

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

KANAUTICA ZAYRE-BROWN,

*Plaintiff,*

v.

THE NORTH CAROLINA  
DEPARTMENT OF PUBLIC SAFETY,  
*et al.,*

*Defendants.*

No. 3:22-cv-00191-MOC-DCK

**PLAINTIFF'S RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION  
FOR A RULE 35 EXAMINATION**

Defendants have had total control over Kanautica Zayre-Brown's medical care for more than five years. They have had Mrs. Zayre-Brown evaluated multiple times, by providers of their choosing, for her gender dysphoria. The providers who evaluated her specifically for gender-affirming surgery agreed that surgery is medically necessary. But Defendants denied that treatment, giving no rationale specific to Mrs. Zayre-Brown's circumstances. This lawsuit followed.

Now, still searching for a justification for their decision, Defendants wish to subject Mrs. Zayre-Brown to more than ten hours of invasive questions and tests by two examiners over three days. The proposed examiners appear to have never evaluated anyone for gender-affirming surgery, and they claim little experience treating gender dysphoria generally.

Defendants' burden on this motion is heavy. Given the immense privacy interests at stake, Rule 35 goes beyond the mere relevance standard of other discovery methods—it requires a showing of “good cause” and “discriminating application by the trial judge.” *Schlagenhauf v. Holder*, 379 U.S. 104, 118 (1964). For multiple reasons, Defendants' motion should be denied.

First, Defendants have not justified why less invasive discovery measures are inadequate given the voluminous information they already have concerning Mrs. Zayre-Brown's health. They have repeatedly had her examined over the last five years, have complete access to her medical records, and may seek to depose her providers and expert. Defendants have already deposed Mrs. Zayre-Brown and served written discovery. Thus, there is no need to “level the playing field” for Defendants. Courts within the Fourth Circuit and elsewhere have denied Rule 35 motions under similar circumstances. *See, e.g., Shumaker v. West*, 196 F.R.D. 454, 457 (S.D.W. Va. 2000).

Second, Defendants' proposed examiners are not qualified to examine Mrs. Zayre-Brown's need for gender-affirming surgery. Based on the affidavits they previously submitted in this case, it appears that Dr. Penn and Dr. Boyd have never evaluated any patient for that specialized treatment. Nor do they claim expertise with treating gender dysphoria more generally. And Dr. Penn has already endorsed Defendants' actions without examining Mrs. Zayre-Brown's specific medical needs. He should not be allowed to conduct an invasive examination of Mrs. Zayre-Brown if he considers her individual circumstances irrelevant.

Finally, Defendants must also show that Mrs. Zayre-Brown’s health is “in controversy.” But her diagnosis of gender dysphoria is not in controversy. This case is primarily about her individual need for a specific *treatment*. And discovery has confirmed that Defendants did not deny that treatment because of an individualized analysis, but because they believe it is never medically necessary for *anyone*. Further examination of Mrs. Zayre-Brown herself would have little if any relevance for defending a categorical ban on gender-affirming surgery for patients with gender dysphoria.

### **BACKGROUND**

Mrs. Zayre-Brown is a transgender woman—a woman who was assigned male at birth but has a female gender identity. Doc. 1 (Verified Complaint) ¶ 43. Before entering state custody in 2017, she was diagnosed with gender dysphoria. *Id.* ¶ 47. Gender dysphoria is a condition involving clinically significant distress and impairment that may result from the incongruence between one’s gender identity and one’s sex assigned at birth. *Id.* ¶ 34.

The medical community and many courts—including the Fourth Circuit—have recognized that, depending on an individual’s needs, gender dysphoria may require treatment such as psychotherapy, hormone therapy, and gender-affirming surgery. *Id.* ¶¶ 37-42; *De’lonta v. Johnson*, 708 F.3d 520, 525 (4th Cir. 2013); *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 595 (4th Cir. 2020), *cert. denied*, 141 S. Ct. 2878 (2021). Gender-affirming surgery is not “experimental or cosmetic,” but “an

accepted, effective, medically indicated treatment for” gender dysphoria. *De’lonta*, 708 F.3d at 523.

