIRECTOR, HOSPITAL ADMINISTRATION, ETC.)

RESEARCH AND SCHOLARSHIP

EDITORSHIPS AND EDITORIAL BOARDS:

Year-Year	*Position*	*Journal/Board Name*
2015 - present	Associate Editor	Journal of Transgender Health

MANUSCRIPT REVIEW:

Year-Year	*Journal*
2014 - present	Pediatrics
2014 - present	Journal of Adolescent Health
2014 - present	LGBT Health
2014 - present	International Journal of Transgenderism
2015 - present	Journal of Transgender Health
2018 - present	Clinical Child Psychology and Psychiatry
2018 - present	Journal of Sexual Medicine
2018 - present	Journal of Transgender Health
2021 - present	JAMA Peds

GRANT REVIEWS:

Year	*Description*	*Awarding agency, City, State, Country*
2017	Cognition and Perception Study Section	National Institutes of Health, Bethesda, Maryland, USA
2017	Neurological, Aging and Musculoskeletal Epidemiology Study Section	National Institutes of Health, Bethesda, Maryland, USA
2018	Social Psychology, Personality and Interpersonal Processes Study Section	National Institutes of Health, Bethesda, Maryland, USA
2018	Neurological, Aging and Musculoskeletal Epidemiology Study Section	National Institutes of Health, Bethesda, Maryland, USA
2019	Special Emphasis Panel Review of Research Conference (R13) Grants	National Institutes of Health, Bethesda, Maryland, USA
2019	The Einstein Foundation Award for Promoting Quality in Research	Einstein Foundation, Berlin
2020	Biobehavioral and Behavioral Sciences Study Section	National Institutes of Health, Bethesda, Maryland, USA
2021	Social Psychology, Personality and Interpersonal Processes Study Section	National Institutes of Health, Bethesda, Maryland, USA

MAJOR AREAS OF RESEARCH INTEREST

Research Areas
1. Transgender and non-binary children, adolescents and young adults
2. HIV medication adherence

GRANT SUPPORT - CURRENT:

Grant No. (PI)2R01HD082554-06A1 (Olson-Kennedy)	*Dates of Award: 2021-2026*
Agency: NICHD	*Percent Effort 25%*
Title: The Impact of Early Medical Treatment in Transgender Youth	
Description: This is the continuations of a multicenter study, the first of its kind in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.	

Role: Principle Investigator
Total Direct Costs: $4,918,586

Grant No. 1R01HD097122-01 (Hidalgo)	*Dates of Award: 2019-2024*
Agency: NICHD	*Percent Effort 2.5%*
Title: A Longitudinal Study of Gender Nonconformity in Prepubescent Children	
Description: The purpose of this study is to establish a national cohort of prepubertal transgender/gender nonconforming (TGNC) children (and their parents), and longitudinally observe this cohort to expand the body of empirical knowledge pertaining to gender development and cognition in TGNC children, their mental health symptomology and functioning over time, and how family-initiated social gender transition may predict or alleviate mental health symptoms and/or diagnoses.	
Role: Site PI	
Total Direct Costs: $2,884,950	

GRANT SUPPORT - PAST:

Grant No. (PI) 1RO1HD082554-01A1	*Dates of Award: 2015-2020*
Agency: NICHD	*Percent Effort 45%*
Title: The Impact of Early Medical Treatment in Transgender Youth	
Description: This is a multicenter study, the first of its kind in the U.S. to evaluate the long-term outcomes of medical treatment for transgender youth. This study will provide essential, evidence-based information on the physiological and psychosocial impact, as well as safety, of hormone blockers and cross-sex hormones use in this population.	
Role: Principle Investigator	
Total Direct Costs: $4,631,970	
Grant No. (COI) R01AI128796-01	Dates of Award: 2/24/17-1/31/18
Agency: NIAID	Percent Effort: 5%
Title: Maturation, Infectibility and Trauma Contributes to HIV Susceptibility in Adolescents	
Description: This proposal explores the overarching hypothesis that fluctuations in sex steroid levels and mucosal trauma (sexual activity) are key determinants of mucosal immune activation and epithelial integrity, and that microbial communities are central to these processes. We will pursue this hypothesis by examining longitudinal changes in the anogenital microbiome as well as protein expression at these mucosal sites during sexual maturation (cisgender youth) and in hormonally-controlled sexual maturation (transgender youth). Associations between sex steroid levels, microbial community composition, mucosal trauma, and vaginal proteins will be determined and modeled.	
Role: Co-Investigator	
Total Direct Costs: $44,816	

Grant No. (PI) U01HD040463	*Dates of Award* 2006 – 2016
Agency: NIH/NICHD	*Percent Effort: 10%*
Title: Adolescent Medicine Trials Network for HIV/AIDS	
Description: Adolescent Medicine Trials Network for HIV/AIDS	

Role: Co-Investigator
Total Direct Costs: 2,225,674

Grant No. (PI) SC CTSI 8KL2TR000131	*Dates of Award: 2012-2014*
Agency: KL2 Mentored Career Research Development Program of the Center for Education, Training and Career Development	*Percent Effort: 37.5%*
Title: The Impact of Hormone Blockers on the Physiologic and Psychosocial Development of Gender Non-Conforming Peri-Pubertal Youth	
Description: This study aimed to understand the impact of puberty blocking medications on mental health and physiolgic parameters in peri-pubertal transgender youth.	
Role: Principal Investigator	
Total Direct Costs: 191,525	

Invited Lectures, Symposia, keynote addresses

Date	***Type***	***Title, Location***
2014	Invited Lecture	Transgender Youth; Needs, Risks, Outcomes and the Role of the System, Including Permanency and Inclusion for Our Youth, Administrative Office of the Courts, Center for Families and Children, San Diego, California
2015	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Lopez Family Foundation Special Lecture for Puerto Rico and Panama, Lopez Family Foundation, Children's Hospital Los Angeles, Los Angeles, California
2015	Symposium	Transgender Youth – An Overview of Medical and Mental Health Needs of Gender Non-Conforming Children and Transgender Adolescents, Public Child Welfare Training Academy, Academy for Professional Excellence at San Diego State University School of Social Work, San Diego, California
2015	Invited Lecture	Meeting the Needs of Transgender Adolescents; 1st Annual Southern California LGBT Health Symposium; USC/UCLA, Los Angeles, California
2015	Symposium	Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; GetReal California's Initiative; "Integrating Sexual Orientation, Gender Identity, and Expression (SOGIE) into California's Child Welfare System," Oakland, California
2016	Invited Symposium	Caring for Gender Nonconforming and Transgender Youth; Idyllwild, California
2016	Educational symposium	Gender 101: A Primer; Vista Mar, California
2016	Invited Lecture	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach, California Association of Marriage and Family Therapists, Los Angeles, California
2016	Invited Lecture	Caring for Gender Nonconforming Children and Transgender Youth, California Psychological Association, Continuing Education Institute, Irvine, California
2016	Invited Lecture	Health Issues Related to Transgender Youth; LA City Health Commission, Los Angeles, California

2016	Invited Lecture	Caring for Gender Nonconforming and Transgender Youth, Medical Directors 12th Annual Update on Reproductive Health and Medical Leadership, Planned Parenthood, Steamboat Springs, Colorado
2016	Invited Lecture	Caring For Transgender Teens, UCLA Meet the Professor, Los Angeles, CA
2017	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Santa Barbara, CA
2017	Invited Lecture	Healthcare for TGNC Youth, Expanding Competency for LGBT Youth in the System, Washington DC
2017	Invited Lecture	Gender Non-conforming and Transgender Children and Youth; Center for Early Education, West Hollywood, CA
2017	Invited Lecture	Rethinking Gender, University of Massachusetts, Annual Convocation Welcome Luncheon, Worcester, MA
2017	Invited Lecture	Gender Non-Conforming Children and Transgender Youth, Board of Behavioral Sciences, Orange, CA
2017	Invited Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, Santa Monica Rape Treatment Center, Santa Monica, CA
2017	Invited Lecture	Transgender Youth Care in the New Millennium, USC Law and Global Health Initiative, Los Angeles, CA
2018	Invited Lecture	Supporting Gender Diverse and Transgender Youth: A Deeper Look at Gender Dysphoria, Studio City, CA
2018	Invited Lecture	Working with Trans and Gender Non-Conforming Youth, Children's Hospital Orange County, CA
2018	Invited Lecture	Caring for gender Non-conforming and Transgender Youth and Young Adults, Ascend Residential, Encino CA
2018	Invited Lecture	Caring for gender Non-conforming and Transgender Youth and Young Adults, California State University Northridge, Northridge, CA
2018	Invited Lecture	Gender Dysphoria; School Nurse Organization of Idaho Annual Conference, Idaho
2018	Invited Lecture	Gender and What You Should Know, Archer School for Girls, Brentwood, CA
2018	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Oceanside, CA
2018	Invited Lecture	Gender Dysphoria: Beyond the Diagnosis, Advance LA, Los Angeles, CA
2018	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Andrology Society of America Clinical Symposium, Portland, OR
2018	Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Los Angeles, CA
2018	Invited Lecture	Caring for Gender Non-Conforming and Transgender Youth, Center for Early Education, Los Angeles, CA
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Cal State Los Angeles, California
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Claremont Colleges, California
2019	Symposium	TransYouth Care; Flagstaff, AZ
2019	Invited Lecture	Transgender and Gender Non-conforming Youth, Ascend Residential Treatment, Utah
2019	Invited Lecture	Gender Diverse and Transgender Youth; What Pediatricians Should Know, Common Problems in Pediatrics Conference, Utah AAP, Utah

2019	Invited Lecture	Gender Diverse and Transgender Youth; What Pediatricians Should Know, Common Problems in Pediatrics Conference, Utah AAP, Utah
2019	Invited Lecture	Caring for Gender Diverse and Transgender Youth, Grand Rounds, UCLA Olive View, CA
2019	Invited Lecture	Caring for Gender Diverse and Transgender Youth, Grand Rounds, Good Samaritan, CA
2019	Invited Lecture	Puberty Suppression in Youth with Gender Dysphoria, Fenway Trans Health Program, Boston
2019	Invited Lecture	Recognizing the Needs of Transgender Youth, California Department of Corrections and Rehabilitation, Ventura, CA
2019	Invited Lecture	Gender Dysphoria; Beyond the Diagnosis, Gender Education Demystification Symposium, GA
2019	Invited Lecture	Caring for Gender Nonconforming and Transgender Youth, Los Angeles Superior Court/Los Angeles Bar Association Training, CA
2019	Invited Lecture	Supporting Gender Diverse and Transgender Youth; A Deeper Look at Gender Dysphoria, Oakwood School, CA
2020	Symposium	Trans Youth Care, Chico Transgender Week, Virtual Presentation
2020	Invited Lecture	Gender Nonconforming and Transgender Youth, Novartis, Virtual Presentation
2020	Invited Lecture	Advanced Hormones; More than Just T and E, CHLA, Virtual Presentation
2020	Invited Lecture	Video Telehealth and Transgender Youth, Telehealth Best Practices for the Trans Community, The Central Texas Transgender Health Coalition, Virtual Presentation
2020	Invited Lecture	Gear Talk, Transforming Families, Virtual Lecture
2020	Invited Lecture	Tips for Parenting a Trans or Gender Diverse Youth, Models of Pride, Virtual Presentation
2020	Invited Lecture	Caring for Gender Diverse and Transgender Youth, LGBTQ+ Clinical Academy, Palo Alto University, Virtual presentation
2020	Invited Lecture	USC Medical School, Los Angeles, CA
2020	Invited Lecture	Medical Interventions for transgender youth, Cal State Los Angeles, Los Angeles
2020	Plenary Session	Understanding Issues Involving Gender Non-Conforming and Transgender Individuals Coming to a Courtroom Near You, Mid-Winter Workshop for Judges of the Ninth Circuit, Palm Springs, CA
2021	Invited Lecture	Gender Affirmation through a Social Justice Lens; Center for Gender Equity in Medicine and Science (GEMS) at Keck School of Medicine, Los Angeles
2021	Invited Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Providence Medical Group – South Bay Pediatrics (Torrance, San Pedro, Redondo Beach), virtual lecture
2021	Invited Lecture	Caring for Gender Diverse and Transgender Youth. SLO Acceptance, Cal Poly, Virtual Presentation
2022	Invited Lecture	Transgender and Non-binary children and youth, Board of Behavioral Sciences
2022	Invited Lecture	Gender Affirmation through a Social Justice Lens; University of Arizona Health Sciences LGBTQ+ Symposium & Health Fair

2022	Invited Lecture	Gender Dysphoria in Children, Adolescents and Young Adults, MedLambda and PsychSIG Keck USC School of Medicine, Virtual Lecture
2022	Invited Lecture	Caring for Transgender and Gender Nonconforming Youth, Presbyterian Healthcare Services, New Mexico, Virtual lecture
2022	Invited Lecture	Transgender and Non-Binary Youth, Rogers Behavioral Health, Virtual Lecture
2023	Invited Lecture	**Transgender and Non-binary Youth and Young Adults 101,** When Healthcare Gets Political; Health Justice and Systems of Care course, Keck USC School of Medicine, Los Angeles

Invited Grand Rounds, CME Lectures

Date	***Type***	***Title, Location***
2014	Grand Rounds	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach; Seattle Children's Hospital, Seattle, Washington
2014	CME lecture	Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; Eisenhower Medical Center Transgender Health Symposium, Palm Springs, California
2014	Grand Rounds	Toddlers to Teens: Comprehensive Health Care for the Transgender Child, Cultural Psychiatry Lecture Series, University of Iowa Carver College of Medicine, Iowa City, Iowa
2014	Grand Rounds	Caring for Gender Non-conforming Children and Teens in the New Millennium; A Multidisciplinary Team Approach, Children's Hospital Los Angeles, Los Angeles, California
2014	CME lecture	Difficult Cases, Gender Spectrum Family Conference, Gender Spectrum, Moraga, California
2014	CME lecture	Difficult Cases, Gender Spectrum Family Conference, Gender Spectrum, Moraga, California
2014	CME lecture	Cross-sex Hormones for Teenagers, How Young is Too Young? Philadelphia Trans Health Conference, Philadelphia, Pennsylvania
2014	CME lecture	Pediatric Update, Philadelphia Trans Health Conference, Philadelphia, Pennsylvania
2015	Grand Rounds	Caring for Gender Nonconforming and Transgender Youth, Stanford Division of Adolescent Medicine, Palo Alto, CA
2015	CME Educational Lecture	The Transgender Experience, St. Joseph's Providence, Burbank, CA
2015	CME Educational Lecture	Update on the Transgender Patient for the PCP, St. Joseph's Providence, Burbank, CA
2015	CME Educational Lecture	Caring for Gender Non-Conforming Children and Transgender Teens, Providence Tarzana, CA
2015	Grand Rounds	Caring for Gender Nonconforming and Transgender Youth, University of Southern California, Los Angeles, California

2015	Grand Rounds	Puberty Blockers and Cross Sex Hormones, Pediatric Endocrinology, Children's Hospital Los Angeles, Los Angeles, California
2015	CME lecture	Youth and Hormones, 2015 Gender Expansion Conference, University of Montana, Missoula Montana
2015	CME lecture	Transyouth Healthcare, 2015 Gender Expansion Conference, University of Montana, Missoula Montana
2015	CME lecture	Supporting Transgender Youth, Southern Oregon University Student Health and Wellness Center Workshop, Southern Oregon University, Ashland, Oregon
2015	PCS Grand Rounds	Caring for Gender Nonconforming Children and Transgender Youth, Children's Hospital Los Angeles, Los Angeles, California
2015	CME lecture	Medical Care for Gender Non-Conforming Children, Transgender Adolescents and Young Adults in the New Millennium, Continuing Medical Education of Southern Oregon, Medford, Oregon
2015	Grand Rounds	Medical Care for Gender Non-Conforming Children and Transgender Youth, Olive View Medical Center-UCLA, Sylmar, California
2015	Grand Rounds	Caring for Gender Non-conforming Children and Transgender Teens, Harbor-UCLA Department of Pediatrics, Torrance, California
2015	CME lecture	Caring for Gender Non-conforming Children and Teens in the New Millennium, Healthcare Partners Pediatric Town Hall Meeting, Healthcare Partners CME, Glendale, California
2016	Pediatric Grand Rounds	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth; Children's Hospital Los Angeles, Los Angeles, California
2016	Endocrine Grand Rounds	Approach to Care of Gender Non-Conforming Children and Transgender Adolescents; Cedars Sinai Hospital, Los Angeles, California
2016	Pediatric Grand Rounds	Care of Gender Non-Conforming Children and Transgender Adolescents in the New Millennium, Stanford Lucille Packard Children's Hospital, Palo Alto, California
2016	Pediatric Update	Caring for Gender Variant Children and Adolescents, St. Louis, Missouri
2016	Grand Rounds	Care of Gender Non-Conforming Children and Transgender Adolescents in the New Millennium, St. Jude's Grand Rounds, Memphis, Tennessee
2016	CME Educational Lecture	Transgender and Gender Non-Conforming Youth: Innovative Approaches to Care in 2016; Integrating Substance Use, Mental Health, and Primary Care Services: Courageous and Compassionate Care, Los Angeles, California
2016	CME; professional conference	Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach, Arizona Psychiatric Society, Tempe, Arizona
2016	CME/Educational Symposium	Caring for Gender Nonconforming and Transgender Youth, San Diego, California
2016	CME/CEU Educational Training	Medical Interventions for Transgender Youth and Young Adults, San Diego State University, San Diego, California
2016	Grand Rounds	Caring for Gender Nonconforming Children and Transgender Youth, Mt. Sinai Hospital, Pediatric Grand Rounds George J. Ginandes Lecture, New York, New York

2016	CME Educational Lecture	The Transgender Experience, Providence Tarzana, CA
2017	CME Educational Seminar	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, San Diego, CA
2017	CME Educational Seminar	The Care of Gender Non-Conforming children and Transgender Youth; Orange County Health Care Agency, Orange County, CA
2017	CME Educational Lecture	Rethinking Gender, Adolescent Grand Rounds, Children's Hospital Los Angeles, Los Angeles, CA
2017	CME Educational Lecture	Gender Non-Conforming Children and Transgender Youth, Pasadena CA
2017	CME Educational Lecture	Gender Non-Conforming and Transgender Children and Adolescents, Developmental Pediatrics continuing education lecture, Children's Hospital Los Angeles, CA
2017	CME Educational Lecture	Care of Gender Non-Conforming Children and Transgender Adolescents, Lopez Family Foundation Educational Lecture, Los Angeles, CA
2017	CME Educational Lecture	Puberty Suppression and Hormones; Medical Interventions for Transgender Youth, USC Keck School of Medicine Reproductive Health, Los Angeles, CA
2017	CME Educational Seminar	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, San Diego, CA
2018	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Glendale Unified School District, CA
2018	CME Educational Lecture	Caring for Gender Non-Conforming Children and Transgender Youth, CME by the Sea, CA
2018	CME Symposium	Caring for Gender Non-Conforming and Transgender Youth, TransYouth Care, Austin, TX
2018	CME Educational Lecture	Approach to the Care of Gender Non-Conforming Children and Transgender Youth, Desert Oasis Healthcare, Palm Desert, CA
2018	CME Workshop	Mental and Medical Healthcare for Transgender Adolescents, California Association of Marriage and Family Therapists, Garden Grove, CA
2018	CME Educational Lecture	Approach to the Care of Gender Non-Conforming Children and Transgender Youth, Keck School of Medicine, Los Angeles, CA