When Mrs. Zayre-Brown entered state custody in 2017, Defendants became entirely responsible for her medical care. Defendants confirmed her diagnosis of gender dysphoria and authorized various forms of treatment and living accommodations. *See, e.g.*, Doc. 1 ¶¶ 65-66, 68, 75. She was evaluated and treated by multiple providers for gender dysphoria, all of whom were employed by or engaged by Defendants. They included:

- Dr. Patricia Hahn, a psychologist employed by Defendants
- Dr. Joseph Umesi, a physician employed by Defendants
- MSW Jennifer Dula, a mental health care provider employed by Defendants
- Susan Garvey, a mental health care provider employed by Defendants
- Dr. Bradley Figler, a specialist in gender-affirming surgery at the UNC Transgender Health Program
- BSN Katherine Croft, a specialist at the UNC Transgender Health Program
- Dr. Donald Carraccio, an endocrinologist at UNC Health Care
- Dr. Karla Pou, an endocrinologist at UNC Health Care

*See id.* ¶¶ 65-66, 79-83, 87-89, 93, 97-98, 101-02, 122, 124-26, 129-31.

Mrs. Zayre-Brown repeatedly informed Defendants that her treatment was not alleviating her gender dysphoria. As contemplated by her providers before entering state custody, she requested gender-affirming genital surgery—specifically, a vaginoplasty or vulvoplasty. *See id.* ¶¶ 52, 103-12. Of the providers who specifically evaluated Mrs. Zayre-Brown for gender-affirming surgery, all agreed that it was medically necessary. *Id.* ¶¶ 93, 124-26, 130-31.

Nevertheless, Defendants repeatedly denied that treatment. They communicated their most recent denial on April 26, 2022, claiming that surgery was not medically necessary. *Id.* ¶ 139. They did not, however, provide any analysis specific to Mrs. Zayre-Brown's medical needs. Ex. A. She filed this case shortly thereafter, seeking injunctive relief and damages. Doc. 1 at 46.

Defendants moved to dismiss and Mrs. Zayre-Brown moved for a preliminary injunction. Docs. 9, 13. The Court denied both motions. Doc. 25. The parties have since engaged in discovery.

Discovery has produced thousands of pages of Mrs. Zayre-Brown's medical records dating back to 2017. Defendants have access to even more records from before her incarceration. *See* Doc. 1 ¶ 93. Defendants' counsel deposed Mrs. Zayre-Brown on January 18. *See* Doc. 34. The deposition covered a wide range of topics including her transgender status, history of gender dysphoria, symptoms, treatment, emotional and physical well-being, other medical history, education, work history, experience while incarcerated, and family background.<sup>1</sup> Defendants have served document requests which Mrs. Zayre-Brown has responded to, and they served interrogatories just before this response was filed. Mrs. Zayre-Brown has disclosed her expert report from Dr. Randi Ettner to Defendants.

Discovery has confirmed that Defendants did not deny Mrs. Zayre-Brown surgery because of a careful, individualized assessment of her medical needs. Instead,

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<sup>1</sup> The official deposition transcript has not yet been finalized, but the deposition was videotaped if the Court wishes to review any portion of it.

while considering her request, Defendants adopted the view that gender-affirming surgery is *never* medically necessary for *anyone*. A “medical analysis” prepared by Defendants last February acknowledges that Mrs. Zayre-Brown “met appropriate criteria for surgery.” Ex. B, DAC 3399. But that document goes on to deny surgery without any analysis of Mrs. Zayre-Brown’s medical needs whatsoever. *Id.* at DAC 3400-3403.

Removing any doubt on the matter, Defendant Campbell—the prison system’s Chief Medical Officer who is also responsible for authorizing gender-affirming care—wrote a “Position Statement” in March. That document confirms Defendants’ view that “gender reassignment surgery (GRS), as a treatment for gender dysphoria, is not medically necessary,” regardless of a patient’s individual circumstances. Ex. C at DAC 3404.

Defendants now seek to subject Mrs. Zayre-Brown to three more evaluations covering the same subject matter contained in her medical records and explored at her deposition. Specifically, Defendants wish to have two examiners spend up to 10.5 hours over three days examining her “psychosocial history, past medical history, past psychiatric history, past trauma history, educational, employment, family, and substance histories, developmental information, [ ] legal information,” “current symptoms,” “history of gender dysphoria, . . . and prior treatments of gender dysphoria,” “psychosocial history, gender-related developmental history, adjustment to incarceration, and informed consent for gender-affirming interventions.” Defs. Br. at 2-3.

## RULE 35 STANDARD

Rule 35 provides: “The court where the action is pending may order a party whose mental or physical condition—including blood group—is in controversy to submit to a physical or mental examination by a suitably licensed or certified examiner.” Fed. R. Civ. P. 35(a)(1). The order “may be made only on motion for good cause . . . .” *Id.* (2)(A).

“Under Rule 35, the invasion of the individual’s privacy by a physical or mental examination is so serious that a strict standard of good cause, supervised by the district courts, is manifestly appropriate.” *E.E.O.C. v. Maha Prabhu, Inc.*, No. 3:07-CV-111-RJC, 2008 WL 2559417, at \*2 (W.D.N.C. June 23, 2008) (quoting *Guilford Nat. Bank of Greensboro v. S. Ry. Co.*, 297 F.2d 921, 924 (4th Cir. 1962)). “[T]here must be greater showing of need under [Rule 35] than under the other discovery rules.” *Guilford Nat. Bank*, 297 F.2d at 924. This “requires discriminating application by the trial judge, who must decide” whether the movant “has adequately demonstrated the existence of the Rule’s requirements . . . .” *Schlagenhauf*, 379 U.S. at 118.

One of the purposes of Rule 35 is “to provide a ‘level playing field’ between the parties in their respective efforts to appraise” a party’s condition. *Holland v. United States*, 182 F.R.D. 493, 495 (D.S.C. 1998) (quoting *Tomlin v. Holecek*, 150 F.R.D. 628, 632 (D. Minn. 1993)). However, a plaintiff being examined by her expert does not automatically entitle a defendant to a Rule 35 examination, especially if there are

less invasive ways to obtain the same information. *See Acosta v. Tenneco Oil Co.*, 913 F.2d 205, 210 (5th Cir. 1990).

### ARGUMENT

**I. Defendants have not shown good cause because they already possess extensive information about Plaintiff's health and have not exhausted less invasive means of discovery.**

Defendants have not exhausted regular discovery methods or explained why those methods are inadequate to evaluate Mrs. Zayre-Brown's medical status. The motion fails on this basis alone.

This Court has observed that a Rule 35 exam is only appropriate where "other means of obtaining information are exhausted." *E.E.O.C.*, 2008 WL 2559417, at \*2. Courts regularly deny Rule 35 motions when movants already have significant information about a person's health and can obtain additional information through written discovery and depositions.

For example, in a disability discrimination case against the Department of Veterans Affairs, "a number of psychological tests and other information [about the plaintiff had] been provided to Defendant, some of which the Department . . . performed itself." *Shumaker*, 196 F.R.D. at 457. The court denied the Rule 35 motion because there was "ample evidence available from which Defendant can obtain the information he currently seeks." *Id.*

In another case, the plaintiff's expert performed a "comprehensive" evaluation of him, and the defendant wished to have its own expert do the same. *Acosta*, 913 F.2d at 207. The Fifth Circuit found a lack of good cause because the defendant had

deposed the plaintiff, deposed his expert, and obtained other information through written discovery. *Id.* at 209. *See also Stanislawski v. Upper River Servs., Inc.*, 134 F.R.D. 260, 262 (D. Minn. 1991) (denying Rule 35 motion where defendant had access to “all of plaintiff’s medical records, ha[d] deposed plaintiff, and ha[d] been provided with information concerning plaintiff’s education, experiences, and medical disability”); *Conforti v. St. Joseph’s Healthcare Sys., Inc.*, No. 217CV00050CCCCLW, 2020 WL 365100, at \*3 (D.N.J. Jan. 22, 2020) (same with transgender plaintiff); *Brennan v. Thomas*, 780 Fed. App’x 813, 819 (11th Cir. 2019) (similar); *Wrangen v. Pennsylvania Lumbermans Mut. Ins. Co.*, No. 07-61879-CIV, 2009 WL 151715, at \*5-6 (S.D. Fla. Jan. 16, 2009) (similar).