2018	CME Educational Lecture	Rethinking Gender, UCSD Medical School, San Diego, CA
2018	CME Educational Lecture	Rethinking Gender, UCLA Medical School, Los Angeles, CA
2019	Symposium	Recognizing the Needs of Transgender Youth, California Department of Corrections and Rehabilitation, Stockton, CA
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Cal State Los Angeles, California
2019	Symposium	The Care of Trans and Gender Non-Conforming Youth and Young Adults, Claremont Colleges, California
2019	CME Lecture	Gender Diverse and Transgender Youth, Harbor UCLA Medical Center Grand Rounds, Torrance, CA
2019	CME Lecture	Gender Dysphoria – Beyond the Diagnosis, Gender Odyssey San Diego, San Diego, CA
2019	Grand Rounds	Transgender Youth; What's New in 2019?, Children's Hospital Los Angeles, CA
2019	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Children's Hospital Orange County, CA
2019	CME Symposium	Caring for Gender Nonconforming and Transgender Youth, Stanislaus County Behavioral Health and Recovery Services, CA
2019	CME Eduational Lecture	Rethinking Gender, Olive View Medical Center Grand Rounds, CA
2020	CME Lecture	Gender Affirmation Through a Social Justice Lens, SAHM Conference, Virtual Presentation
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, AAP Conference, Virtual Lecture
2020	CME Lecture	Conversations with LGBTQ youth; the role of the pediatrician, AAP Conference, Virtual Lecture
2020	Grand Rounds	Creating Affirming Environments for Trans and Gender Diverse Patients, USC OB/Gyn Grand Rounds, Virtual Presentation
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Resident Lecture, CHLA
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Facey Medical Group, Los Angeles, CA
2020	Plenary Lecture	Reframing Gender Dysphoria, LEAH Conference, Los Angeles, CA
2020	CME Lecture	Gender Affirming Care for Pre and Peri-pubertal Trans and Gender Diverse Youth, LEAH Conference, Los Angeles, CA
2020	CME Lecture	Introduction to the Care of Gender Diverse and Transgender Youth, Division of Endocrinology, USC, Los Angeles, CA
2021	CME Lecture	Transitioning: From Invalidation and Trauma to Gender Affirming Care; Department of Anesthesiology at CHLA

2021	CME Lecture	Transitioning from Invalidation and Trauma to Gender Affirming Care; ACCM Grand Rounds, Children's Hospital Los Angeles, Virtual presentation
2021	CME Symposium	TransYouth Care; Transfamily Support San Diego, Virtual Symposium
2021	Symposium	TransYouth Care for Parents; Santa Clara, CA
2022	CME Lecture	Gender affirming medical interventions; An Evolving landscape, Critical Issues in Child and Adolescent Mental Health Conference, San Diego, California
2022	CME Symposium	TransYouth Care for Mental Health Providers; Santa Clara, CA
2022	CME Symposium	TransYouth Care; Transfamily Support San Diego, Virtual Symposium

International Lectures

Date	***Type***	***Title, Location***
2013	Keynote	Caring for Gender Non-conforming Children and Adolescents in the New Millennium, Vancouver, Canada
2016	CME; professional conference	Social Transitions in Pre-pubertal Children; What do we know? World Professional Association of Transgender Health, Amsterdam, The Netherlands
2016	CME; professional conference	Beyond Male and Female; Approach to Youth with Non-Binary Gender Identities, World Professional Association of Transgender Health, Amsterdam, The Netherlands
2016	CME; professional conference	Workgroup on Gender Nonconforming/Transgender Youth: Biopsychosocial Outcomes and Development of Gender Identity, World Professional Association of Transgedner Health, Amsterdam, The Netherlands
2017	Invited Lecture	Gender Dysphoria, Beyond the Diagnosis, Pink Competency, Oslo Norway
2017	Invited Lecture	Caring for Gender Non-Conforming Children and Transgender Adolescents: A United States Perspective, Pink Competency, Oslo Norway
		Caring for Gender Non-conforming and Transgender youth and Young Adults. Diverse Families Forum: The Importance of Family Support in

2018	Invited Lecture	Uso de Hormonas Reaffirmantes de Genero en Adolescentes Transgenero, Trans Amor Congreso Nacional de Transexualidad Juvenil y Infantos, Monterey, Mexico
2018	Invited Lecture	Bloquedores de la Pubertad, Trans Amor Congreso Nacional de Transexualidad Juvenil y Infantos, Monterey, Mexico
2018	CME Educational Lecture	Puberty Blockers and Gender Affirming Hormones for Transgender Youth: What Do We Know, and What Have We Learned, Pediatric Academic Societies, Toronto, Canada
2019	Grand Rounds	Rethinking Gender, Grand Rounds, The Hospital for Sick Children, Toronto, Canada
2019	Keynote	***Gender Dysphoria; Beyond the Diagnosis,*** Promoting Innovation and Collaboration to Support Gender Diverse Youth Conference, The Hospital for Sick Children, Toronto, Canada, December 2019
2019	Invited Lecture	Hormonas que Affirman el Genero pasa Juventud y Adultos Menores Trans, Transformando Desde el Amor y Las Familias, Colombia
2019	Invited Lecture	Infancia Trans y da Genero Diverso, Transformando Desde el Amor y Las Familias, Colombia
2019	Invited Lecture	Transgender Youth: Medical and Mental Health Needs, Bristol, United Kingdom
2019	Invited Lecture	Rethinking Gender, University of Bristol, United Kingdom
2019	CME; professional conference	Male Chest Reconstruction and Chest Dysphoria in Transmasculine Adolescents and Young Adults, European Professional Association of Transgender Health, Rome Italy
2019	CME; professional conference	Transgender Youth and Gender Affirming Hormones; 5-7 Year Follow Up, European Professional Association of Transgender Health, Rome Italy
2019	CME Educational Lecture	Gender Dysphoria; Beyond the Diagnosis, European Professional Association of Transgender Health, Rome Italy
2022	Plenary Session	The Landscape of Gender Affirming Care for Youth in the US, AusPATH, Virtual
2022	CME; professional conference	Emotional Functioning of Adolescents with Gender Dysphoria After Two Years of Treatment; WPATH Conference, Montreal, Canada
2022	CME; Professional Conference	Creating Enduring Materials; WPATH Conference, Montreal, Canada
2023		

Keynote/Plenary Presentations

Date	*Type*	*Title, Location*
2015	Keynote	The Future of Trans Care in the New Millennium, Gender Infinity Conference, Houston, Texas
2016	Plenary Session	Caring for Trans Youth and Gender Non-Conforming Children, Transgender Spectrum Conference, St. Louis, Missouri
2018	Keynote	Future Directions, USPATH, Washington DC
2019	Keynote	Gender Dysphoria; A Deeper Dive Beyond the Diagnosis, Inaugural LGBTQ summit, Santa Clara CA
2021	CME; professional conference	Advances and Challenges in the Care of Transgender/Gender Diverse Youth; USPATH Conference, Virtual presentation
2022	Keynote	Gender Affirmation Through a Social Justice Lens, Indiana University School of Medicine
2022	Invited Lecture	Transgender and Non-Binary Youth, Supporting the Well-Being of LGBTQ Youth Certificate Program Center for Juvenile Justice Reform Georgetown University, virtual training
2022	Invited Lecture	Transgender and Non-Binary Youth, Young Women's Career Conference (YWCC) for the Girls Academic Leadership Academy; virtual lecture

PUBLICATIONS:

*** INDICATES TRAINEES**
**** INDICATE YOURSELF AS CO-FIRST OR CO-CORRESPONDING OR SENIOR AUTHORS**

REFEREED JOURNAL ARTICLES:

1. Belzer M, Sanchez K, **Olson J**, Jacobs AM, Tucker D. Advance supply of emergency contraception: a randomized trial in adolescent mothers. J Pediatr Adolesc Gynecol. 2005 Oct;18(5):347-54. PubMed PMID: 16202939.

2. Puccio JA, Belzer M, **Olson J**, Martinez M, Salata C, Tucker D, Tanaka D. The use of cell phone reminder calls for assisting HIV-infected adolescents and young adults to adhere to highly active antiretroviral therapy: a pilot study. AIDS Patient Care STDS. 2006 Jun;20(6):438-44. PubMed PMID: 16789857.

3. **Olson J**,** Forbes C, Belzer M. Management of the transgender adolescent. Arch Pediatr Adolesc Med. 2011 Feb;165(2):171-6. doi: 10.1001/archpediatrics.2010.275. Review. PubMed PMID: 21300658.

4. Simons L*, Schrager SM, Clark LF, Belzer M, **Olson J**.** Parental support and mental health among transgender adolescents. J Adolesc Health. 2013 Dec;53(6):791-3. DOI: 10.1016/j.jadohealth.2013.07.019. Epub 2013 Sep 4. PubMed PMID: 24012067; PubMed Central PMCID: PMC3838484.

5. Belzer ME, Naar-King S, **Olson J**, Sarr M, Thornton S, Kahana SY, Gaur AH, Clark LF; Adolescent Medicine Trials Network for HIV/AIDS Interventions. The use of cell phone support for non-adherent HIV-infected youth and young adults: an initial randomized and controlled intervention trial. AIDS Behav. 2014 Apr;18(4):686-96. doi: 10.1007/s10461-013-0661-3. PubMed PMID: 24271347; PubMed Central PMCID: PMC3962719.

6. **Olson J****, Garofalo R. The peripubertal gender-dysphoric child: puberty suppression and treatment paradigms. Pediatr Ann. 2014 Jun;43(6):e132-7. doi: 10.3928/00904481-20140522-08. PMID: 24972421.

7. **Olson J****, Schrager SM, Clark LF, Dunlap SL, Belzer M. Subcutaneous Testosterone: An Effective Delivery Mechanism for Masculinizing Young Transgender Men. LGBT Health. 2014 Sep;1(3):165-7. doi: 10.1089/lgbt.2014.0018. Epub 2014 Jun 26. PMID: 26789709.

8. Schrager SM, **Olson J,** Beharry M*, Belzer M, Goldsich K*, Desai M, Clark LF. Young men and the morning after: a missed opportunity for emergency contraception provision? J Fam Plann Reprod Health Care. 2015 Jan;41(1):33-7. doi: 10.1136/jfprhc-2013-100617. Epub 2014 Jan 24. PubMed PMID: 24465024.

9. Belzer M, Kolmodin MacDonell K, Clark L, Huang J, **Olson J**, Kahana S, Naar S, Sarr M, Thornton S. Acceptability and Feasibility of a Cell Phone Support Intervention for Youth Living with HIV with Nonadherence to Antiretroviral Therapy, AIDS Patient Care and STDs, Vol. 29, No. 6, June 2015: 338-345. doi: 10.1089/apc.2014.0282;

10. Klein DA, Ellzy JA, **Olson J****. Care of a Transgender Adolescent. Am Fam Physician. 2015 Jul 15;92(2):142-8. PMID: 26176373.

11. **Olson J****, Schrager SM, Belzer M, Simons LK*, Clark LF. Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria. J Adolesc Health. 2015 Oct;57(4):374-80. doi: 10.1016/j.jadohealth.2015.04.027. Epub 2015 Jul 21. PMID: 26208863; PMCID: PMC5033041.

12. **Olson-Kennedy J****, Cohen-Kettenis PT, Kreukels BP, Meyer-Bahlburg HF, Garofalo R, Meyer W, Rosenthal SM. Research priorities for gender nonconforming/transgender youth: gender identity development and biopsychosocial outcomes. Curr Opin Endocrinol Diabetes Obes. 2016 Apr;23(2):172-9. doi: 10.1097/MED.0000000000000236. PMID: 26825472; PMCID: PMC4807860.

13. **Olson-Kennedy J****, Okonta V, Clark LF, Belzer M. Physiologic Response to Gender-Affirming Hormones Among Transgender Youth. J Adolesc Health. 2018 Apr;62(4):397-401. doi: 10.1016/j.jadohealth.2017.08.005. Epub 2017 Oct 19. PMID: 29056436; PMCID: PMC7050572.

14. **Olson-Kennedy J****, Warus J*, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. JAMA Pediatr. 2018 May 1;172(5):431-436. doi: 10.1001/jamapediatrics.2017.5440. PMID: 29507933; PMCID: PMC5875384.

15. Sayegh CS, MacDonell KK, Clark LF, Dowshen NL, Naar S, **Olson-Kennedy J**, van den Berg JJ, Xu J, Belzer M. The Impact of Cell Phone Support on Psychosocial Outcomes for Youth Living with HIV Nonadherent to Antiretroviral Therapy. AIDS Behav. 2018 Oct;22(10):3357-3362. doi: 10.1007/s10461-018-2192d-4. PMID: 29948339; PMCID: PMC6530981.

16. Pang KC, Notini L, McDougall R, Gillam L, Savulescu J, Wilkinson D, Clark BA, **Olson-Kennedy J**, Telfer MM, Lantos JD. Long-term Puberty Suppression for a Nonbinary Teenager. Pediatrics. 2020 Feb;145(2):e20191606. doi: 10.1542/peds.2019-1606. PMID: 31974217.

17. **Olson-Kennedy J****, Chan YM, Garofalo R, et al. Impact of Early Medical Treatment for Transgender Youth: Protocol for the Longitudinal, Observational Trans Youth Care Study. JMIR Res Protoc. 2019;8(7):e14434. Published 2019 Jul 9. doi:10.2196/14434

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19. **Olson-Kennedy J****, Chan YM, Rosenthal S, Hidalgo MA, Chen D, Clark L, Ehrensaft D, Tishelman A, Garofalo R. Creating the Trans Youth Research Network: A Collaborative Research Endeavor. Transgend Health. 2019 Nov 1;4(1):304-312. doi: 10.1089/trgh.2019.0024. PMID: 31701011; PMCID: PMC6830532.

20. Lee JY, Finlayson C, **Olson-Kennedy J**, Garofalo R, Chan YM, Glidden DV, Rosenthal SM. Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings from the Trans Youth Care Study. Journal of the Endocrine Society. 2020 September 1;4(9):bvaa065. PubMed PMID: 32832823; PubMed Central PMCID: PMC7433770; DOI: 10.1210/jendso/bvaa065

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

AUGUST DEKKER, et al., *Plaintiffs*, v. JASON WEIDA, et al., *Defendants*.	Case No. 4:22-cv-00325-RH-MAF

EXPERT REPORT OF DANIEL SHUMER, M.D.

I, Daniel Shumer, M.D., hereby declare and state as follows:

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

2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

3. 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

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Comprehensive Gender Services Program at Michigan Medicine, University of Michigan.

4. 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.

5. 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. Concurrent with the 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.

6. I have extensive experience in working with and treating children and adolescents 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.

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

8. 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 the treatment of gender dysphoria, and research articles on a variety of topics with a focus on mental health in transgender adolescents.

9. I am involved in 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."

10. 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.

11. 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.

12. 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 21 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 actively conduct research related to transgender medicine, gender dysphoria treatment, and mental health concerns specific to transgender youth.

13. I also provide care in 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 influence 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.

14. 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.

15. 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

16. In the past four years, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Roe et al v. Utah High School Activities Association et al* (Third District Court in and for Salt Lake County, UT); and *Menefee v. City of Huntsville Bd. of Educ.*, No. 5:18-cv-01481 (N.D. Ala.). 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).

C. Compensation

17. 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

18. This report sets forth my opinions in this case and the bases for my opinions.

19. In preparing this report, I reviewed the text of *Florida Medicaid – Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria*, including the attachments, as well as the Complaint in this case.

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 Plaintiffs or their parents. 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.

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 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 (sometimes descried as "conversion therapy") 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 the same gender identity (Luders, et al., 2009; Rametti, et al., 2011; Berglund, et al., 2008; Savic, et al., 2011). 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 cisgender 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 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 cisgender 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 ADOLECENTS AND ADULTS

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

35. There are several studies demonstrating positive results of gender-affirming care in adolescents and adults (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 from early adolescence through young adulthood showed that gender-affirming 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). More recently, Green et al. (2022) describe that gender-affirming hormone therapy is correlated with reduced rates of depression and suicidality among transgender adolescents. Turban et al. (2022) documented that access to gender-affirming 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, ADOLESCENTS, AND ADULTS

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 both 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 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 sex assigned at birth. 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 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.

39. In transgender adults, the WPATH SOC recommends that a health care provider assessing and treating a transgender patient should ensure diagnostic criteria are met prior to initiating gender-affirming treatments and ensure that any health conditions that could negatively impact the outcome of treatment are assessed, with risks and benefits discussed, before a decision is made regarding treatment. The capacity of the adult. to consent for the specific treatment should be confirmed prior to initiation (Coleman, et al., 2022).

D. EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES FOR THE TREATMENT OF GENDER DYSPHORIA IN CHILDREN, ADOLESCENTS AND ADULTS

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

41. 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).

42. 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).

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

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

45. 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.

46. 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.

47. 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.

48. 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).

49. 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.

50. 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. 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).

51. The previous version (SOC 7), published in 2012 (Coleman, et al., 2012), was the most recent version at the time of the adoption of Florida Administrative Code, 59G-1.050(7) (the "Challenged Exclusion"). SOC 7 was similar to SOC 8 in the basic tenets of management for transgender adolescents and adults; however, SOC 8 further reinforces these guidelines with data published since the release of SOC 7.

52. 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).

53. 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 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).

54. 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).

55. 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).

56. 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

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.

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 (e.g., GAPMS Memo at 14; Attachment D (Cantor) to GAPMS Memo at 6-9). 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 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 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 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. Designed benefit of treatment is to reduce the risk of worsening gender dysphoria and mental health deterioration. More specifically, use of GnRHa in transmasculine adolescents allows for decreased chest development, reducing the need for breast binding and surgical intervention in adulthood. For transfeminine adolescents GnRHa limits facial and body hair growth, voice deepening, and masculine bone structure development, which greatly reduce distress both at the time of treatment and later in life and reduce the need for later interventions such as voice therapy, hair removal, and facial feminization surgery.

67. The goal in using GnRHa is to minimize the patient's dysphoria related to progression of puberty and allow for later initiation of puberty consistent with gender identity. When a patient presents to care, the provider assesses the patient's

pubertal stage, pubertal history, and individual needs. A patient may present prior to the onset of puberty (Tanner Stage 1), at the onset of puberty (Tanner Stage 2), or further along in puberty (Tanner Stages 3-5). The pubertal stage and individual needs of the patient then direct conversations regarding care options. A patient at Tanner Stage 2 may benefit from GnRHa, while an older patient who has completed puberty may benefit from pubertal initiation with hormones, as described below. I have observed that providing individualized care based on individual patient characteristics, using the WPATH Standards of Care as the foundation of this care, provides significant benefit to patients, minimizes gender dysphoria, and can eliminate the need for surgical treatments in adulthood.

68. 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.

69. 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 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

70. 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. In adult patients, use of GnRHa is uncommon, but rather medical decisions are focused more on testosterone or estrogen therapy.

71. These hormone therapies are used to treat gender dysphoria in adolescents and adults to facilitate development of sex-specific physical changes congruent with their gender identity. For example, a transgender man prescribed testosterone will develop a lower voice as well as facial and body hair, while a

transgender woman prescribed estrogen will experience breast growth, female fat distribution, and softer skin.