Here, the lack of good cause is even more apparent. Since entering Defendants’ custody in 2017, Mrs. Zayre-Brown has been repeatedly evaluated—by providers *chosen by Defendants*—for her gender dysphoria and requests for surgery. Defendants have full access to Mrs. Zayre-Brown’s extensive medical records. Defendants have deposed Mrs. Zayre-Brown and could have sought their experts’ assistance. *See Wrangen*, 2009 WL 151715, at \*2 (denying Rule 35 motion where defendant’s expert assisted counsel at plaintiff’s deposition). Mrs. Zayre-Brown has produced documents responsive to Defendants’ Rule 34 requests. She has disclosed her expert report and Defendants may seek to depose the expert. Defendants know the identities of Mrs. Zayre-Brown’s providers and may seek to depose them as well. Defendants have served interrogatories and may serve more at any time.

Defendants’ motion confirms the redundancy of the proposed examinations. Dr. Penn would address Mrs. Zayre-Brown’s “psychosocial history, past medical history, past psychiatric history, past trauma history, educational, employment, family, and substance histories, developmental information, [] legal information,” “current symptoms,” “history of gender dysphoria . . . , and prior treatments of gender dysphoria.” Defs. Br. at 2. Dr. Boyd would “focus[] primarily on psychosocial history, gender-related developmental history, adjustment to incarceration, and informed consent for gender-affirming interventions.” *Id.* at 3. In other words, Defendants seek information that is already contained in Mrs. Zayre-Brown’s voluminous medical records—which include evaluations and treatments ordered by Defendants themselves—and was covered in detail at her deposition.

Defendants offer little explanation of why they should be allowed to retread these sensitive topics through an invasive Rule 35 examination. They instead focus on “[t]he relevancy of the proposed examination[.]” *Id.* at 10. But relevance is not the standard under Rule 35—Defendants must also make a “greater showing of need.” *Schlagenhauf*, 379 U.S. at 118. They have failed to do so.

Consider a case where a plaintiff with gender dysphoria sued for discrimination on the basis of sex and transgender status. The defendants moved for a Rule 35 exam, arguing that “Plaintiff’s complex history of depression and anxiety, his gender dysphoria diagnosis, and potential contributing factors to Plaintiff’s emotional distress other than Defendants’ conduct are ‘highly relevant’ to both liability and damages.” *Conforti*, 2020 WL 365100, at \*3. The court denied the motion.

Much like Defendants here, those defendants “already had the opportunity to ‘question the plaintiff on these issues, request psychological records, and depose [his therapist] on [her] treatment of the plaintiff.’” *Id.* (quoting *Bowen v. Parking Auth. of City of Camden*, 214 F.R.D. 188, 195 (D.N.J. 2003) (brackets original)).

Defendants argue that the examinations are necessary to rebut the report of Mrs. Zayre-Brown’s expert, Dr. Ettner, who conducted an in-person examination. Defs. Br. at 11-13. But Defendants’ handpicked providers have been examining Mrs. Zayre-Brown since 2017—the parties are already on equal footing in that respect. And again, Defendants offer zero explanation as to why depositions of Dr. Ettner, Mrs. Zayre-Brown, and her providers, along with full access to her medical records, should not suffice. Defendants cite no cases granting a Rule 35 motion where the movant had access to a comparable wealth of information.