72. 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 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).

73. Under the Endocrine Society Clinical Guidelines and SOC 8, hormone therapy is an appropriate treatment for transgender adults with gender dysphoria when the experience of dysphoria is marked and sustained, other possible causes of apparent gender dysphoria are excluded, any mental and physical health conditions that could negatively impact the outcome of treatment are assessed, the adult has capacity to understand risks and benefits of treatment and provide consent for treatment (Coleman, et al., 2022; Hembree, et al., 2017).

74. 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.

75. 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).

F. SAFETY AND EFFICACY OF PUBERTY-DELAYING MEDICATIONS AND HORMONE THERAPY TO TREAT GENDER DYSPHORIA

76. 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.

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

78. 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.

79. 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).

80. 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).

81. 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.

82. 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-affirming 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).

83. 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.

84. 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, agonism, premature ovarian failure, and disorders of sex development all require treatment with these hormones, often times 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, discussed, and easily managed in all individuals needing hormone therapy regardless of the diagnosis necessitating these medications.

85. 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.

86. 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 gender-affirming hormone therapy is correlated with reduced rates of depression and suicidality among transgender adolescents. Turban et al. (2022) documented that access to gender-affirming 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.

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

88. The efficacy of hormone treatment in transgender adults is similarly robust. At least 11 longitudinal studies document improvement in various mental health parameters including depression, anxiety, self-confidence, body image and self-image, general psychological functioning (e.g., Colizzi, et al., 2013; Colizzi, et al., 2014; Corda, et al., 2016; Defreyne, et al., 2018; Fisher, et al., 2016; Heylens, et

al., 2014; Keo-Meier, et al., 2015; Manieri, et al., 2014; Motta, et al., 2018; Oda, et al., 2017; Turan, et al., 2018).

89. In sum, the use of GnRHa and hormones in adolescents, and hormones in adults 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 adolescent and adult age groups. 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

90. Prohibition of gender-affirming care, or coverage thereof, for adolescents and adults is likely to have devastating consequences. I am concerned that the Challenged Exclusion might lead to a staggering increase in mental health problems including suicidality for transgender Floridians. One study which highlights my concern is a study of over 21,000 patients who report ever desiring gender-affirming 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 had lower odds of suicidality compared to those waiting to access until adulthood (Turban, et al., 2022).

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

III. CONCLUSION

92. In summary, banning coverage of gender-affirming care runs counter to evidence-based best practices and standards of care for the treatment of gender dysphoria in adolescence and adulthood.

93. 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.

94. Lack of access to these treatments will result in worse outcomes for countless individuals in Florida. Furthermore, banning coverage for evidence-based treatment for gender dysphoria sends a message that transgender people are not valid and should be stigmatized.

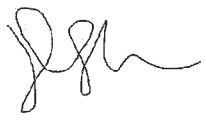
95. In my own clinical practice in Michigan, I have seen an influx of patients from states banning medically proven treatments for gender dysphoria who

report not feeling safe living in the community that they have always called home. Adult patients, and 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.

96. Banning coverage of effective treatment for gender dysphoria will not eliminate transgender people, but will, unfortunately, lead to an increase in mental health problems and suicidality in an already vulnerable population.

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 February 2023.



Daniel Shumer, M.D.

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

	Michigan, Medical License
	Michigan, Controlled Substance
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
PI
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 Đorđević 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 FinlaysonElsevier, (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

6. Araya A, Shumer D, Warwick R, Selkie E: 37. “I’ve Been Happily Dating For 5 Years” - Romantic and Sexual Health, Experience and Expectations in Transgender Youth, *Journal of Adolescent Health*.66(2): s20, 02/2020

7. Araya A, Shumer D, Warwick R, Selkie E: 73. "I think sex is different for everybody" - Sexual Experiences and Expectations in Transgender Youth, *Journal of Pediatric and Adolescent Gynecology*.33(2): 209-210, 04/2020

8. Araya AC, Warwick R, Shumer D, Selkie E, Rath T, Ibrahim M, Srinivasan A: Romantic Health in Transgender Adolescents, *Pediatrics*.Pediatrics01/2021

9. Martin S, Sandberg ES, **Shumer DE**: Criminalization of Gender-Affirming Care - Interfering with Essential Treatment for Transgender Children and

Adolescents, *New England Journal of Medicine*.385(7): 579-581, 08/2021. PM34010528

Editorial Comment

1. **Shumer DE**, Harris LH, Opipari VP: The Effect of Lesbian, Gay, Bisexual, and Transgender-Related Legislation on Children, 01/2016. PM27575000

2. **Shumer DE**: Health Disparities Facing Transgender and Gender Nonconforming Youth Are Not Inevitable, 01/2018. PM29437859

3. Martin S, Sandberg ES, Shumer DE: Criminalization of Gender-Affirming Care - Interfering with Essential Treatment for Transgender Children and Adolescents, 01/2021

Erratum

1. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Correction to Serving Transgender Youth: Challenges, Dilemmas, and Clinical Examples, [Professional Psychology: Research and Practice, 46(1), (2015) 37-45], *Professional Psychology: Research and Practice*.46(4): 249, 08/2015

Journal Articles

1. **Shumer DE**, Thaker V, Taylor GA, Wassner AJ: Severe hypercalcaemia due to subcutaneous fat necrosis: Presentation, management and complications, *Archives of Disease in Childhood: Fetal and Neonatal Edition*.99(5)01/2014. PM24907163

2. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Serving transgender youth: Challenges, dilemmas, and clinical examples, *Professional Psychology: Research and Practice*.46(1): 37-45, 02/2015. PM26807001

3. Reisner SL, Vetters R, Leclerc M, Zaslow S, Wolfrum S, **Shumer DE**, Mimiaga MJ: Mental health of transgender youth in care at an adolescent Urban community health center: A matched retrospective cohort study, *Journal of Adolescent Health*.56(3): 274-279, 03/2015. PM25577670

4. **Shumer DE**, Tishelman AC: The Role of Assent in the Treatment of Transgender Adolescents, *International Journal of Transgenderism*.16(2): 97-102, 04/2015. PM27175107

5. **Shumer DE**, Roberts AL, Reisner SL, Lyall K, Austin SB: Brief Report: Autistic Traits in Mothers and Children Associated with Child's Gender Nonconformity, *Journal of Autism and Developmental Disorders*.45(5): 1489-1494, 05/2015. PM25358249

6. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Reply to comment on "serving transgender youth: Challenges, dilemmas, and clinical examples" by Tishelman et al. (2015), *Professional Psychology: Research and Practice*.46(4): 307, 08/2015. PM26858509

7. **Shumer DE**, Reisner SL, Edwards-Leeper L, Tishelman A: Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic, *LGBT Health*.3(5): 387-390, 10/2016. PM26651183

8. Tishelman AC, **Shumer DE**, Nahata L: Disorders of sex development: Pediatric psychology and the genital exam, *Journal of Pediatric Psychology*.42(5): 530-543, 01/2017. PM27098964

9. Edwards-Leeper L, **Shumer DE**, Feldman HA, Lash BR, Tishelman AC: Psychological profile of the first sample of transgender youth presenting for medical intervention in a U.S. pediatric gender center, *Psychology of Sexual Orientation and Gender Diversity*.4(3): 374-382, 01/2017

10. **Shumer DE**, Abrha A, Feldman HA, Carswell J: Overrepresentation of adopted adolescents at a hospital-based gender dysphoria clinic, *Transgender Health*.2(1): 76-79, 07/2017. PM28861549

11. Strang JF, Meagher H, Kenworthy L, de Vries AL C, Menvielle E, Leibowitz S, Janssen A, Cohen-Kettenis P, **Shumer DE**, Edwards-Leeper L, Pleak RR, Spack N, Karasic DH, Schreier H, Balleur A, Tishelman A, Ehrensaft D, Rodnan L, Kuschner ES, Mandel F, Caretto A, Lewis HC, Anthony LG: Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents, *Journal of Clinical Child and Adolescent Psychology*.47(1): 105-115, 01/2018. PM27775428

12. Selkie E, Adkins V, Masters E, Bajpai A, **Shumer DE**: Transgender Adolescents' Uses of Social Media for Social Support, *Journal of Adolescent Health*.66(3): 275-280, 03/2020. PM31690534

13. Warwick RM, **Shumer DE**: Gender-affirming multidisciplinary care for transgender and non-binary children and adolescents, *Children's Health Care*.01/2021

14. Araya AC, Warwick R, **Shumer DE**, Selkie E: Romantic relationships in transgender adolescents: A qualitative study, *Pediatrics*.147(2)02/2021. PM33468600

15. Warwick RM, Araya AC, **Shumer DE**, Selkie EM: Transgender Youths' Sexual Health and Education: A Qualitative Analysis, *Journal of Pediatric and Adolescent Gynecology*.35(2): 138-146, 04/2022. PM34619356

Letters

1. 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 DE**, 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*.57(11): 885-887, 11/2018. PM30392631

Letters to editor

1. **Shumer DE**: Doctor as environmental steward, 01/2009. PM19364173

Notes

1. **Shumer DE**, Mehringer J, Braverman L, Dauber A: Acquired hypothyroidism in an infant related to excessive maternal iodine intake: Food for thought, *Endocrine Practice*.19(4): 729-731, 07/2013. PM23512394

Podcasts

1. Gaggino L, Shumer WG D: Pediatric Meltdown: Caring for Transgender Youth with Compassion: What Pediatricians Must Know, 01/2020

Reviews

1. **Shumer DE**, Spack NP: Current management of gender identity disorder in childhood and adolescence: Guidelines, barriers and areas of controversy, *Current Opinion in Endocrinology, Diabetes and Obesity*.20(1): 69-73, 02/2013. PM23221495

2. Guss C, **Shumer DE**, Katz-Wise SL: Transgender and gender nonconforming adolescent care: Psychosocial and medical considerations, *Current Opinion in Pediatrics*.27(4): 421-426, 08/2015. PM26087416

3. **Shumer DE**, Nokoff NJ, Spack NP: Advances in the Care of Transgender Children and Adolescents, *Advances in Pediatrics*.63(1): 79-102, 08/2016. PM27426896

Short Surveys

1. **Shumer DE**, Spack NP: Transgender medicine-long-term outcomes from 'the Dutch model', *Nature Reviews Urology*.12(1): 12-13, 01/2015. PM25403246

Abstracts/Posters

1. Shumer D, Kinnear H, McLain K, Morgan H: Development of a Transgender Medicine Elective for 4th Year Medical Students, National Transgender Health Summitt, Oakland, CA, 2017

2. Shumer D: Overrepresentation of Adopted Children in a Hospital Based Gender Program, World Professional Association of Transgender Health Biennial International Symposium, Amsterdam, The Netherlands, 2016

3. Shumer D: Mental Health Presentation of Transgender Youth Seeking Medical Intervention, World Professional Association of Transgender Health Biennial International Symposium, Amsterdam, The Netherlands, 2016

4. Adkins V, Masters E, Shumer D, Selkie E: Exploring Transgender Adolescents' Use of Social Media for Support and Health Information Seeking (Poster Presentation), Pediatric Research Symposium, Ann Arbor, MI, 2017

Exhibit B

Bibliography

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Chen D, Berona J, Chan YM, Ehrensaft D, Garofalo R, Hidalgo MA, Rosenthal SM, Tishelman AC, Olson-Kennedy J. (2023). Psychosocial Functioning in Transgender Youth after 2 Years of Hormones. *New England Journal of Med.* 2023 Jan 19;388(3):240-250.

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

AUGUST DEKKER, et al., *Plaintiffs*, v. JASON WEIDA, et al., *Defendants*.	Case No. 4:22-cv-00325-RH-MAF

EXPERT DECLARATION OF LOREN S. SCHECHTER, M.D.

Preliminary Statement

1. I am a board-certified plastic surgeon. I specialize in performing gender confirming surgeries[1] (including chest reconstruction surgeries, genital reconstruction surgeries, and other procedures to feminize or masculinize the face

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

Pl. Trial Ex. 010

and body, as described in more detail below), and I am a recognized expert in this field.

2. I have been retained by counsel for Plaintiffs in the above-captioned lawsuit to provide an expert opinion on the standards of care for treating individuals diagnosed with gender dysphoria. In particular, I have been asked: 1) whether gender confirming surgeries are safe and effective medical treatment for gender dysphoria experienced by transgender people, including adults age 21 and over and adolescents up to age 21; 2) whether gender confirming surgeries are experimental or investigational; and 3) whether a categorical exclusion on Medicaid coverage for gender confirming surgeries violates the prevailing standards of care for treating transgender people, including for adults age 21 and over and for adolescents up to age 21, who have been diagnosed with gender dysphoria. Additionally, I submit this declaration to respond to points raised in the Florida Agency for Health Care Administration's "Florida Medicaid Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria" report ("GAPMS Report") and the assessment drafted by Patrick W. Lappert, M.D. that was attached to the GAPMS Report ("Lappert Assessment").

Qualifications and Experience

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**.

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.

6. I have been performing gender confirming surgeries for more than 28 years. For at least the past five years, I have been performing approximately 150 gender confirmation procedures every year. I have performed over 1,500 gender confirmation surgeries during my medical career. Currently,

approximately 90 percent of the patients in my clinical practice are transgender people seeking gender confirmation surgeries.

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.[2] I was the co-lead author of the surgical and postoperative care chapter of Version Eight.

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

[2] Coleman, E. et al. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int'l J. of Transgender Health, 23: S1-S259, doi: 10.1080/26895269.2022.2100644 [hereinafter "Standards of Care"].

and effective treatment for gender dysphoria, in order to maximize their overall health, psychological well-being, and self-fulfillment.

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

10. 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 International Journal of Transgender Health. Each of these publications is a peer-reviewed medical journal. A full and complete list of my reviewerships and editorial roles is included in my CV.

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

12. 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.

13. 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.

14. 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.

Previous Testimony

15. In the past four years, I have provided expert testimony in the following matters: *Kadel v. Folwell*, M.D.N.C. (deposition); *Toomey v. State of Arizona*, D. Ariz. (deposition); and *Fain v. Crouch*, S.D.W.V. (deposition).

Compensation

16. I am being compensated at an hourly rate of $400/hour plus expenses for my time spent preparing this declaration and for providing any local testimony (including deposition or 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.

Basis for Opinions

17. My 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 experience teaching other surgeons and medical students to care for this population; (2) my review and familiarity with relevant peer-reviewed literature,[3] 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. The research and

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

materials I relied on in preparing this declaration are cited in the footnotes and detailed in the reference list attached as **Exhibit B** to this declaration.

18. Additionally, in preparing this declaration, I reviewed the GAPMS Report and the Lappert Assessment, as well as the coverage exclusion challenged in this case (Fla. Admin. Code R. 59G-1.050(7)).

DISCUSSION

Background on Gender Identity and Gender Dysphoria

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

20. Many transgender people experience gender dysphoria at some point in their lives. Gender dysphoria is a serious medical condition, defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5TR) published by the American Psychiatric Association as clinically significant distress or impairment related to gender incongruence, which may include desire to change primary and/or secondary sex characteristics. Gender dysphoria is also recognized by the International Classification of Diseases-11 (ICD-11), under the label of gender incongruence, and the International Classification of Diseases-10 (ICD-10).

21. Individuals diagnosed with gender dysphoria have an intense and persistent discomfort with the primary and/or secondary sex characteristics of the sex they were assigned at birth. Gender dysphoria can lead to debilitating anxiety and depression, as well as serious incidents of self-harm, including self-mutilation, suicide attempts, and suicide.

22. Appropriate medical care, including mental health services, hormone therapy, and gender confirmation surgeries can help alleviate gender dysphoria. Gender confirmation surgeries, which bring a person's body into better alignment with their gender identity, have been shown to be a safe and effective treatment for gender dysphoria.

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

23. It is my professional opinion, supported by the prevailing consensus of the medical community, that surgical procedures used to treat gender dysphoria are medically necessary treatments for many transgender people. Decades of clinical practice and peer-reviewed research have demonstrated that these procedures are safe and effective treatments for gender dysphoria.

Applicable Standards of Care for Treating Gender Dysphoria

24. WPATH is a non-profit professional and educational organization devoted to transgender health. WPATH's mission is "to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health."[4] As described above, WPATH publishes the Standards of Care, which are based on the best available scientific evidence and expert professional consensus.[5] WPATH published the first version of the Standards of Care in 1979. Since that time, the guidelines have been updated through eight versions, reflecting the significant advances made in the understanding, management, and care of transgender individuals. The Standards of Care are widely recognized guidelines for the clinical management of transgender people with gender dysphoria. Most surgeons who are actively involved in academic training and research in the field and regularly treat people experiencing gender dysphoria, including myself, practice in accordance with the Standards of Care.

25. As indicated in the Standards of Care, medically necessary gender affirming treatments include mental health care, puberty suppression, hormone therapy, and various surgical procedures to align a person's primary and/or

[4] WPATH, Mission and Vision, https://www.wpath.org/about/mission-and-vision.
[5] *See* Standards of Care at S247-251 (describing the methodology used to develop the Standards of Care).

secondary sex characteristics with the person's gender identity.[6] Surgery is often the last and most considered of the treatment options for gender dysphoria in transgender people. Not every transgender person may undergo every available surgical procedure. As highlighted in the seventh version of the Standards of Care, and as now well-accepted, "[t]he number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs."[7] Evidence shows that while some transgender people do not require surgery, "for many others surgery is essential and medically necessary to alleviate their gender dysphoria. For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity."[8]

26. The Endocrine Society—the leading professional organization devoted to research on hormones and the clinical practice of endocrinology—has also issued clinical guidelines for the treatment of transgender people.[9] The

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[6] Standards of Care at S18, S128.
[7] Coleman, E. et al. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People. Version 7, Int'l J. of Transgenderism, 13(4): 165-232, 201 doi: 10.1080/15532739.2011.70087358.
[8] *Id*. at 199. *See also* Standards of Care at S18.
[9] Hembree, W.C. et al. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, J. Clin. Endocrinology & Metabolism, 102(11): 3869-3903, doi: 10.1210/jc.2017-01658.

guidelines indicate, that for transgender people, gender confirming surgeries often are necessary and effective treatments.[10]

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

Surgical Treatments for Gender Dysphoria

28. Surgical treatment options that are generally accepted in the medical community and are consistent with the Standards of Care include, but are not limited to:

- Breast/chest surgery: augmentation (breast implants) and mastectomy/liposuction (chest masculinizing);
- Genital surgeries: phalloplasty and/or metoidioplasty (creation of the penis and/or scrotum), vaginoplasty, and/or vulvoplasty (creation of the vulva and/or vagina, including the labia minora and majora);

[10] *Id.*

- Gonadectomy: hysterectomy (removal of the uterus), orchiectomy (removal of the testes);
- Other surgical interventions: gender affirming facial surgery, body contouring, voice surgery, thyroid cartilage reduction, and hair reconstruction, among others.

29. The Standards of Care set forth criteria for initiation of any gender affirming medical treatment, including surgery. For adults, the criteria for surgery are:

- The patient's experience with gender incongruence is marked and sustained.
- In regions where a diagnosis is necessary to access health care (as it is in the United States), the patient fulfills the diagnostic criteria for gender incongruence.
- Other possible causes of apparent gender incongruences have been identified and excluded prior to the initiation of treatment.
- Any physical or mental health conditions "that could negatively impact the outcome" of treatment were assessed, "with risks and benefits discussed, before a decision was made regarding treatment."

- The patient has the capacity to consent for the specific gender affirming treatment.
- The patient understands "the effect of the treatment on reproduction" and has explored reproductive options.
- "[P]rofessionals who have competencies in the assessment of transgender and gender diverse people wishing gender-related medical treatment consider[ed] the role of social transition" with the patient.
- The patient has a recommendation for the initiation of the treatment "from a professional who has competencies in the assessment of transgender and gender diverse people wishing gender-related medical and surgical treatment."
- Prior to genital reconstruction surgery, the patient has received a minimum of 6 months of hormone therapy as appropriate to their gender goals prior to undergoing the surgery.[11]

30. The Standards of Care recognize that chest masculinization surgery "can be considered in minors when clinically and developmentally appropriate

[11] Standards of Care at S32; *see also id*. at S256.

as determined by a multidisciplinary team experienced in adolescent and gender development"[12] They also indicate that breast augmentation may be needed by adolescents. In addition, while it is rare to perform genital surgeries on adolescents, the Standards of Care recognize that studies suggest that some adolescents may benefit from vaginoplasty procedures.[13] They recommend that clinicians undertake a "comprehensive biopsychosocial assessment of adolescents" seeking gender-affirming treatment "to guide treatment decisions and optimize outcomes."[14] As they do for adults, the Standards of Care set forth criteria for initiation of surgery in adolescents.[15]

Gender Confirmation Surgeries Are Medically Necessary

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

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[12] *Id.*at S66.
[13] *Id.*
[14] *Id.* at S50.
[15] *Id.* at S48, S256.

32. With respect to surgical treatments for gender dysphoria, the medical community generally considers those surgeries to be medically necessary. This is true even though the same surgical procedures might be considered cosmetic when performed on someone without gender dysphoria (e.g., a cisgender woman obtaining a breast augmentation for aesthetic reasons). Gender confirming surgeries are not cosmetic because, when performed in accordance with the Standards of Care, they are clinically indicated to treat the underlying medical condition of gender dysphoria. Because these medically necessary procedures help transgender people live and present in a manner more consistent with their gender identity and therefore reduce and/or treat their gender dysphoria, the professional medical consensus is that these are appropriately categorized as medically necessary.

33. Dr. Lappert asserts that distinguishing "cosmetic breast surgery from 'medically necessary' surgery is based upon the diagnosis of the underlying pathology."[16] I agree. What Dr. Lappert fails to acknowledge, however, is that

[16] Lappert Assessment at 13.

breast augmentation or mastectomy may be medically indicated for the treatment of gender dysphoria, in addition to other pathologies.[17]

34. Dr. Lappert misunderstands that gender dysphoria is a medical condition for which there are effective medical and surgical treatments. While plastic surgeons may encounter individuals with mental health conditions, such as body dysmorphic disorder, surgery for this condition is highly ineffective. This is in contrast to surgery as treatment for gender dysphoria; where medically indicated, surgical procedures for gender dysphoria are both safe and medically effective.

35. Dr. Lappert also wrongly suggests that a mastectomy performed to treat gender dysphoria is cosmetic because it results in a "complete loss of function" that is "two fold (breast feeding and erotic sensibility)."[18] Here, he makes several incorrect assumptions. First, he fails to recognize that for many transgender people (especially transgender men), nipple sensation is rarely a source of erotic sensibility, and the presence of breasts may interfere with romantic relationships. In fact, my research, as well as my clinical experience,

[17] Dr. Lappert incorrectly refers to breast growth in transgender women as "gynecomastia." Gynecomastia refers to enlargement of the male breast, not to breast growth in transgender women.
[18] Lappert Assessment at 10.

shows that gender-affirming mastectomy is associated with an increase in sexual satisfaction.[19] What is more, Dr. Lappert ignores that a mastectomy performed to treat breast cancer or a breast reduction performed in a cisgender woman to relieve symptoms of breast hypertrophy or macromastia may also result in the loss of nipple sensation. A mastectomy performed to treat breast cancer will likewise result in the loss of the ability to breast feed. So, his assertion that any procedure that causes a loss of function is cosmetic cannot be correct. As another example, a prostatectomy performed to treat prostate cancer in a cisgender man may result in the loss of erectile function and impotence.

Gender Confirming Surgeries Are Safe and Effective

36. The prevailing peer-reviewed clinical research, as well as my own clinical expertise as a plastic surgeon specializing in gender confirmation surgeries for nearly three decades, shows that surgical procedures for gender dysphoria are safe, effective, and medically accepted. Indeed, many of these procedures are analogous to surgical procedures used to treat other medical conditions.

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[19] *See, e.g.*, Agarwal, C.A. et al. (2018). Quality of Life Improvement After Chest Wall Masculinization in Female-To-Male Transgender Patients: A Prospective Study Using the BREAST-Q and Body Uneasiness Test, J. Plastic, Reconstructive & Aesthetic Surgery, 71(5): 651-657, doi: 10.1016/j.bjps.2018.01.003.

Safety

37. It is my professional opinion that gender confirmation surgeries are safe. My opinion is informed in part by my experience as the former Chair of the Patient Safety Committee for the American Society of Plastic Surgeons and the current Patient Safety Officer for the Division of Plastic Surgery at Rush University Medical Center. Notably, when performing gender confirmation surgeries, surgeons use many of the same procedures that they use to treat other medical conditions. The fact that the medical community deems these analogous procedures sufficiently safe to treat conditions other than gender dysphoria is by itself more than sufficient to support the safety of those surgeries to treat gender dysphoria. There is no medical basis to conclude that the same surgical procedures are more or less safe simply because they are used to treat gender dysphoria, versus other underlying medical conditions.

38. For example, surgeons regularly perform mastectomies and chest/breast reconstruction, hysterectomies/salpingo-oophorectomies (which includes removal of the fallopian tubes and ovaries), and orchiectomies to treat individuals with cancer, or a genetic predisposition to cancer (BRCA 1, 2 genes in the case of prophylactic mastectomy or oophorectomy). Similarly, surgeons perform procedures to reconstruct external genitalia for individuals who have

certain medical conditions (e.g., cancer) or who have suffered traumatic injuries or disabling infections to their genitalia. This would include procedures to correct conditions such as hypospadias (a disorder in which the urinary opening is not in the typical location on the glans penis), epispadias (a condition where the urethra is not properly developed), exstrophy (where the bladder develops outside the fetus), fournier's gangrene (where tissue dies because of an infection), penile webbing, or buried penis (which can occur as a result of obesity, diabetes, or recurrent infections). This would also include procedures to correct conditions such as congenital absence of the vagina or reconstruction of the vagina/vulva following oncologic resection, traumatic injury, or infection.

Notably, Dr. Lappert concedes that chest reconstructive surgery in the form of a mastectomy is "very safe, and typically performed in the outpatient setting."[20] Dr. Lappert also concedes that "[s]urgical enhancement procedures are exactly the same in both men and women."[21]

[20] Lappert Assessment at 13.
[21] *Id.*

Efficacy

39. It is my professional opinion that standard surgical treatments for gender dysphoria are effective when performed in accordance with the Standards of Care.

40. Peer-reviewed studies find that transgender women who undergo one or more gender confirmation surgeries report positive health outcomes.[22] For example, a peer-reviewed study of transgender women found that those who underwent breast reconstruction surgeries experienced statistically significant improvements in their psychosocial well-being.[23] In a study published in 2019 by Miller, et al., 100% of transgender women who underwent breast augmentation reported improvement in their gender dysphoria and "would undergo the operation again."[24] Another peer-reviewed study of transgender women who had vaginoplasty found that study participants' mean improvement in quality of life

[22] *See* Standards of Care at S128-129 (gathering studies on breast augmentation and vaginoplasty).
[23] Weigert, R. et al. (2013). Patient Satisfaction with Breasts and Psychosocial, Sexual, and Physical Well-Being after Breast Augmentation in Male-to-Female Transsexuals. Plastic and Reconstructive Surgery, 132(6): 1421-1429. doi: 10.1097/01.prs.0000434415.70711.49.
[24] Miller. T.J. et al. (2019). Breast Augmentation in Male-to-Female Transgender Patients: Technical Considerations and Outcomes. JPRAS Open, 21: 63-74, doi: 10.1016/j.jpra.2019.03.003.

after surgery was 7.9 on a scale from one to ten.[25] Another study of transgender women found that surgical interventions were highly correlated with alleviating gender dysphoria.[26] A recent literature review concluded that in appropriately selected individuals, gender confirmation surgery is effective at improving quality of life, overall happiness, and sexual functioning in transgender women who are diagnosed with gender dysphoria.[27] Another recent post-operative and six-month follow-up survey of transgender female patients found improvements in quality of life in a significant majority of patients.[28]

41. The available peer-reviewed literature likewise concludes that when performed in accordance with the prevailing standards of care, male chest reconstruction surgery is safe and effective in alleviating gender dysphoria.[29] For example, one study found that transgender men who received chest reconstruction experienced few clinical complications and were overwhelmingly

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[25] Horbach, S. E. R. et al. (2015). Outcome of Vaginoplasty in Male-to-Female Transgenders: A Systematic Review of Surgical Techniques. J. Sexual Medicine, 12(6): 1499-1512, doi: 10.1111/jsm.12868.

[26] Hess, J. et al. (2014). Satisfaction with Male-to-Female Gender Reassignment Surgery. Deutsches Arzteblatt Int'l, 111: 795-801, doi: 10.3238/arztebl.2014.0795 (Among survey respondents, the majority (90.2%) said that that their expectations for life as a woman were fulfilled after surgery. A similarly high percentage (85.4%) saw themselves as women.)

[27] Hadj-Moussa, M., et al. (2018). Feminizing Genital Gender-Confirmation Surgery. Sexual Medicine Reviews, 6(3): 457-468.e2, doi: 10.1016/j.sxmr.2017.11.005.

[28] Papadopulos, N.A., et al. (2017). Male-to-Female Sex Reassignment Surgery Using the Combined Technique Leads to Increased Quality of Life in a Prospective Study. Plastic and Reconstructive Surgery, 140(2): 286-294. doi: 10.1097/PRS.0000000000003529.

[29] *See* Standards of Care at 128 (gathering studies).

satisfied with their surgical outcomes.[30] Another peer-reviewed study of transgender men who received chest reconstruction found that the procedure improved psychosocial well-being and physical well-being among participants.[31] A 2021 study using a validated quality of life assessment tool demonstrated significant improvements in quality of life among transgender men up to one year following chest surgery.[32] The authors indicated that "the effect sizes were large and…exhibited excellent internal validity." The authors report that "every patient surveyed at 1 year reported that gender-affirming surgery changed their life for the better" and that, "every patient surveyed after surgery said they would choose it [surgery] again knowing what they know." Numerous other studies have reached similar conclusions.[33]

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[30] Frederick, M. et al. (2017). Chest Surgery in Female to Male Transgender Individuals. Annals of Plastic Surgery, 78(3): 249-253, doi: 10.1097/SAP.0000000000000882.

[31] Agarwal, C.A. et al. (2018). Quality of Life Improvement After Chest Wall Masculinization in Female-To-Male Transgender Patients: A Prospective Study Using the BREAST-Q and Body Uneasiness Test, J. Plastic, Reconstructive & Aesthetic Surgery, 71(5): 651-657, doi: 10.1016/j.bjps.2018.01.003.

[32] Alcon, A. et al. (2012). Quantifying the Psychosocial Benefits of Masculinizing Mastectomy in Trans Male Patients with Patient-Reported Outcomes: The University of California, San Francisco, Gender Quality of Life Survey. Plastic and Reconstructive Surgery, 147(5): 731e-740e, doi: 10.1097/PRS.0000000000007883. *See also* Schechter, L.S. (2012). Discussion: Quantifying the Psychosocial Benefits of Masculinizing Mastectomy in Trans Male Patients with Patient-Reported Outcomes: The University of California, San Francisco, Gender Quality of Life Survey. Plastic and Reconstructive Surgery, 147(5): 741e-742e. doi: 10.1097/PRS.0000000000007902.

[33] *See, e.g.,* Olson-Kennedy, J. et al. (2018). Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults. JAMA Pediatrics, 172(5): 431-436, doi: doi:10.1001/jamapediatrics.2017.5440; Van de Grift, T., et al. (2017). Surgical Indications and

42. These findings extend to adolescents; for example, a recent study in JAMA Pediatrics concluded that: "Chest dysphoria was high among presurgical transmasculine youth, and surgical intervention positively affected both minors and young adults."[34] In addition, a 2022 study in JAMA Pediatrics found that in transgender and nonbinary adolescents and young adults, top surgery is associated with low complication rates and improved chest dysphoria, gender congruence, and body image satisfaction.[35]

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

Outcomes of Mastectomy in Transmen: A Prospective Study of Technical and Self-Reported Measures. Plastic and Reconstructive Surgery, 140(3): 415e-424e. doi:10.1097/PRS.0000000000003607; Berry, M.G. et al. (2012). Female-to-male transgender chest reconstruction: A large consecutive, single-surgeon experience. J. Plastic, Reconstructive & Aesthetic Surgery, 65: 711-719, doi: 10.1016/j.bjps.2011.11.053; Newfield, E. et al. (2006). Female-to-Male Transgender Quality of Life Quality of Life Research, 15(9): 1447-1457. doi: 0.1007/s11136-006-0002-3.

[34] Olson-Kennedy, J. supra note 33. Additionally, Frederick et al., *supra* note 30, included adolescents aged 15-17, as well as adults.

[35] Ascha, M. et al. (2022). Top Surgery and Chest Dysphoria Among Transmasculine and Nonbinary Adolescents and Young Adults. JAMA Pediatrics, 176(11): 1115-1122, doi:10.1001/jamapediatrics.2022.3424.

Gender Confirmation Surgeries Are Not Experimental

44. It is my professional medical opinion that Dr. Lappert's contention that gender-confirming surgeries are experimental is unsupported by the professional medical consensus and prevailing standards of care for treating gender dysphoria. To the contrary, the prevailing consensus of the medical community recognizes that procedures used to treat gender dysphoria are medically necessary and not experimental or investigational.

45. Surgical care is not considered experimental when it uses accepted techniques and has demonstrative benefits. The techniques used in gender affirming care are employed in other surgeries and are well-established. For example, urethroplasties, orchiectomies, skin grafts, and mastectomies are all accepted techniques for congenital, oncological, and traumatic conditions. They are not experimental simply because they are applied to the well-established diagnosis of gender dysphoria.

46. Gender affirming surgery has been performed for almost 100 years, utilizes accepted surgical techniques, and yields demonstrated benefits for patients. Sir Harold Gilles, the 'father' of plastic surgery performed a phalloplasty on a transgender man in 1946. Sir Harold Gilles also performed a vaginoplasty on a patient in the 1950s. Subsequent to that, the gynecologist

Georges Borou in Casablanca, developed the pedicled flap for vaginoplasty. This technique remains the mainstay of modern procedures. In fact, pioneering work in gender affirming surgery was performed at Eastern Virginia Medical School in Norfolk, Virginia, where Dr. Lappert was noted to have a faculty appointment. The Center for Gender Reassignment was established in 1984 at Eastern Virginia Medical School. The founder of the program, Dr. David Gilbert, indicated that by 1992, he and his colleagues had performed more than 50 microsurgical phalloplasty procedures. Many of the techniques used in gender affirming surgery were developed in Norfolk, including the 'Norfolk Glansplasty' used in gender affirming phalloplasty.

47. In addition, gender affirming surgeries are: 1) part of the core curriculum in plastic surgery resident education; and 2) a component of both the written and oral board exams in plastic surgery. I have given presentations at multiple professional societies—including, the American Society of Plastic Surgeons, American Association of Plastic Surgeons, American Society for Reconstructive Microsurgery, American College of Surgeons—and none of those societies consider gender affirming surgery experimental. In the disclosures required to give presentations of this kind there is no requirement that they be called experimental. It is widely accepted by professional surgical societies that

gender affirming surgeries are not experimental. Indeed, gender affirming surgery is part of the standard resident education in plastic surgery and is included in both the written and oral exams (in order to obtain board certification).

The Opinions of Dr. Lappert Are Inconsistent With the Mainstream Medical Consensus and Scientific Literature and Are Fatally Flawed

Qualifications of Dr. Lappert

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

49. Dr. Lappert is not a member of the American Society of Plastic Surgeons (ASPS), despite its role as the largest plastic surgery specialty organization in the world. ASPS represents 92% of all board-certified plastic surgeons in the United States, and more than 11,000 plastic surgeons worldwide.[36] Dr. Lappert does not appear to be a member of any other major or relevant surgical organization, such as the American College of Surgeons.

[36] *See* American Society of Plastic Surgeons, About ASPS, plasticsurgery.org/about-asps (2023).

50. Dr. Lappert lists no current hospital affiliations, nor does he appear to perform surgical procedures any longer. Dr. Lappert has no recent or relevant scientific publications pertaining to the field of gender-affirming surgery. Dr. Lappert references having performed an unspecified number of surgeries for patients who previously identified as transgender, however, he does not disclose any experience in treating individuals in a manner consistent with the Standards of Care.

51. Additionally, Dr. Lappert is not a member of WPATH, which is recognized by the mainstream medical community as the authoritative entity that has established comprehensive Standards of Care in this field.

Quality of Evidence

52. Dr. Lappert repeatedly contends that the body of evidence supporting gender affirming surgery is low-quality, and as a result, the treatment is considered experimental. But that is incorrect. The quality of the evidence supporting gender affirming surgeries is comparable to that supporting many surgeries and clinical procedures. Prospective, randomized, double-blind, placebo-controlled studies cannot be used to evaluate many clinical procedures, especially surgical procedures. For example, there are simply inherent limitations to our ability to conduct such studies in clinical medicine. First, it is unethical to

withhold medically necessary care. As such, in many situations, clinicians cannot conduct a study that uses a control group who is deprived of the treatment being studied. Practice guidelines published in 2013 by the Royal College of Psychiatrists indicated that a randomized controlled study to evaluate feminizing vaginoplasty would be "impossible to carry out."[37] The withholding of medically necessary care that would be required for such a comparison would be considered unethical.

53. Second, it is not possible to perform a double-blind study of surgeries that modify body parts, nor is there a placebo that can mimic such a surgery – unlike studies that use placebo drug regimens, for example, people will know if they have had an operation or not. Third, for relatively uncommon conditions like gender dysphoria, sample sizes of individuals with the condition who are available to participate in a clinical study tend to be small. This is especially true where treatment for a condition has not been covered by insurance programs and plans, and where additional barriers (such as ongoing stigmatization) prevent patients from accessing care. That very lack of access to

[37] Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria, Royal College of Psychiatrists, at 50 (2013).

the procedure results in there being fewer people who have received treatment and who can participate in a prospective study of that treatment's effect.

54. Put simply, the scientific literature pertaining to gender affirming surgical interventions is similar to that of other accepted plastic surgery procedures. For example, Dr. Lappert points to his experience performing surgery to treat cleft palate and craniofacial differences.[38] However, there are only a small number of Level 1 (randomized controlled trials) for that treatment.[39] Scientific ratings of evidence generally employ extremely high standards that are not satisfied for many commonly-prescribed treatments and procedures.[40] Such ratings do not mean that the treatment is unsupported in the literature and clinical practice, or that it is not medically necessary.