Moreover, it is true that Dr. Ettner criticized Dr. Penn and Dr. Boyd for not basing their opinions on evaluations of Mrs. Zayre-Brown. The thrust of that criticism, however, was that Dr. Penn and Dr. Boyd did not address Mrs. Zayre-Brown’s individual circumstances *at all*. See Doc. 22-1 ¶ 21. Defendants can still glean an extraordinary amount of information about her from their available sources. And, perhaps more importantly, such criticism does not automatically entitle a party to a Rule 35 examination where, as here, they otherwise cannot satisfy all of Rule 35’s demanding criteria. See *Acosta*, 913 F.2d at 209 (defendant did not establish good cause even though plaintiff’s expert had evaluated plaintiff and defendant’s expert had not).

In sum, Defendants have ample information about Mrs. Zayre-Brown's health. They have not shown that "other means of obtaining information are exhausted" or that "a wide-ranging intrusion into her privacy is merited . . ." *E.E.O.C.*, 2008 WL 2559417, at \*2, \*4. The motion should be denied.

**II. Defendants' examiners are not qualified because they have never evaluated anyone for gender-affirming surgery and have limited experience with gender dysphoria generally.**

Even if Defendants can establish good cause, they must also show that their proposed examiners are sufficiently qualified. Dr. Penn and Dr. Boyd's credentials show that they are not.

Rule 35(a)(1) only permits "examination by a suitably licensed or certified examiner." Thus, the court must "assess the credentials of the examiner to assure that no person is subjected to a court-ordered examination by an examiner whose testimony would be of such limited value that it would be unjust to require the person to undergo the invasion of privacy associated with the examination." Fed. R. Civ. P. 35, Ad. Comm. Notes (1991). "The court's responsibility to determine the suitability of the examiner's qualifications applies even to a proposed examination by a physician. If the proposed examination and testimony calls for an expertise that the proposed examiner does not have, it should not be ordered[.]" *Id.*

This case is not about diagnosing gender dysphoria or treating that condition generally. Rather, as Defendants have put it, "Plaintiff's claims are centered on the Department's decision to not approve her request for surgery." Doc. 10 at 7. Defendants offer minimal information on their examiners' qualifications. But a

review of their previous affidavits reveal that they are grossly unqualified to opine on the core issue in this case: the medical necessity of gender-affirming surgery.

Dr. Penn claims some experience working with patients with gender dysphoria. But it is unclear how many patients he has worked with, what clinical guidelines he has used, or what treatments he has provided. *See* Docs. 18-8 at 1-6; 18-9. Most importantly here, Dr. Penn does not claim to have ever evaluated a patient for a vulvoplasty—or any other gender-affirming surgery—which he describes as “a highly specialized urologic surgical procedure.” Doc. 18-8 ¶ 40. What’s more, Dr. Penn has not published any articles on gender-affirming surgery or gender dysphoria generally. Nor does he claim to have ever provided expert testimony on these subjects. *See* Doc. 18-9. Thus, any opinion from Dr. Penn on this issue would have negligible value to the factfinder that cannot justify the heavy burden on Mrs. Zayre-Brown.

Those are not Dr. Penn’s only problems. Earlier in this case, Dr. Penn endorsed Defendants’ refusal to treat Mrs. Zayre-Brown, but did so based on general principles—he did not address her individual circumstances at all. Doc. 18-8 ¶¶ 69-71. Thus, Dr. Penn has already reached his conclusion on the main issue in this case. Any further examination of Mrs. Zayre-Brown would seem to be irrelevant in his view (and as discussed below, Defendants’ view as well).

Finally, in a recent case concerning prison health care, the district court found that Dr. Penn’s testimony was “simplistic,” “deeply flawed,” “erroneous,” “not credible,” “appalling,” “ma[d]e[] no sense,” used “circular logic,” “ha[d] no merit,” and was “ambiguous, inconsistent and of no value.” *Jensen v. Shinn*, No. CV-12-00601-

PHX-ROS, 2022 WL 2911496, at \*40, \*49, \*51-\*52 (D. Ariz. June 30, 2022). The court went on: “It is difficult to overstate Dr. Penn’s lack of credibility. He was evasive when asked direct, simple questions. . . . His ignorance of fundamental aspects of Defendants’ health care system was obvious and his testimony contradicted the undisputed evidence at trial.” *Id.* at \*51 n.28. The court concluded that Dr. Penn’s opinions were “unworthy of any weight.” *Id.* at \*53.