55. The recommendation for ongoing research is a standard recommendation in many, if not most or all clinical scenarios. This recommendation for ongoing study in a particular clinical area does not mean that surgical care is withheld.

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[38] *See* Lappert Assessment as 15.

[39] *See, e.g.*, Bekisz, J.M. (2018). A Review of Randomized Controlled Trials in Cleft and Craniofacial Surgery. J. Craniofacial Surgery, 29(2): 293-301, doi: 10.1097/SCS.0000000000004100.

[40] *See, e.g.*, Lee, B.T., et al. (2017). Evidence-Based Clinical Practice Guideline: Autologous Breast Reconstruction with DIEP or Pedicled TRAM Abdominal Flaps, Plastic and Reconstructive Surgery. 140(5): 651e-664e, doi: 10.1097/PRS.0000000000003768.

56. In addition, Dr. Lappert is wrong to suggest that studies are the only way for surgeons to determine the appropriate course of treatment for a particular condition. Critical review of the scientific literature is certainly an important component as to how surgeons evaluate whether a particular procedure is generally safe and effective and whether it is appropriate or recommended for an individual patient. But in addition to considering the literature en masse, we must also account for our own clinical experience and that of our colleagues, as well as our patients' experiences and input. Here, the existing literature, taken as a whole, combined with my own experience and that of many colleagues, indicates that gender affirming surgery is a safe and effective treatment for individuals with gender dysphoria.

57. In fact, in his effort to discredit the research on gender affirming surgery, Dr. Lappert reveals that his lack of experience in the area of gender affirming care is coloring his ability to properly interpret the results of the relevant studies. For example, he suggests that flaws in the methodology of one study could be masking significant numbers of patients who had poor outcomes or regretted having surgery.[41] If significant numbers of patients were having poor outcomes or experiencing regret, those of us who regularly perform gender

[41] *See* Lappert Assessment at 7-8.

affirming procedures, consult with our colleagues in the field, and attend lectures and conferences on gender affirming care would know about it. We would see many transgender patients requesting revision surgery. That is simply not happening. In contrast, I am aware that some cisgender women who undergo implant-based breast reconstruction subsequently request implant removal.

58. Finally, while criticizing the existing body of research on gender affirming surgical procedures, neither the GAPMS Report nor Dr. Lappert point to any research demonstrating a safe and effective alternative to gender affirming treatment for gender dysphoria.

Informed Consent

59. Dr. Lappert appears to assert that patients cannot provide informed consent for surgical procedures to treat gender dysphoria because of the purported insufficiency of the evidence supporting this care.[42] Dr. Lappert misunderstands informed consent, both generally and in the context of gender-affirming surgery. And, his view directly contradicts that of the American Society of Plastic Surgeons, which offers documents for surgeons to use to memorialize the process of obtaining informed consent for gender affirming care.

[42] Lappert Assessment at 4.

60. Gender affirming surgeries are not experimental, as discussed above. Gender affirming surgical procedures have been shown beneficial by multiple surgeons, in multiple countries, over many decades. The risks of gender affirming surgical procedures are well-known and well-described in the literature.[43]

61. The Standards of Care specifically discuss the importance of a shared decision-making approach (between the patient and the surgeon) that is multidisciplinary and includes a discussion of the patient's goals and expectations, the surgical options and associated risks and benefits, and a plan for care after surgery.[44] For adolescents, these discussions include the caregiver or parents who must consent as well.[45]

62. The process of securing informed consent is done in a multidisciplinary way. The health care team, which could consistent of a mental health professional, a primary care provider, an endocrinologist, and a surgeon, must assess the ability of the patient to provide informed consent.[46] And, as noted

[43] *See, e.g.*, Schechter, L.S. (2009). The Surgeon's Relationship with the Physician Prescribing Hormones and the Mental Health Professional: Review for Version 7 of the World Professional Association for Transgender Health's Standards of Care. Int'l J. of Transgenderism, 11(4): 222-225, doi: 10.1080/15532730903439468.
[44] *See* Standards of Care at S130-132.
[45] *See id.* at S57-58.
[46] *See id*. at S38-39, S61-62.

above, a competent health care professional must assess a patient seeking gender affirming surgery prior to the initiation of the treatment. This represents a clinical standard which exceeds the threshold to perform many surgical interventions to treat conditions other than gender dysphoria, including those that are sterilizing. However, this kind of multidisciplinary approach is not unique to gender affirming care. A psychosocial assessment is often performed in other areas of surgery, including transplantation and bariatrics, and has been shown to improve patient outcomes.

Few Patients Experience Regret When Gender Confirming Surgery is Provided in Accordance with the Standards of Care

63. Dr. Lappert suggests that gender confirming surgery is not safe and effective because some patients could later regret their transition and the procedure.[47] All available research—as well as my own clinical experience—indicates that very few patients experience regret when gender confirming surgery is provided in accordance with the Standards of Care and by a qualified surgeon. Regret of any kind is rare (0.6% in transgender women and 0.3% in transgender men),[48] but "true regrets," as opposed to regrets due to lack of social

[47] *See, e.g.*, Lappert Assessment at 7-8, 10-11.
[48] Wiepjes, C.M. et. al. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, And Regrets. J. of Sexual Medicine, 15(4): 582-590. doi: 10.1016/j.jsxm.2018.01.016.

or familial acceptance, comprise an even smaller percentage (approximately half this group, roughly 0.3% in transgender women and 0.15% in transgender men).[49] Having performed gender confirming surgeries for over 20 years, I have only seen two individuals who have requested a reversal of gender affirming surgery.

64. In a recent study I co-authored regarding regret following gender affirming surgery, Narayan, et al. queried 154 surgeons surgically treating between 18,125 to 27,325 individuals.[50] The rate of regret was found to be between 0.2-0.3%, consistent with previous literature.

65. Moreover, issues pertaining to regret following surgical procedures are not limited to gender-affirming surgical interventions.[51] Some cisgender women experience regret following breast reconstruction (40%)[52], prophylactic

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[49] *Id*. at 585, 587 (Researchers classified transgender women as having "social regrets" when they still identified as women, but reported feeling "ignored by surroundings" or they regretted loss of relatives. Researchers classified "true regrets" as those experienced by individuals who "thought gender affirming treatment would be a 'solution' for, for example, homosexuality or [lack of] personal acceptance, but, in retrospect, regretted the diagnosis and treatment.").

[50] Narayan, S.K. et al. (2021). Guiding the Conversation—Types of Regret After Gender-Affirming Surgery and Their Associated Etiologies. Annals of Translational Medicine, 9(7): 605-616, doi: 10.21037/atm-20-6204.

[51] *See, e.g.*, Christie, D.R.H. et al. (2015). Why do patients regret their prostate cancer treatment? A systematic review of regret after treatment for localized prostate cancer. Psycho-Oncology 24(9): 1002-1011. doi: 10.1002/pon.3776.

[52] Zhong, T. et al. (2013). Decision regret following breast reconstruction: the role of self-efficacy and satisfaction with information in the preoperative period. Plastic and Reconstructive Surgery, 132(5): 724e-734e, doi: 10.1097/PRS.0b013e3182a3bf5d.

mastectomy (6%),[53] and prophylactic oophorectomy (7%).[54] A study of breast cancer survivors found that five years after diagnosis, 24% expressed regret about primary surgery, and nearly 18% expressed regret about reconstruction.[55]

66. Even if we were to assume that some small percentage of patients who undergo gender-affirming surgery will experience regret, that does not mean that the surgery should never be performed. For example, some patients who undergo an appendectomy are found to have a normal appendix. No one would suggest that surgeons stop performing this procedure altogether. Rather, the appropriate response is to further refine our ability to accurately determine who is most likely to benefit from the procedure.

67. Finally, Dr. Lappert fails to consider that regret can be bidirectional. In other words, a patient may regret not having surgery. In my practice, it is far more common to see a patient who regretted not having access to surgery due to lack of insurance coverage than a patient who regretted having gender affirming surgery.

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[53] Montgomery, L.L. et al. (1999). Issues of regret in women with contralateral prophylactic mastectomies. Annals of Surgical Oncology, 6(6): 546-552, doi: 10.1007/s10434-999-0542-1.
[54] Swisher, E.M. et al. (2001). Prophylactic oophorectomy and ovarian cancer surveillance. J. of Reproductive Medicine, 46(2): 87-94 (2001).
[55] Fernandes-Taylor, S. & Bloom, J.R. (2011). Post-treatment regret among young breast cancer survivors. Psycho-Oncology 20(5): 506-516, doi: 10.1002/pon.1749.

Patient Self-Reporting

68. Dr. Lappert claims that gender confirming surgeries are based on "the patient's subjective report of dysphoria."[56] Dr. Lappert misrepresents the preoperative process and multidisciplinary assessment that occurs prior to gender affirming surgical interventions.[57] He demonstrates a lack of familiarity with both the assessment process done before the transgender patient is eligible for surgery and the role and responsibility of the surgeon in providing this care.

69. When a person is referred to a surgeon to receive gender confirming surgery, the surgeon receives in writing one or more assessments from one or more health professionals outlining the patient's diagnosis and the medical necessity of the care, as required under the Standards of Care.[58] But that is only one step in the assessment for surgical interventions. Contrary to Dr. Lappert's suggestions, the surgeon remains ultimately responsible for deciding whether a particular surgical intervention is medically indicated. The surgeon evaluates the patient and makes the final decision about whether it is safe and medically indicated to proceed. This includes an evaluation of the patient's understanding

[56] Lappert Assessment at 13.
[57] *See* Standards of Care at S133; Schechter, L.S., *supra* note 43.
[58] The Standards of Care recommend that health care professionals assessing patients for gender-affirming surgical care have specific qualifications. *See* Standards of Care at S33-35.

of the condition, their self-awareness, and their goals and expectations for the intervention. The surgeon also evaluates other factors that would affect the patient's fitness for the surgery, such as obesity or smoking, and determines whether additional information might be required, such as x-rays or laboratory work. The surgeon also typically obtains an assessment from the person's primary care physician about their overall health. In my own clinical practice, I have declined to perform a requested intervention based on my exercise of professional judgment.

70. What is more, his reliance on "objective" tests is misplaced. What he considers to be objective tests – an x-ray, pathology report or lab value – are open to interpretation. It is not uncommon to have conflicting opinions regarding an x-ray or a pathology report. In addition, while various tests may be considered in regards to establishing a diagnosis, the tests are usually interpreted within the clinical context. For example, x-ray reports typically include the phrase "clinical correlation is recommended."

71. Finally, Dr. Lappert ignores that once a diagnosis is established, treatment then depends on a discussion with the patient. That discussion includes information from the literature, but also includes other clinical considerations,

such as the patient's values, preferences, choices, and autonomy, which Dr. Lappert disregards.

72. Finally, Dr. Lappert also suggests that the difference between reconstructive surgery (which he states that insurance will cover) and cosmetic surgery (which he states that insurance will not) turns on pathology reports, using surgery to treat gynecomastia as an example.[59] Similarly, he alleges that the need for breast reduction surgery is determined by objective tests, including the weight of the specimen which is removed.[60] But, for both of those procedures, the American Society of Plastic Surgeons states that symptomatology – not pathology reports or the weight of the specimen which is removed – is the important determinant for insurance coverage.[61]

The GAPMS Report Misrepresents the Literature in Medical Necessity, Safety, and Effectiveness

73. The overwhelming weight of the scientific and medical literature supports the benefits of gender affirming surgical interventions. Gender

[59] *See* Lappert Assessment at 9.
[60] *Id*. at 10.
[61] *See* American Society of Plastic Surgeons, ASPS Recommended Insurance Coverage Criteria for Third-Party Payers, Reduction Mammaplasty (2021), https://www.plasticsurgery.org/documents/Health-Policy/Reimbursement/insurance-2021-reduction-mammaplasty.pdf; American Society of Plastic Surgeons, ASPS Recommended Insurance Coverage Criteria for Third-Party Payers, Gynecomastia, https://www.plasticsurgery.org/documents/Health-Policy/Positions/Gynecomastia_ICC.pdf.

affirming interventions have been performed for decades, and the safety and efficacy of these procedures have been reported by multiple surgeons practicing at different institutions in different countries and continents.

74. The GAPMS Report cites a study by Dhejne, et al. to imply that because individuals who received gender confirming surgeries had higher morbidity and mortality rates compared to the general population, the surgeries are not effective.[62] The Agency misunderstands that study. First, while the study itself clearly states that it is not intended to evaluate whether gender affirming surgeries are "an effective treatment or not," it did conclude that surgeries alleviate gender dysphoria. Second, the study found that those who receive medically necessary surgery generally have reduced morbidity and mortality compared to those with the same condition who do not, even if morbidity and mortality for both groups is higher than average. Third, the study includes patients who had surgery prior to the development of the current standards of care. Finally, the fact that gender confirming surgeries do not entirely resolve all possible causes of morbidity and mortality among transgender individuals is completely unsurprising. While surgery can treat gender dysphoria by aligning transgender people's bodies with their gender identity, surgery alone cannot fully

[62] GAPMS Report at 24-25.

eliminate the stigma and discrimination that transgender people face. Surgery does not occur in a vacuum. The Standards of Care specifically recognize the need for patients to receive continued social and medical support after surgery.[63]

75. Moreover, it is rare for any surgery to eliminate morbidity and mortality. For example, people who have surgery to remove a cancerous tumor may still experience higher rates of morbidity and mortality than the general population, but that does not mean that they should not undergo the surgery. In addition, individuals suffering from other medical conditions (including chronic conditions and traumatic injuries such as burns) are also at elevated risk of suicide. The increased risk of suicide does not preclude treatment of burn patients.[64]

76. The fact that surgery does not always reduce morbidity for everyone who receives it does not mean that the surgery is not safe or effective, particularly given the number of potential confounding factors that can impact

[63] *See* Standards of Care at S131 (recommending that prior to surgery, surgeons inform patients about aftercare requirements, travel and accommodations, and the importance of postoperative follow-up care), S133 (recommending that surgeons encourage life-long urological follow-up for patients who have undergone metoidioplasty/phalloplasty), S134 (recommending surgeons encourage patients who have undergone vaginoplasty follow-up with their primary surgeon, primary care physician, or gynecologist).

[64] Lerman, S.F. et al. (2021). Suicidality After Burn Injuries: A Systematic Review. J. of Burn Care & Research, 42(3): 357-364, doi: 10.1093/jbcr/irab014.

morbidity. Similarly, the continued existence of elevated morbidity and mortality rates, compared to the population at large, say nothing about whether a treatment is a safe and effective way to treat a particular condition. Moreover, while suicide is not necessarily the correct marker for efficacy of treatment, in the Dhejne study, suicide attempts in the years 1989-2003 were reduced (and death by suicide during that time is listed as NA). Additionally, the number of mental health visits following surgical care is not a marker for treatment efficacy. For example, people receiving care for cancer will continue to see their oncologist – this does not imply that care received for the treatment of cancer was not successful. We continue to provide care to patients with cancer even though treatments may be "temporary" (i.e., some forms of care may extend the lifespan of a patient with cancer for several years). This does not suggest that withholding medically necessary care is appropriate for patients with cancer, any more than it is for transgender people.

77. The GAPMS Report also misunderstands Medicare policy on coverage of gender-affirming surgery. In 2014, an impartial adjudicative board in the Department of Health & Human Services concluded, based on decades of studies, that surgical care to treat gender dysphoria is safe, effective, and

medically necessary.[65] As a result, the Centers for Medicare & Medicaid Services (CMS) within HHS started covering surgical care for gender dysphoria and continues to provide that coverage, including for patients in my practice.

78. In 2016, CMS decided not to issue national standards (called a National Coverage Determination or "NCD") for determining under what circumstances Medicare will cover gender confirming surgical care because "the clinical evidence . . . was inconclusive *for the Medicare population*."[66] The result of CMS's review of the evidence is not applicable to other population groups. For the most part, the Medicare population consists of individuals over the age of 65. While the number of older adults who have gender affirming surgery is increasing, most individuals who undergo gender affirming surgery are under age 65, meaning that fewer older adults have been included in studies assessing the effectiveness of the treatment. That was a significant factor in CMS's decision. As CMS articulated, "older adults may respond to health care treatments

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[65] *See* Dep't of Health & Human Servs., Departmental Appeals Bd., Appellate Div., Decision No. 2676 (May 30, 2014), hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf. That decision also discussed the quality of data demonstrating the efficacy of surgical care to treat gender dysphoria, noting regardless of whether the studies were randomized double-blind trials, there was sufficient evidence to prove "a consensus among researchers and mainstream medical organizations that transsexual surgery is an effective, safe and medically necessary treatment for [gender dysphoria]." *Id.* at 20.

[66] Ctrs. for Medicare & Medicaid Servs., *Decision Memo for Gender Dysphoria and Gender Reassignment Surgery* (Aug. 30, 2016) (emphasis added) [hereinafter "CMS Decision Memo"].

differently than younger adults. These differences can be due to, for example, multiple health conditions or co-morbidities, longer duration needed for healing, metabolic variances, and impact of reduced mobility."[67]

79. What is more, CMS acknowledged that gender confirming surgery may be necessary for certain Medicare beneficiaries and concluded that the appropriateness of surgical care for this population should continue to be determined on a case-by-case basis, as is already required by the Standards of Care. Many widely accepted surgical procedures and surgical conditions do not have NCDs under Medicare. The fact that gender confirming surgery does not have an NCD is not unusual.

80. Notably, I have performed gender confirming surgeries on a number of Medicare beneficiaries in recent years, and Medicare has covered the cost of that care. Indeed, most medical and surgical care provided to patients should be individualized, taking into account each patient's unique clinical circumstances. In contrast, the exclusion challenged in this case does not evaluate the medical necessity of surgical care for gender dysphoria on a case-by-case basis. It categorically excludes all coverage regardless of an individualized showing of medical necessity.

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[67] *Id*. at 57.

Summary of Opinions and Conclusions

81. Based on over 28 years of clinical experience performing gender confirmation procedures and caring for transgender people, my knowledge of the Standards of Care and relevant peer-reviewed literature, and my discussions and interactions with experts throughout the world, it is my professional opinion that gender confirmation surgeries are safe, effective, and medically necessary treatments for gender dysphoria in transgender people. Gender affirming surgeries are not experimental or investigational. In my experience, the overwhelming number of individuals who undergo gender confirmation procedures describe relief and/or reduction of their gender dysphoria and improvement in their quality of life and overall functioning.

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

83. In conclusion, it is my professional opinion that the categorical exclusion of transition-related surgical care in Florida's Medicaid program is: 1) inconsistent with the Standards of Care for treating transgender individuals

diagnosed with gender dysphoria; 2) inconsistent with the peer-reviewed scientific and medical research demonstrating that gender confirmation surgeries are safe and effective; and 3) inconsistent with expert medical and surgical consensus. To the extent the exclusion is premised on the conclusion in the GAPMS Report that gender confirming surgical care is experimental and not medically necessary, that conclusion is wrong. The Standards of Care confirm, based on clinical evidence, that gender confirmation surgeries are medically necessary to help people alleviate the often serious and life-threatening symptoms of gender dysphoria.

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

Executed this 16th day of February, 2023.

Loren S. Schechter, M.D.

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 Pritzker School of Medicine	MD, 1994

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 48th Annual Senior Scientific Session in The Area of Clinical Investigation
1993	Alpha Omega Alpha
1991	University of Chicago National Institutes Of Health Summer Research Award
1990	Bachelor of Science with High Distinction And Honors in Economics
1990	James B. Angell Award for Academic Distinction
1989	Omicron Delta Epsilon-National Economic Honor Society
1988	College Honors Program Sophomore Honors Award For Academic Distinction
1988	Class Honors (Dean's List)

MEMBERSHIPS:

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:

WPATH Executive Committee

Treasurer, The World Professional Association for Transgender Health

Chair, Finance and Investment Committee, The American Society of Plastic Surgeons

WPATH 2020 Biennial Meeting Steering Committee

American Society of Breast Surgeons Research Committee, ASPS representative

American Board of Plastic Surgery, Guest Oral Board Examiner

WPATH Ethics Committee

American College of Radiology Committee on Appropriateness Criteria Transgender Breast Imaging Topic, Expert Panel on Breast Imaging: Transgender Breast Cancer Screening Expert Panel on Breast Imaging

American Society of Plastic Surgeons, Finance and Investment Committee

Board of Directors, at-large, The World Professional Association for Transgender Health

PlastyPac, Board of Governors

Medicare Carrier Advisory Committee

OTHER:

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
-Subcomittee 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, October3-4, 2019, Ann Arbor, MI

9. Georgetown University, Department of Plastic Surgery, July 21, 2022

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 Prophylatic 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 - LGBQT 2S Stigma Reduction & Life Course Mental Wellness (application in process)

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PEER REVIEWED ARTICLES:

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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.

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12. Iris A Seitz, MD, PhD, Craig Williams, MD, **Loren S. Schechter, MD,** Facilitating Harvest of the Serratus Fascial Flap With Ultrasonic Dissection, *Eplasty 2010 Feb 23;10:e18*

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14. Iris A. Seitz, Sally Friedwald, MD; Jonathon Rimler, **Loren S. Schechter,** Breast MRI to Define The Blood Supply to The Nipple-Areolar Complex. *Plast Recon Surg Suppl 126 (26) p. 27 Oct 2010*

15. Kalliainen LK; ASPS Health Policy Committee Evidence-Based Clinical Practice Guidelines: Reduction Mammaplasty, The American Society of Plastic Surgeons Plast Reconstr Surg. 2012 Oct;130(4):785-9 **Loren S. Schechter** (member and contributor, ASPS Health Policy Committee)

16. Eli Coleman, Walter Bockting, Marsha Botzer, Peggy Cohen-Kettenis, Griet DeCuypere, Jamie Feldman, Lin Fraser, Jamison Green, Gail Knudson, Walter J. Meyer, Stan Monstrey, Richard K. Adler, George R. Brown, Aaron H. Devor, Randall Ehrbar, Randi Ettner, Evan Eyler, Rob Garofalo, Dan H. Karasic, Arlene Istar Lev, Gal Mayer, Heino Meyer-Bahlburg, Blaine Paxton Hall, Friedmann Pfäfflin, Katherine Rachlin, Bean Robinson, **Loren S. Schechter,** Vin Tangpricha, Mick van Trotsenburg, Anne Vitale, Sam Winter, Stephen Whittle, Kevan R. Wylie & Ken Zucker, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, *International Journal of Transgenderism, 13 (4) p. 165-232, August 2012.*

17. Jonathan Bank, M.D., Lucio A. Pavone, M.D., Iris A. Seitz, M.D., Ph.D., Michelle C. Roughton M.D., **Loren S. Schechter M.D.** Case Report and Review of the Literature - Deep Inferior Epigastric Perforator Flap for Breast Reconstruction after Abdominal Recontouring, eplasty Ref.: Ms. No. EPLASTY-D-12-00050R1

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22. **Loren S. Schechter**, Mimis N. Cohn, Gender Confirmation Surgery: A New Frontier in Plastic Surgery Education, Journal of Plastic and Reconstructive Surgery, October 2016, 138 (4): 784 e

23. Berli JU, Knudson G, Fraser L, Tangpricha V, Ettner R, Ettner FM, Safer JD, Graham J, Monstrey S, **Schechter L**, Gender Confirmation Surgery: What Surgeons Need To Know When Providing Care For Transgender Individuals,JAMA Surg. 2017 Apr 1;152(4):394-400. doi: 10.1001/jamasurg.2016.5549

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25. **Loren S. Schechter**, Salvatore D'Arpa, Mimis Cohen, Ervin Kocjancic, Karel Claes, Stan Monstrey, Gender Confirmation Surgery: Guiding Principles J Sex Med. 2017 Jun;14(6):852-856. doi: 10.1016/j.jsxm.2017.04.001. Epub 2017 May 3

26. Response to Letter to the Editor: "Gender Confirmation Surgery: Guiding Principles". **Schechter LS**. J Sex Med. 2017 Aug;14(8):1067. doi: 10.1016/j.jsxm.2017.06.002. PMID: 28760249

27. Iris A. Seitz, **Loren S. Schechter**, "Successful Tongue Replantation Following Segmental Auto-Amputation Using Supermicrosurgical Technique," J Reconstr Microsurg Open 2017; 02(02): e132-e135 DOI: 10.1055/s-0037-1606584

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29. Randi Ettner, Fred Ettner, Tanya Freise, **Loren Schechter**, Tonya White, "Tomboys Revisited: A retrospective comparison of childhood behavioral patterns in lesbian women and transmen" Journal of Child and Adolescent Psychiatry ISSN: 2643-6655 Volume No: 1 Issue No: 1

30. Editor: **Loren S. Schechter**, Bauback Safa, Gender Confirmation Surgery, Clinics in Plastic Surgery, Vol. 45 (3), July 2018

31. **Loren S. Schechter**, Bauback Safa, Preface: Gender Surgery: A Truly Multidisciplinary Field, Gender Confirmation Surgery, Clinics in Plastic Surgery, Vol. 45 (3), p. xiii July 2018 (editors Loren S. Schechter, Bauback Safa)

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40. Bustos SS, Kapoor T, **Schechter LS**, Ciudad P, Forte AJ, Del Corral G, Manrique OJ."Impact of Social Media Presence on Online Reviews Among Plastic Surgeons Who Perform Gender Affirming Surgeries" J Plast Reconstr Aesthet Surg. 2020 Apr;73(4):783-808. doi: 10.1016/j.bjps.2019.11.031. Epub 2019 Nov 28.

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43. "The Affordable Care Act and Its Impact on Plastic Surgery and Gender-Affirmation Surgery," The Journal of Plastic and Reconstructive Surgery, (accepted for publication)

44. Ara A. Salibian, MD; **Loren S. Schechter, MD**, FACS; Wiliam M. Kuzon, MD; Mark-Bram Bouman, MD, PhD; Lee C. Zhao, MD; Rachel Bluebond-Langner, MD

"Vaginal Canal Reconstruction in Penile Inversion Vaginoplasty with Flaps, Peritoneum or Skin Grafts: Where Is The Evidence," The Journal of Plastic and Reconstructive Surgery (submitted for publication)

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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. 23nd Annual Clinical Symposium on Advances in Skin & Wound Care: The Conference for Prevention and Healing October 26-30, 2008, Las Vegas, Nevada,poster presentation "Use of Dual Therapies Consisting of Negative Pressure Wound Therapy (NPWT) and Small Intestine Mucosa (SIS) on a Complex Degloving Injury With an Expose Achilles Tendon: A Case Report."

41. The American Society of Plastic Surgeons Annual Meeting, October 31-November 3, 2008, Chicago, Il "Panel: Fresh Faces, Real Cases"

42. The American Association for Hand Surgery Annual Meeting, January 7-13, 2009, Maui, Hawaii, poster session: "Omental Free Tissue Transfer for Coverage of Complex Upper Extremity and Hand Defects-The Forgotten Flap."

43. Plastic Surgery At The Red Sea Symposium, March 24-28, 2009 Eilat, Israel, "Omental Free Tissue Transfer for Coverage of Complex Upper Extremity and Hand Defects-The Forgotten Flap."

44. ASPS/IQUAM Transatlantic Innovations Meeting, April 4-7, 2009 Miason de la Chimie, Paris, France, "Advertising in Plastic Surgery?"

45. ASPS/IQUAM Transatlantic Innovations Meeting, April 4-7, 2009 Miason de la Chimie, Paris, France, "Cost-Effectiveness of Physician Extenders in Plastic Surgery"

46. Midwestern Association of Plastic Surgeons, 47th Annual Meeting, April 18-19, 2009, Chicago, Il, "Microvascular Reconstruction of Iatrogenic Femoral Artery Injury in a Neonate"

47. Midwestern Association of Plastic Surgeons, 47th Annual Meeting, April 18-19, 2009, Chicago, Il,"Two Birds, One Stone: Combining Abdominoplasty with Intra-Abdominal Procedures"

48. The 11th Annual Chicago Trauma Symposium, August 1, 2009, Chicago, Il "Management of Complex Injuries"

49. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Omental Free Tissue Transfer for Coverage of Complex Extremity Defects: The Forgotten Flap."

50. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Challenging Cases."

51. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, "President's Panel: The Future of the Solo Practice-Can We, Should We Survive?"

52. The 12th Annual Chicago Trauma Symposium, August 5-8, 2010, Chicago, Il "Management of Complex Injuries"

53. Breast MRI to Define The Blood Supply to the Nipple-Areolar Complex. German Society of Plastic, Reconstructive and Aesthetic Surgery (DGPRAEC), Dresden, Germany, September 2010

54. Roundtable Discussion: Electronic Health Records-Implications for Plastic Surgeons, The American Society of Plastic Surgeons Annual Meeting, October 3, 2010, Toronto, CA

55. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, The American Society of Plastic Surgeons Annual Meeting, October 3, 2010, Toronto, CA.

56. ASPS/ASPSN Joint Patient Safety Panel: Patient Selection and Managing Patient Expectations, The American Society of Plastic Surgeons Annual Meeting, October 4, 2010, Toronto, CA

57. Lunch and Learn: Prevention of VTE in Plastic Surgery Patients, The American Society of Plastic Surgeons Annual Meeting, October 5, 2010, Toronto, CA

58. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, 16th Congress of The International Confederation for Plastic Reconstructive and Aesthetic Surgery, May 22-27, 2011, Vancouver, Canada

59. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland

60. Applications of the Omentum for Limb Salvage: The Largest Reported Series, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland

61. Successful Tongue Replantation Following Auto-Amputation Using Supermicrosurgical Technique, Poster Session, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland

62. The 13th Annual Chicago Trauma Symposium, August 25-28, 2011, Chicago, Il "Soft Tissue Defects-Getting Coverage"

63. WPATH: Pre-conference Symposium, September 24, 2011, Atlanta, GA "Surgical Options and Decision-Making"

64. American Society of Plastic Surgeons Annual Meeting, September 27, 2011, Denver, CO Closing Session Lunch and Learn: Pathways to Prevention-Avoiding Adverse Events, Part I: Patient Selection and Preventing Adverse Events in the Ambulatory Surgical Setting

65. American Society of Plastic Surgeons Annual Meeting, September 27, 2011, Denver, CO Closing Session Lunch and Learn: Pathways to Prevention-Avoiding Adverse Events, Part III: Preventing VTE

66. XXIV Congresso Nazionale della Societa Italiana di Microchirugia 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 Microchirugia 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, Tansgender 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 Developlment 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

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. Mulitspecialty Course for Operating Room Personnel-Craniomaxillofacial, Orthopaedics, and Spine, A Team Approach, AO North American, June 26-27, 2010, The Westin Lombard Yorktown Center.

9. Management of Emergency Cases in the Operating Room, The American Society of Plastic Surgeons Annual Meeting, October 4, 2010, Toronto, CA.

10. Surgical Approaches and Techniques in Craniomaxillofacial Trauma, November 6, 2010, Burr Ridge, Il.

11. The Business of Reconstructive Microsurgery: Maximizing Economic value (Chair)The American Society for Reconstructive Microsurgery, January 14-17, 2012, Las Vegas, Nevada.

12. Strategies to Identify and Prevent Errors and Near Misses in Your Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 25th-30th, 2012, New Orleans, LA

13. Strategies to Identify and Prevent Errors and Near Misses in Your Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 11th-15th, 2013, San Diego, CA

14. Mythbusters: Microsurgical Breast Reconstruction in Private Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 11th-15th, 2013, San Diego, CA

15. Minimizing Complications in Perioperative Care, The American Society for Reconstructive Microsurgery, January 11-14, 2014, Kauai, Hawaii

16. Genitourinary and Perineal Reconstruction, The American Society for Reconstructive Microsurgery, January 11-14, 2014, Kauai, Hawaii

17. Transgender Breast Surgery, The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA

18. Gender Confirmation Surgery, The School of the Art Institute (recipient of American College Health Fund's Gallagher Koster Innovative Practices in College Health Award), October 27, 2015, Chicago, Il

19. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, Il Overview of Surgical Treatment Options

20. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015 Chicago, Il Surgical Procedures

21. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, Il Surgical Complications

22. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, Il Post-operative Care

23. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, Il Case Discussions: The Multidisciplinary Team

24. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, January 20-23,2016, Atlanta, GA Overview of Surgical Treatment Options

25. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, January 20-23, 2016, Atlanta, GA Surgical Treatment Options

26. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, March 30-April 1, 2016, Springfield, MO, Surgical Treatment Options.

27. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, March 30-April 1, 2016, Springfield, MO, Multi-disciplinary Case Discussion.

28. Introduction to Transgender Surgery, ASPS Breast Surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016

29. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course, September 28, 2016, Ft. Lauderdale, FL.

30. Cirugias de Confirmacion de Sexo Paso a Paso, XXXV Congreso Confederacion Americana de Urologia (CAU), Panama City, Panama, October 4-8, 2016.

31. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course, December 3, 2016, Arlington, VA.

32. PSEN (sponsored by ASPS and endorsed by WPATH), Transgender 101 for Surgeons, January 2017-March 2017

33. Surgical Anatomy and Surgical Approaches to M-to-F Genital Gender Affirming Surgery and the Management of the Patient Before, During and After Surgery: A Human Cadaver Based Course, Orange County, CA, Feb. 1, 2017

34. Gender Confirmation Surgery, ALAPP, 2 Congreso Internacional de la Asociacion Latinoamericana de Piso Pelvico, Sao Paulo, Brasil, 9-11 de marzo de 2017

35. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course, Overview of Surgical Treatment, March 31-April 2, 2017, Minneapolis Minnesota.

36. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course, The Multi-Disciplinary Team Case Discussions, March 31-April 2, 2017, Minneapolis Minnesota.

37. Transfeminine Cadaver Course, WPATH, May 19-20, 2017, Chicago, Il

38. Transgender/Penile Reconstruction-Penile Reconstruction: Radial Forearm Flap Vs. Anterolateral Thigh Flap, Moderator and Presenter, The World Society for Reconstructive Microsurgery, June 14-17, 2017, Seoul, Korea

39. Primer of Transgender Breast Surgery, ASPS Breast Surgery and Body Contouring Symposium, San Diego, CA, August 10-12, 2017

40. Confirmation Surgery in Gender Dysphoria: current state and future developments, International Continence Society, Florence, Italy, September 12-15, 2017

41. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, ASPS/WPATH Joint Session, Session Planner and Moderator

42.Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course: Overview of Surgical Treatment, Columbus, OH, October 20-21, 2017

43. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course: Medical Care in the Perioperative Period, Aftercare: Identifying Potential Complications, Columbus, OH, October 20-21, 2017

44. Webinar: Gender Affirming Surgeries 101: Explore The Latest Topics in Gender Affirmation Surgery, PSEN, April 18, 2018

45. Course Director: MT. Sinai/WPATH Live Surgery Training Course for Gender Affirmation Procedures, April 26-28, 2018, New York, NY

46. Philadelphia Trans Wellness Conference, Perioperative Care of the Transgender Woman Undergoing Vaginoplasty (Workshop), Philadelphia, PA, August 3, 2018

47. Philadelphia Trans Wellness Conference, Gender Confirmation Surgery (Workshop), Philadelphia, PA, August 3, 2018

48. Gender Confirmation Surgery, 2018 Oral and Written Board Preparation Course, The American Society of Plastic Surgeons, August 16-18, 2018, Rosemont, Il

49. Confirmation Surgery in Gender Dysphoria: Current State and Future Developments, The International Continence Society, Philadelphia, PA August 28, 2018

50. WPATH Global Education Initiative, Foundations Training Course, "Overview of Surgical Treatment," Cincinnati, OH, September 14-15, 2018

51. WPATH Global Education Initiative, Foundations Training Course, "The Multi-Disciplinary Team: Case Discussions," Cincinnati, OH, September 14-15, 2018

52. WPATH Global Education Initiative, Advanced Training Course, "Medical Care in the Perioperative Period After Care: Identifying Potential Complications," Cincinnati, OH, September 14-15, 2018

53. 25th WPATH Symposium, Surgeons Conference, November 1, 2018, Buenos Aires, Argentina, Moderator

54. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Global Education Initiative (GEI): Surgery and Ethics

55. WPATH GEI: Best Practices in Medical and Mental Health Care, Foundations in Surgery, New Orleans, March 22, 2019

56. WPATH GEI: Best Practices in Medical and Mental Health Care, Advanced Surgery, New Orleans, March 22, 2019

57. Program Chair: ASPS/WPATH GEI Inaugural Gender-Affirming Breast, Chest, and Body Master Class, Miami, Fl, July 20, 2019

58. Overview of Surgical Management and The Standards of Care (WPATH, v. 7) ASPS/WPATH GEI Inaugural Gender-Affirming Breast, Chest, and Body Master Class, Miami, Fl, July 20, 2019

59. Program Director, Gender Affirming Breast,Chest, and Body Master Class, The American Society of Plastic Surgeons, Miami, Fl, July 20, 2019

60. Gender Confirmation Surgery, The American Society of Plastic Surgeons Oral and Written Board Preparation Course, August 15, 2019, Rosemont, Il

61. Upper Surgeries (chest surgery & breast augmentation), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC

62. Preparing for Upper Surgeries-Case Based (chest surgery & breast augmentation), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC

63. Preparing for Feminizing Lower Surgeries-Case Based (vaginoplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC

64. Lower Surgeries-Masculinizing (phalloplasty & metoidioplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC

65. Preparing for Masculinizing Lower Surgeries-Case Based (phalloplasty & metoidioplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC

66. Panel Discussion about Ethics in Surgery and Interdisciplinary Care, WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC

67. Discussion about Ethics and Tensions in Child and Adolescent Care, WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC

68. Transgender Health: Best Practices in Medical and Mental Health Care Foundation Training Courses, Hanoi, Viet Nam, Jan 14-17, 2020 (Foundations in Surgery, Advanced Medical-surgery and complicated case studies), Planning & Documentation (upper surgeries-chest surgery and breast augmentation, preparing for upper surgeries-case based (chest surgery and breast augmentation), lower surgeries (feminizing-vaginoplasty), preparing for feminizing lower surgeries-case based, lower surgeries-masculinizing (phalloplasty and metoidioplasty), preparing for masculinizing lower surgeries-case-based (phalloplasty and metoidioplasty), Ethics-panel discussion about ethics in surgery and interdisciplinary care)

69. WPATH GEI Panel Cases Discussion, via Webinar, May 29, 30, 31, 2020

70. WPATH GEI: Illinois Dept. of Corrections, Foundations in Surgery, November 20, 2020

71. WPATH GEI: Illinois Dept. of Corrections, Ethical Considerations in Transgender Healthcare, November 20, 2020

72. WPATH GEI: Illinois Dept. of Corrections, Foundations in Surgery, February 26, 2021

73. WPATH GEI: Illinois Dept. of Corrections, Ethical Considerations in Transgender Healthcare, February 26, 2021.

74. Current Concepts in Gender Affirming Surgery for Women in Transition, March 11-12, 2021 (online event), Moderator, Transgender Health.