This damning assessment of Dr. Penn’s testimony—on subjects he arguably has far more experience with than gender-affirming surgery—further shows how his testimony here “would be of such limited value that it would be unjust to require [Plaintiff] to undergo the invasion of privacy associated with the examination.” Fed. R. Civ. P. 35, Ad. Comm. Notes (1991). To allow him to conduct a lengthy examination on deeply sensitive issues would only serve to cause Mrs. Zayre-Brown needless distress.

Defendants also propose that Dr. Sandra Boyd conduct a four-hour evaluation. Like Dr. Penn, Dr. Boyd’s credentials on treating gender dysphoria are sparse. She does not claim to have ever evaluated a patient for gender-affirming surgery. Nor does she have any relevant peer-reviewed publications or prior expert testimony on the topic. Dr. Boyd claims to have “[c]onducted gender dysphoria evaluations” between 2013 and 2014, but does not explain what that means or how it qualifies her to participate in this case. Doc. 18-7 at 2. Thus, any opinion she provides on that subject would offer minimal value.

Accordingly, Defendants' proposed experts are, at best, novices in the field of treating gender dysphoria. They are not qualified to examine Mrs. Zayre-Brown regarding her need for gender-affirming surgery.

**III. The proposed examinations are not necessary considering the limited extent Mrs. Zayre-Brown's health may be "in controversy."**

Defendants say that a Rule 35 examination is appropriate because Mrs. Zayre-Brown's medical condition is "in controversy." But Defendants have never disputed her diagnosis. *See, e.g.*, Doc. 26 ¶ 65 (admitting diagnosis). Nor have they disputed her need for treatment such as hormone therapy or living accommodations. *See id.* ¶¶ 68, 75. Rather, as discussed above, the only aspects of Mrs. Zayre-Brown's health arguably in controversy are her need for gender-affirming surgery and the harm she has suffered without it.

Discovery has confirmed, however, that Defendants' decision to deny treatment had nothing to do with Mrs. Zayre-Brown herself. Instead, Defendants have instituted a blanket ban on gender-affirming surgery. First, Defendants' "medical analysis" of Mrs. Zayre-Brown prepared last February did not assess her individual circumstances at all. It denied surgery based on broad principles that would apply to any patient. Ex. B, DAC 3400-3403. Shortly thereafter, Defendant Campbell—the Chief of Medicine for state prisons—wrote a "Position Statement" concluding that "gender reassignment surgery (GRS), as a treatment for gender dysphoria, is not medically necessary," regardless of a patient's individual needs. Ex. C, DAC 3404. Consistent with these documents, Defendants gave no individualized

rationale when they communicated their decision to Mrs. Zayre-Brown last April. Ex. A.

With this in mind, *Plaintiff's* individual health status is not truly in controversy—Defendants would have denied gender-affirming surgery to anyone who requested it. To prevail in this case, Defendants will have to justify their blanket prohibition. Further examination of Mrs. Zayre-Brown herself would be irrelevant to Defendants' actual basis for their decisions.

A court recently addressed this scenario in a case about a Medicaid exclusion for gender-affirming care. *Dekker v. Weida*, 4:22-cv-00325-RH-MAF (N.D. Fla.). The plaintiffs opposed a Rule 35 motion, arguing that “[g]iven the categorical nature of the Challenged Exclusion,” examination of their individual medical needs would be irrelevant. Ex. D, ECF. No. 92 at 2. The motion was denied. Ex. E, ECF No. 95.

For these reasons, the Court should not allow Defendants an obvious and burdensome fishing expedition that would not even yield evidence relevant to the core issue in this case. *Cf. Bowen*, 214 F.R.D. at 195 (explaining that defendants “may not engage in a fishing expedition” when examining a plaintiff’s emotional injury).