75. GEI Foundations Course, Live Q&A, March 21, 2021

76. GEI Foundations Course, Live Case Panel Discussion, March 23, 2021

77. GEI Advanced Ethics Workshop; Surgical and Interdisciplinary care ethics panel, May 1, 2021 (virtual)

78. Wpath GEI Foundations course for the Illinois Dept of Corrections, Foundations in Surgery, May 21, 2021

79. Wpath GEI, Foundations course for the Illinois Dept of Corrections, Ethical considerations in Transgender Healthcare, May 21, 2021

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

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 hMSCsFirst Place, Rosalind Franklin University Summer Research Poster Session

11. J. Siwinski, MS II, Iris A. Seitz, MD PhD, Dana Rioux Forker, MD, Lucio A. Pavone, MD, Loren S Schechter, MD FACS. Upper and Lower Limb Salvage With Omental Free Flaps: A Long-Term Functional Outcome Analysis. Annual Dr. Kenneth A. Suarez Research Day, Midwestern University, Downers Grove, IL, May 2014

12. Whitehead DM, Kocjancic E, Iacovelli V, Morgantini LA, **Schechter LS**. A Case Report: Penile Prosthesis With an Alloderm Wrap Positioned After Radial Forearm Phalloplasty. Poster session presented at: American Society for Reconstructive Microsurgery Annual Meeting, 2018 Jan 13-16; Phoenix, AZ.

13. Whitehead DM, Kocjancic E, Iacovelli V, Morgantini LA, **Schechter LS**. An Innovative Technique: Single Stage Urethral Reconstruction in Female-to-Male Patients. Poster session presented at: American Society for Reconstructive Microsurgery Annual Meeting, 2018 Jan 13-16; Phoenix, AZ.

14. Whitehead, DM Inflatable Penile Prosthesis Implantation Post Phalloplasty: Surgical Technique, Challenges, and Outcomes, MAPS 2018 Annual Scientific Meeting, April 14, 2018, Chicago, Il

15. Whitehead, DM, Inverted Penile Skin With Scrotal Graft And Omission of Sacrospinal Fixation: Our Novel Vaginoplasty Technique MAPS 2018 Annual Scientific Meeting, April 14, 2018, Chicago, Il

16. S. Marecik, J. Singh. **L. Schechter**, M. Abdulhai, K. Kochar, J. Park, Robotic Repair of a Recto-Neovaginal Fistula in a Transgender Patient Utilizing Intestinal Vaginoplasty, The American College of Surgeons Clinical Congress 2020, October 7, 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

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 Vaccuum Assisted Closure Device in Plastic Surgery, Indianopolis, 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 Successs: 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 Surgey: 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," Brazlian 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' Affaris, 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 Feminiztion 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. Demystifing 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

Exhibit B

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

AUGUST DEKKER, et al., *Plaintiffs*, v. JASON WEIDA, et al., *Defendants*.	Case No. 4:22-cv-00325-RH-MAF

EXPERT REBUTTAL REPORT OF DAN H. KARASIC, M.D.

I, Dan H. Karasic, M.D., hereby state as follows:

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

2. I am over the age of 18.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

4. I previously submitted an expert witness report in this case ("Karasic Report"). I submit this report to respond to points raised in the reports of Defendants' designated experts: Michael Biggs, Ph.D.; G. Kevin Donovan, M.D.; Paul W. Hruz, M.D.; Kristopher Kaliebe, M.D.; Michael K. Laidlaw, M.D.; Patrick Lappert, M.D.; Stephen B. Levine, M.D.; Sophie Scott, Ph.D.; and Joseph Zanga, M.D.

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5. My background, qualifications, and compensation for my services in this case, and the bases for my opinions in this case are described in my original report.

6. In preparing this report, I was provided with and reviewed the reports from defendants' designated experts described above and the accompanying exhibits, as well as the expert reports of Dr. Armand Antommaria, Dr. Kellan Baker, Dr. Johanna Olson-Kennedy, Dr. Loren Schechter, and Dr. Daniel Shumer, submitted by plaintiffs.

7. In preparing this rebuttal report, I have relied on my training and years of research and clinical experience, as set out in my curriculum vitae (attached as **Exhibit A** to my original report) and on the materials listed therein; the materials listed in the bibliography attached as **Exhibit B** to my original report; and the additional materials listed in the supplemental bibliography attached as **Exhibit C** to 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.

8. I also reviewed medical records pertaining to the plaintiffs, as provided by counsel.

9. 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.

EXPERT OPINIONS

10. The critiques below apply to more than one expert. The experts for the defense are outside the mainstream of transgender health. Instead, they are better known for their political efforts to deny care to transgender people, rather than for providing care for or clinical research regarding transgender people. Their views are outside the mainstream of experts in transgender health and mainstream medical organizations.

A. Dr. Levine's Report

11. Stephen Levine, MD, was an editor of Standards of Care 5 ("SOC 5") of the Harry Benjamin Gender Dysphoria Association (the precursor to WPATH), which were released in 1998. After widespread criticism of the SOC 5, it was replaced by the SOC 6 in just three years. By contrast, the SOC 6 (published in 2001)

and SOC 7 (published in 2012) were each in use for approximately 10 years. Dr. Levine was critical of the changes in transgender care in 1998, and has been a critic of modern transgender care since. His involvement in transgender health in recent years has centered on the denial of care to transgender people through his role providing testimony with respect to prison systems.

12. Dr. Levine quotes the Endocrine Society repeatedly in his discussion of "biological sex." (Levine Report, para. 19-27). However, he omits that the Endocrine Society states, "the terms biological sex and biological male and female are imprecise and should be avoided." (Hembree, et al. 2017).

13. Dr. Levine states, "Contrary to assertions and hopes that medicine and society can fulfill the aspiration of the trans individual to become 'a complete man' or 'a complete woman,' this is not biologically attainable," because will nevertheless be unable to reproduce (Levine Report, para. 27). For one, transgender individuals may find other ways to build families, as do other individuals who need medical assistance with reproduction or choose to adopt. Reproductive capacity is not what makes a person a man or a woman, and we do not describe others as less of a man or woman for needing assistance with family building or choosing not to raise children. For another, the goal of health practitioners in this field is not to facilitate "trans individual to become 'a complete man' or 'a complete woman'," the goal of

practitioners in this field is to treat the clinically significant distress of Gender Dysphoria and to improve the quality of life of those living with gender dysphoria.

14. In paragraph 29 of his report, Dr. Levine uses his prior writing as the reference for the assertion that "There are at least five distinct pathways to gender dysphoria…." What he describes is that the patient with Gender Dysphoria may present to clinicians at different times of life, not that these are "five distinct pathways to gender dysphoria," or even that there are "distinct pathways."

15. Dr. Levine discusses pre-pubertal desistance and social transition. Dr. Levine's criticism is based on studies relying on the now obsolete and overly broad categorizations contained in the DSM III-R and DSM IV for "Gender Identity Disorder in Children." None of the studies cited by Dr. Levine use the current DSM-5 gender dysphoria diagnosis. As noted above, a child could meet criteria for the DSM III-R or DSM-IV diagnosis of gender identity disorder without identifying as transgender because the diagnostic criteria did not require identification with a gender other than the one assigned to the person at birth. This problem with the diagnosis was remedied with the new DSM-5 diagnosis of "Gender Dysphoria in Children," which requires a child to have "a strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)." It is therefore not surprising that children discussed

in the studies cited by Dr. Levine did not identify as transgender at follow-up as these children did not necessarily identify as transgender to begin with.

16. Moreover, the cohorts from UCLA and Toronto in those studies were all or largely *prepubertal* boys who engaged in feminine behavior, leading their parents in the 1960's, 1970's and 1980's to bring them to clinical attention before they came out as gay or bisexual. The one large modern American study of pre-pubertal children who were using a pronoun other than one that aligned with their sex assigned at birth, found that only 2.5% of them later identified as cisgender (Olson, et al., 2022). Clearly these are different populations of gender diverse children with different trajectories. There is no evidence that a psychotherapeutic intervention changes gender identity.

17. Dr. Levine states "engaging in social transition starts a juvenile on a "conveyor belt" path that almost inevitably leads to the administration of puberty blockers, which in turn almost inevitably leads to the administration of cross-sex hormones." (Levine Report, at ¶130). A recently published study, which Dr. Levine fails to cite, has found this not to be true. The study authors found that gender identification did not meaningfully differ before and after social transition. (Rae, et al., 2019).

18. What is more, this case involves is about the coverage of medical care, and no medical care is provided to youth before the onset of puberty. Indeed, there is broad consensus that once youth reach the earliest stages of puberty (i.e., Tanner 2) and identify as transgender, desistance is rare. The notion of desistance therefore is not generally applied to transgender people once they reach the Tanner 2 stage of puberty. Even the researchers who published the dataset about desistance that Dr. Levine cites are clear that once a child reaches puberty, it is not medically appropriate to withhold affirming treatment.

19. Moreover, social transition is not a medical intervention, involving instead hair length, clothes, and in some cases using another name and pronouns. And while there may be differing views on social transition before puberty, even the practitioner cited by Dr. Levine, Dr. Anderson (Levine Report, at ¶¶ 74, 83), is a strong supporter of medical interventions after onset of puberty, when indicated, and has referred our mutual patients for such care.

20. There are also many possible reasons for the increase in the number of transgender youth counted in surveys and the change in the ratio of those assigned female at birth to those assigned male at birth, to which Dr. Levine alludes to. Transmasculine youth (assigned female at birth) have long received care where it was available and were a majority of my patients at Dimensions Clinic for trans

youth, which provided services without regard to insurance status, since my work began there in 2003. Insurance coverage for transgender care and the availability of clinics for trans youth nationwide were uncommon until a decade later in much of the United States. When the old Gender Identity Disorder diagnosis was an exclusion for reimbursement, the diagnosis was rarely submitted to insurance. Therefore, when measured by clinic enrollment or by insurance reimbursement by diagnosis, the numbers of trans youth counted was low until about 10 years ago, when insurance reimbursement allowed for the counting by diagnosis.

21. Population-based surveys only started counting transgender identity with Conron, 2012, based on data from BRFSS health surveys from 2007-2009. The share of the population identifying as transgender on the BRFSS has not changed dramatically since then, with similar numbers of each gender, though the number of estimated transgender youth increased with use of another survey, the YRBS, which surveyed large urban school districts. (Herman, et al., 2022).

22. Compared with those counted on surveys as having a transgender identity, much smaller numbers get a Gender Dysphoria diagnosis or receive gender-affirming medical care.

23. These statistics show that only a minority of those identifying as transgender get clinical care to get a Gender Dysphoria diagnosis, and only a small

share of these receive gender affirming medical or surgical treatment. These numbers reflect the careful process of assessment and medical care provision. There must be at least a 6-month duration of symptoms that are strong enough to cause clinically significant distress or social or occupational impairment to receive the Gender Dysphoria diagnosis. To receive gender-affirming care, the patient, their parents, and their medical and mental health care team must agree that this is the best course for treating gender dysphoria. There is no other treatment of Gender Dysphoria with any evidence of efficacy for these patients, as Dr. Levine admits.

24. Dr. Levine discusses providing psychotherapy for co-occurring mental health conditions, but states, "To my knowledge, there is no evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescence, and men, or return to female identification for genetically female girls, adolescents, and women."

25. Dr. Levine further states, "I don't know what proportion of practitioners are using which model," before stating that practitioners are practicing in ways that "disregard principles of child development and family development." WPATH SOC 8 requires that practitioners have knowledge of child development and family development and approach the child in a way that "does not favor any identity." (Coleman, et al., 2022).

26. In paragraph 72 of his report, Dr. Levine states that "In 2010 the WPATH Board of Directors issued a statement advocating that incongruence between sex and felt gender identity should cease to be identified in the DSM as a pathology. This position was debated but not adopted by the (much larger) American Psychiatric Association." This is patently false. In fact, I was a member of WPATH's committee advising the American Psychiatric Association on diagnostic revision for DSM-5 (after editing a book on the subject). WPATH stated that transgender identity should not be pathology but that the diagnosis should focus on the distress of gender dysphoria and be named Gender Dysphoria. The American Psychiatric Association agreed with WPATH and replaced the Gender Identity Disorder diagnosis with Gender Dysphoria. Indeed, the American Psychiatric Association's own "Guide for Working With Transgender and Gender Nonconforming Patients" states that "[w]ith the publication of DSM–5 in 2013, 'gender identity disorder' was eliminated and replaced with 'gender dysphoria.' This change further focused the diagnosis on the gender identity-related distress that some transgender people experience (and for which they may seek psychiatric, medical, and surgical treatments) rather than on transgender individuals or identities themselves." (Yarbrough, et al., 2017). It goes on to state that "[t]he presence of gender variance is not the pathology but dysphoria is from the distress caused by the

body and mind not aligning and/or societal marginalization of gender-variant people." *Id.*

27. Dr. Levine states without basis that WPATH members and mental health professionals working with transgender people are not qualified to do so. I have been practicing in this field for over 30 years and have provided training and instruction to thousands of healthcare providers across the United States, including in Florida as well as psychiatrists and other mental health providers at UCSF and elsewhere. It has not been my experience that practitioners in this field are unqualified. To the contrary, they are highly specialized professionals living up to their calling of providing the best care possible for their patients.

28. Regarding Dr. Levine and others use of Dhejne et al., 2011 for the proposition that gender-affirming is not effective (*e.g.*, Levine Report, at ¶150), Dr. Dhejne has specifically cited Dr. Levine as someone who misinterprets her study. "The findings have been used to argue that gender-affirming treatment should be stopped since it could be dangerous (Levine, 2016) … Despite the paper clearly stating that the study was not designed to evaluate whether or not gender-affirming is beneficial, it has been interpreted as such." (Dhejne, 2017).

29. Mainstream medicine, transgender health advocates, and Dr. Levine all agree on the centrality of informed consent in the provision of healthcare. Dr.

Levine's version of informed consent includes his confirmation bias on the futility of care for transgender people. Informed consent should encapsulate the risks and benefits of the given treatment as best known through the perspective of scientific evidence and modern health practice.

30. There are limits on the capacity of children to consent, which is why parents consent for healthcare, including for transgender youth.

B. Dr. Kaliebe's Report

31. Dr. Kaliebe states there is "no consensus in the field regarding the treatment of gender dysphoria." (Kaliebe Report, at ¶4(b)). In fact, there is an international consensus of leaders in providing and researching care for transgender people, which is published as the WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. The use of the WPATH Standards of Care is supported and/or adopted by, among others, the American Psychiatric Association, the American Psychological Association, the American Medical Association, the American Academy of Pediatrics, by the Federal Bureau of Prisons, and by many insurance companies, and health systems, as well as by Maximus, which administers independent medical reviews for insurance appeals in many states as well as federal appeals. The fact that there some dissenting views, which no matter how loud constitute a minority within the medical and scientific

community, does not mean that there is no broad consensus among the larger medical and scientific community about the propriety, safety, and effectiveness of gender-affirming medical care for the treatment of gender dysphoria.

32. Dr. Kaliebe asserts that gender dysphoria "has been rare until the last two decades." (Kaliebe Report, at ¶4(a)). This observation by Dr. Kaliebe illustrates his lack of experience and involvement in this field. Gender-affirming care dates back decades and the WPATH Standards of Care have been in existence since 1979. In fact, there is documentation of transgender youth and adults taking hormones for over 70 years. The UCLA Gender Identity Research Clinic met regularly starting in the early 1960's. During my psychiatry residency training at UCLA from 1987-1991, I was trained in transgender care by two experts who had worked with gender diverse and transgender youth and adults for decades—Drs. Robert Stoller and Richard Green. My training included watching films of transgender people being interviewed by Dr. Stoller in the 1950's and 1960's. Gender dysphoria was studied at gender centers in many United States academic centers in the 1960's and 1970's, before the 1981 federal decision at the start of the Reagan administration to ban federal support for such care, a decision that was only reversed in 2014 (Fritz and Mulkey, 2021). After the 1970's, American research efforts largely ended as funding was cut off, and research into treatment of gender dysphoria and outcomes of care

mostly took place in other countries that continued to fund gender-affirming care, such as the Netherlands, Belgium, and Sweden.

33. Care in the United States during these years largely was provided either in private offices or in public health clinics, without resources for research.

34. Despite the long cutoff of funding and consequent hiatus of research programs in the United States, there is some data from that earlier era of transgender care. A 40 year follow up of patients who received gender-affirming surgery at University of Virginia before its program was shut down was published recently, showing continuing positive effects and no regrets from gender affirming surgery among 15 participants that could be found 40 years later. (Park, et al., 2022).

35. With resumption of funding, robust research programs are ongoing in the United States, with longitudinal studies of pre-pubertal gender diverse youth by Kristina Olson, PhD and her colleagues at Princeton and University of Washington that have shown low rates of pre-pubertal desistance (Olson, et al., 2022), and a longitudinal multicenter NIH-funded study that has recently published improvement with gender affirming hormones in youth (Chen, et al., 2023).

36. Dr. Kaliebe states that none of his patients expressed gender dysphoria from 2005-2016. Meanwhile in San Francisco, from 2003-2020, I had a psychiatric clinic that only saw youth experiencing gender dysphoria. Does that mean that

transgender youth didn't exist in Florida and that all transgender youth were in San Francisco during those years? Of course not. An individual psychiatrist's practice does not reflect the broader population. Perhaps patients were not being asked about gender dysphoria or didn't feel comfortable disclosing gender dysphoria during these years, and particularly with Dr. Kaliebe. Transgender people don't disappear or don't exist simply because they don't receive care from a particular provider. And based on my work with practitioners in Florida and elsewhere, I know there were transgender patients in Florida who worked with other providers.

37. Take just two of my experiences related to transgender youth in Florida in the 2000s and 2010s:

a. Around the year 2000 I received a call from a man in Florida who said he had a transgender child for whom he was seeking care. He stated he was unable to find care in Florida. He stated he had the means to go anywhere to find a knowledgeable provider to work with his child. I referred him to a child and adolescent psychiatrist with expertise working with transgender youth in Atlanta.

b. In 2012, I attended the first UCSF Child and Adolescent Gender Clinic. There was a meeting with a family that had just moved from Florida to San Francisco because they were unable to find adequate healthcare and

an accepting school environment in Florida for their transgender adolescent.

38. Even if transgender youth were invisible to Dr. Kaliebe during that time, they existed and needed care.

39. Many parents who seek psychiatric care with me for their adolescents have stated that it was, in part, because their prior psychiatrist or mental health provider lacked knowledge to provide competent care. Not infrequently, the youth have told me that they had never discussed their gender dysphoria with prior mental health professionals because they didn't think they would be understood or they didn't feel safe doing so.

40. Dr. Kaliebe references a study by Kaltiala et al. in 2020 to state that "The Finnish experience shows that 'treating' the gender dysphoria with affirmative medications and surgeries does not resolve the patients' mental disorders." (Kaliebe Report, at ¶ 151). In fact, in the Kaltiala et al. study, of the 52 youth studied, 54% needed treatment for depression before initiation of gender-affirming hormones, versus 15% needing treatment for depression after initiation of gender-affirming hormones. In the study, 48% of the trans youth needed treatment for anxiety before starting hormones, versus 15% after starting hormones. And 35% of the trans youth

needed treatment for suicidality/self-harm before starting hormones, versus 4% after initiation of gender affirming hormones (Kaltiala, et al., 2020).

C. Dr. Lappert's Report

41. Dr. Lappert, who is a retired surgeon with no experience in transgender health care and who is not trained in nor a provider of mental health care, opines that because "WPATH v.8 speak[s] of the need to have these psychological disturbances 'well-controlled' prior to surgery," it must mean "self-harming or suicidal thoughts must be well controlled before one can proceed with surgery" and that therefore "the main reason for the consenting the [sic] child for surgery has been successfully treated medically, and the patient no longer requires the surgery." (Lappert Report, at ¶71). Not only is this wrong, but it also gets it backwards. First of all, surgery is not recommended for any child. Surgery is appropriate when medically indicated for adults and some older adolescents (typically for chest masculinization surgery). Second, SOC 8 does not say that mental health symptoms must be resolved before gender affirming care, rather that these must be assessed and risks/benefits weighed. Indeed, to make a Gender Dysphoria diagnosis prior to providing gender-affirming care, there must be clinically significant distress or social/occupational impairment lasting at least 6 months.

42. With regards eligibility for surgery, SOC 8 also recommends for adults that "[m]ental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits have been discussed," and for adolescents that "Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally." (Coleman, et al., 2022). But that refers to *other* conditions that *may interfere* with diagnosis, capacity to understand the risks and benefits, or the medical treatments. It takes intentional misrepresentation and leaps of logic to argue that SOC 8 recommends that the condition for which the surgery may be medically indicated must be resolved in order to obtain the surgery.

43. Dr. Lappert asserts that "[t]he fact that gender affirmation physicians and surgeons cite the DSM as a source document for diagnostic criteria is further proof that the condition exists in the subjective life of the patient." (Lappert Report, at ¶ 75). But just because a diagnosis is in the DSM doesn't mean it is "subjective" only. A mental health professional makes a diagnosis. Psychiatrists and psychologists have many years of training to make diagnoses, which are made primarily by the clinical interview with the patient. This process is similar to that of

diagnosing other DSM diagnoses, to determine treatment for other disorders. The process of taking a history of symptoms from a patient is not only used to determine most psychiatric treatment, but also many medical and pediatric treatments. It is surprising to hear any medical professional dismiss the importance of taking a good history from a patient. Even medical disorders that rely on blood tests and imaging for a definitive diagnosis rely first on taking a history to know which tests to order. And treatment of many DSM diagnoses is considered medically necessary and covered by Medicaid.

44. Dr. Lappert states that selection for surgery "begins in psychology continues with psychological support, and concludes with certification by psychological services that the patient is ready for surgical modification." (Lappert Report, at ¶ 76). Again, this is false. In fact, the patient is receiving in most cases ongoing medical care, with history taking and physical exam by both the primary care provider or endocrinologist, as well as the surgeon. An outcome measure used in gender affirming surgery and other surgeries is quality of life. As with other surgeries, medical providers are involved before surgery, in the perioperative period, and in aftercare. (Karasic and Fraser, 2018).

45. Lappert mistakenly cites the Dhejne et al. study published in 2011 to say "that long term longitudinal population studies show that there is a dramatic rise

in post-surgical in post-surgical problems such as depression, hospitalization, substance abuse, and suicide beginning around year 7 post surgery." (Lappert Report, at ¶ 86). But the Dhejne et al. study explicitly states that the study cannot be used to make any conclusions about the outcome of surgery. (Dhejne, et al., 2011). And since 2011, Dr. Dhejne has repeatedly stated that interpretations like the above are incorrect. Dr. Dhejne compared morbidity and mortality statistics from a national database of transgender people with those in the general Swedish population, and only made comparisons between these groups, not before and after surgery, or transgender people with surgery and without surgery, or "year 7" with prior years. (e.g., Dhejne, 2017).

46. Dr. Lappert opines at length about the "experimental nature" of gender-affirming care, in particularly surgery. However, as explained in my original report and in the reports of Plaintiffs' other experts, there is ample documentation of the safety and efficacy of gender-affirming care, going back decades, which includes a 40 year follow of patients who received gender-affirming care showing continuing benefit. (*See* Karasic Report, at ¶¶ 55-59).

47. Dr. Lappert makes reference to "watchful waiting" as a model of care. (Lappert Report, at ¶ 94). Note that the debate over desistance in pre-pubertal children and of watchful waiting versus affirming approaches is for the period of life

before medical and surgical interventions are warranted. "Watchful waiting" was coined by the same Dutch researchers who pioneered the use of puberty blockers once the same children reached puberty, and found that puberty blockers, hormones, and later surgery successfully treated gender dysphoria in the same youth once they were of developmental stage for puberty blockers. (Ehrensaft, 2017). The result was that mental health outcomes significantly improved in the youth who received transition care in the study. (de Vries, et al., 2014). Other studies have also shown improvement in mental health measures in trans youth with gender-affirming medical treatment. (*e.g.*, van der Miesen, et al., 2020; Kuper, et al., 2020). It is important to emphasize that in the Dutch research, the youth who were going to desist from the gender identity disorder diagnosis were not treated with medications and surgery, and desistance occurred before puberty. The youth whose gender dysphoria persisted to puberty, and who were therefore treated, did not have a reversion to the gender identity congruent with sex assigned at birth, nor did any research participants who transitioned experience regret at doing so. Furthermore, "watchful waiting" is not a psychotherapeutic approach. In fact, no psychotherapeutic intervention has been demonstrated effective to change gender identity, and mainstream health organization call conversion therapy unethical. (*See* Karasic Report, at ¶¶ 23, 30, 37).

48. Dr. Lappert claims a "5000% increase" in the "diagnosis of transgender" in the past decade. Transgender is an identity, and only started being asked in the general population in studies published in the last 11 years. There is a great difference between the percentages of people responding to a question of identity with the number of people receiving a diagnosis or care for Gender Dysphoria— less than 1 in 1000 people are diagnosed with Gender Dysphoria.

D. Dr. Hruz's Report

49. Dr. Hruz is not a psychiatrist or psychologist and his use of the DSM in his ordinary work as a pediatrician is therefore limited.

50. Dr. Hruz says that "[t]he reliability and validity of various usages of the term 'gender' is controversial and not accepted by the relevant scientific community." (Hruz Report, at ¶ 19). The term "gender identity" is credited to Dr. Robert Stoller, a professor of psychiatry at UCLA. Dr. Stoller started the Gender Identity Research Clinic in 1963. The use of the term has been well established in the intervening years since 1963. It is used in research and medicine, and by every major medical organization in the United States.

51. Dr. Hruz opines that "[t]here are no long-term, peer-reviewed published, reliable and valid research studies documenting the reliability and validity of assessing gender identity by relying solely upon the expressed desires of a

patient." (Hruz Report, at ¶ 127). There are multiple fallacies contained within Dr. Hruz's statement. First, the validity and reliability of each diagnosis in DSM-5 were field tested prior to inclusion.

52. Dr. Hruz opines that providers are "not permitted to openly ask questions, properly investigate alternative diagnoses, or explore alternative hypotheses for the symptoms of gender dysphoric patients" and "are instead compelled (sometimes under fear of employment termination or legal attacks) to adopt a patient's self-diagnosis and only support 'affirming' medical interventions." (Hruz Report, at ¶ 90). Dr. Hruz provides no support for this opinion other than citing to two documents that speak to how the discredited and unethical practice of "conversion" or "reparative" therapy is harmful and ineffective. What is more, this opinion is directly contrary to WPATH's SOC 8 which for adults sets forth as a criteria for treatment that "other possible causes of apparent gender incongruence have been identified and excluded" and for adolescents sets forth as criteria that a "comprehensive biopsychosocial assessment including relevant mental health and medical professionals" and that "[m]ental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally." (Coleman, et al., 2022).

53. What is more, Gender Dysphoria is not a "self-diagnosis"; the Gender Dysphoria diagnosis is made by mental health professionals and SOC 8 sets forth the criteria necessary to be qualified to make and for making that diagnosis. The diagnosis of Gender Dysphoria under the DSM-5 is made the same way as other DSM diagnoses, through an interview in which the health professional determines if DSM-5 diagnostic criteria are met. Mental health professionals are well-trained to conduct such interviews. The validity and reliability of DSM-5 diagnoses were assessed and determined in the process of creating the DSM-5. Clinicians do not simply defer to the reported experiences of the patient, but instead rely on the application of professional experience and expertise to assess whether the patient meets the relevant diagnostic criteria.

E. Dr. Zanga's Report

54. Dr. Zanga appears to have no experience in transgender health or working with patients with gender dysphoria, let alone in the assessment, diagnosis, and treatment of this condition.

55. Dr. Zanga states that "the brains of children are incapable of making long term, life changing decisions until their early to mid-20s." (Zanga Report, at ¶ 18(c)). However, this case concerns coverage of medical care as treatment for gender dysphoria. People at the age of 18 are legally adults, and are presumed to be

able to consent for all other medical care. Before the age of 18, parents consent for health care. The parents of adolescent youth are older than their mid-20's, and therefore, even by Zanga's standard are capable to giving consent. WPATH SOC 8 does recommend healthcare professionals working with transgender youth assess the ability of minors to assent to the healthcare for which their parents consent. (Coleman, et al., 2022).

56. Dr. Zanga states that it is "puzzling" that we provide medically necessary care to a transgender adolescent "when a youth, incapable of making such a decision, requests to transition to the opposite sex" and notes "[t]his is especially concerning when good studies have shown that the desire to do this disappears in most (80-90%) after passing through puberty or by late adolescence." (Zanga Report, at ¶ 18(f)). To be clear, gender-affirming care is not provided simply because someone requests it, it is recommended and provided by health professionals when such care is medically indicated. Moreover, though numbers vary by study, desistance is a pre-pubertal phenomenon. Older longitudinal studies included gender nonconforming children who were not transgender due to the broad criteria for the since-abandoned "gender identity disorder in children" diagnosis, and the one large modern American longitudinal study showed very low desistance rates. (Karasic Report, at ¶¶ 87-88, *citing* DeVries, et al., 2011; van der Loos, et al., 2022).

Moreover, because no medical treatment, let alone irreversible medical and surgical interventions, is used prior to puberty, the persistence and desistance statistics of pre-pubertal children do not inform the decision whether or not to initiate these treatments.

F. Dr. Donovan's Report

57. In his report, in reference to me, Dr. Donovan states "pathways upon which he has set patients for 'gender affirming care' should have included protocols for the 'detransitioning.'" (Donovan Report, at ¶ 27).

58. Dr. Donovan appears to not have read WPATH SOC 8, which explicitly "recommend[s] health care professionals assessing adults who wish to detransition and seek gender-related hormone intervention, surgical intervention, or both, utilize a comprehensive multidisciplinary assessment that will include additional viewpoints from experienced health care professional in transgender health and that considers, together with the individual, the role of social transition as part of the assessment process" and explicitly discusses detransition. (Coleman, et al., 2022).

59. In addition to WPATH SOC 8, WPATH has provided education on working with detransitioners, including a session I helped organized at USPATH in 2017 and trainings by WPATH's Global Education Initiative. As clinicians, we did not anticipate drafting protocols for forced detransition because the state of Florida

has stopped paying for care. However, WPATH SOC 8 warns against the involuntary cessation of hormones, e.g., in hospitals and other institutional settings. (Coleman, et al 2022).

G. Dr. Scott's Report

60. Dr. Sophie Scott, who has no experience in transgender health care, discusses whether adolescents, based on their brain development, can consent to gender affirming care. But Dr. Scott ignores that in Florida, it is the parents of the adolescent who consent for gender-affirming care, and the parents' brains are presumable fully mature to make this decision.

61. **The following section of this rebuttal report (Section H – Dr. Laidlaw's Report) is designated as CONFIDENTIAL pursuant to the Protective Order in this matter (ECF No. 77).**

H. Dr. Laidlaw's Report

62. Dr. Laidlaw is an adult endocrinologist, which no experience or specialized training as a mental health provider, no apparent experience experiences working with pediatric patients, and no apparent experience providing or researching medical treatment for gender dysphoria. Notwithstanding his lack of experience and that he has not met any of the plaintiffs, Dr. Laidlaw opines at length about the course of treatment for the plaintiffs, including their mental health.

Dr. Laidlaiw's misrepresentations as to KF

63. Dr. Laidlaw writes that KF did not see a qualified mental health professional before treatment for Gender Dysphoria. In fact, the endocrinology clinical notes state that the "initial GEMS-Y visit" was by a psychologist, Dr. Williams. In addition, a GI note from 4/27/20, when the patient was 10 years old, stated that KF has been seeing a psychotherapist "Jessica" for "a few months now" and was in ongoing treatment with a psychiatrist, who was prescribing buspirone for anxiety.

64. The website of the Gender Multispecialty Service (GeMS) at Boston Children's Hospital states, "We take a team approach to gender-affirmative care, partnering with experts from many different specialties…." (GeMs website). GeMS structured its program after the pioneering Dutch clinic, with a strong mental health

assessment component, as well as endocrinology (Edwards-Leeper & Spack, 2012). Dr. Laidlaw suggests that KF's providers did not have the proper qualifications to provide care, but in fact, they are considered experts in care by this pioneering Harvard-affiliated clinic. Dr. Laidlaw takes issue with the fact that some of KF's care was provided by a nurse practitioner, but she was providing care as part of a team led by a Harvard pediatric endocrinologist. There is documentation that the risks and benefits of pubertal suppression were discussed with KF's parents when consent from them was obtained.

65. Dr. Laidlaw states of KF's subsequent provider, Kevin Ray Lewis, DNP, "…there is no evidence that Kevin Ray Lewis holds a doctoral degree of any kind." In fact, the Johns Hopkins All Children's website states that Dr. Lewis holds a Doctorate in Nursing Practice, from West Virginia University. Dr. Lewis provides care in pediatric endocrinology for transgender youth as well as children with diabetes. (Johns Hopkins website).

66. Dr. Laidlaw states, "As to informed consent for puberty blockers, there is no evidence from the medical records indicating signed documentation or a discussion regarding benefits, adverse effects or alternatives…" In fact, on an endocrinology visit of 6/22/18, there was substantial discussion with KF and his mother of the risks and benefits of puberty blockers, including a discussion of the

effects of blocking puberty, as well as potential risks with bone density and fertility, and the need for hormonal studies, metabolic studies, DEXA scans and bone age studies. On 6/26/20, there is documentation that informed consent was obtained for puberty blockers from KF's parents, with a detailed description of the treatment offered and of possible side effects of treatment, including possible risks to bone health and fertility. Signatures were not obtained at the June 2020 due to COVID protocols at the time, necessitating a remote visit. Risks and benefits were again discussed by Michael Kurtz, MD, a pediatric urologist, before insertion of Supprelin. Dr. Kurtz states that KF is aware of "all options," and there is documentation of a fertility discussion.

67. Dr. Laidlaw states that if KF takes "testosterone, the is a high probability that KF with have permanent abnormal sexual function." If fact, many trans men and trans women have good sexual functioning after transitioning. (Garcia, et al., 2014; Jerome, et al., 2022).

68. Dr. Laidlaw suggests without foundation that KF's co-occurring ADHD and anxiety are caused or worsened by social transition, puberty blockers, and hormones, and that testosterone "would be dangerous to start in this patient." (Laidlaw Report, at ¶ 249). There is substantial evidence, discussed in my original report, that many youth benefit from gender-affirming care (Karasic Report, at ¶¶

54-56), and no evidence that KF's co-occurring psychiatric conditions were caused by or exacerbated by transition or gender-affirming care.

Dr. Laidlaiw's misrepresentations as to Brit Rothstein (BR)

69. Dr. Laidlaw states that BR is on "high dose testosterone," but notes show a dose of 100mg/month, a low dose as demonstrated by a testosterone level of 233 ng/dL, which is at the low end of the testosterone range for those assigned male at birth.

70. Dr. Laidlaw misleadingly cites a review of psychiatric side effects of anabolic steroid abuse in cisgender men (Hall, et al., 2005) to make the claim that testosterone use is dangerous to mental health. In Pope et al. 2000, which was one study cited in the Hall, 2005 paper, even 600mg/week of testosterone usually didn't cause psychiatric symptoms. This dose is over 20 times BR's dose of 100mg/month. (Pope, et al., 2000).

71. When used at proper doses in transgender males, testosterone is safe and well-tolerated, usually without clinically significant mental health complications. A prospective study showed improved psychological functioning on multiple domains on initiation of testosterone in transgender males. (Keo-Meier, et al., 2015).

Dr. Laidlaiw's misrepresentations as to Susan Doe (SD)

72. Dr. Laidlaw mistakenly suggests that the psychiatric history that SD has ADHD and experiences anxiety at times somehow disqualifies her from receiving gender-affirming care. Co-occurring mental health conditions are to be addressed but, in most cases, do not disqualify a patient from care. (Coleman, et al., 2022). I provide care for many transgender youth with co-occurring mental health conditions who benefit from gender-affirming care as well as treatment of ADHD, anxiety, and other mental health conditions.

Dr. Laidlaiw's misrepresentations as to August Dekker (AD)

73. Dr. Laidlaw discusses at length the licensure status of Abbie Aldridge, LMHC, but also states that AD had a letter written by AD's psychiatrist, Troy Paulus, MD. WPATH and most insurance only require one letter for chest surgery, yet AD had two.

74. Dr. Laidlaw states: "Dr. Paulus follows the advice of advocacy group WPATH. '[AD] has met the WPATH SOC v7 criteria for double mastectomy surgery. This procedure has been deemed medically necessary by WPATH.'" The reason this statement is used in the letter is not because Dr. Paulus is following the advice of an advocacy group. Medical necessity of care must use "accepted standards of medicine." Insurance companies require the wording used by Dr.

Paulus, because insurance companies use meeting WPATH Standards of Care criteria for the specific intervention as documentation of the generally accepted standards of medicine.

75. Dr. Laidlaw states that AD is receiving "high-dose" testosterone, when AD is receiving testosterone cypionate 0.5mg/week. Again, Dr. Laidlaw misleadingly cites a Hall, 2005 review of studies of cisgender body builders takes several times that dose, and having elevated rates of mood symptoms as a result. There is no evidence that trans men taking dosages of testosterone to achieve testosterone levels that are within the normal range for men are comparable to those who abuse very high dosages of steroids, and there no reason except to mislead to repeatedly use of this reference to wrongfully suggest that the much lower dosages of testosterone used by trans men are dangerous.

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

Executed this 9th day of March 2023.

Dan H. Karasic, M.D.

Exhibit C

Supplemental Bibliography

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