**IV. If the Court grants Defendants’ motion, it should limit the examination’s duration, scope, and participants.**

For all the reasons discussed above, Defendants have not established the necessity, propriety, or relevance of the proposed examinations. But if the Court grants Defendants’ motion, any examination must still be proportional to the needs of the case under Rule 26. Fed. R. Civ. P. 26(b)(1).

Ten hours and thirty minutes of invasive tests covering well-trod subject matter is not proportional. If the Court allows any examination at all, it should give Defendants no more than five hours total, the same time taken by Dr. Ettner. The Court should not permit examination of Mrs. Zayre-Brown by Dr. Penn, who has already reached his conclusions on the necessity of gender-affirming surgery. The Court should also carefully limit the examination to subjects that are clearly disputed. *See Simon v. Bellsouth Advert. & Pub. Corp.*, No. CIV.A. 3:09-CV177RJC, 2010 WL 1418322, at \*5 (W.D.N.C. Apr. 1, 2010) (limiting duration and subject matter of examination).

### CONCLUSION

Defendants have not carried their heavy burden of justifying a “serious” “invasion of [an] individual’s privacy.” *Guilford Nat. Bank of Greensboro v. S. Ry. Co.*, 297 F.2d 921, 924 (4th Cir. 1962). Nor have they shown that their examiners are qualified, or that Mrs. Zayre-Brown’s unique medical needs are truly “in controversy” as contemplated by Rule 35. The motion should be denied. If the Court grants the motion, Mrs. Zayre-Brown asks the Court to limit the examination to be proportional to the needs of this case.

Respectfully submitted, this the 24th day of February, 2023.

/s/ Daniel K. Siegel

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**CERTIFICATE OF SERVICE**

I certify that on February 24, 2023, I filed the foregoing using the Court's CM/ECF system which will effect service on all counsel of record.

/s/ Daniel K. Siegel

Daniel K. Siegel

*Counsel for Plaintiff*

# EXHIBIT A

**North Carolina Department of Public Safety  
Division Transgender Accommodation Committee Report**

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Offender Name:	██████████	Sex:	F	Off #:	0618705
Date of Birth:	1981	Facility:	ANSO		
Date:	04/26/2022 12:00	Provider:	Peiper, Lewis J Ph.D Dir. of		

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**Comment**

The following note is a summary of related input and considerations from the 2/17/2022 Division Transgender Accommodation Review Committee and concludes with a medical analysis from the Division of Prisons Medical Authority related to (Kanautica Zayre-Brown, 0618705), referred to as Offender Brown and/or patient below with she/her pronouns used where applicable.

Offender Brown was admitted to prison 10/10/2017 with a current projected release date of 11/2/2024. She is currently housed at Anson CI where she was transferred from Warren CI on 8/15/2019. Offender Brown is currently assigned to Medium Custody after being promoted from Close Custody on 1/4/2022.

In response to Offender Brown's request for vaginoplasty or vulvoplasty surgery, the DTARC recommended receiving a consult from a surgical specialist experienced in performing vaginoplasty surgeries to obtain information to further evaluate treatment options and proposed course going forward. Offender Brown participated in a telehealth appointment with Kristia Vasilof from the UNC Transhealth Program as part of the initial review for consult and Katherine Croft (UNC Transhealth Program Manager) completed a telehealth consult with Offender Brown as part of the planned surgical consult with the UNC Transhealth program. An in-person consultation with Dr. Figler from the UNC Transhealth Program on 7/12/2021 indicated the patient's desire for vulvoplasty (versus vaginoplasty) and the need for weight loss from the recorded weight of 288 at the time down to a maximum of 250 with an identified weight goal of 210.

**DTARC Review 2/17/2022:**

Offender Brown has maintained the minimum weight goal identified by the UNC Transhealth program. Weight has been below 240 since 11/15/2021 and at the time of the DTARC was most recently (2/11) at 236. Patient is now eligible for review related to DTARC recommendation on requested vulvoplasty surgery.

Review of patient's related mental health and behavioral health record, and the baseline criteria identified by UNC Transhealth Program could make her a candidate for surgery. The patient has a well-documented, persistent transgender identity with a desire for "bottom surgery." The patient has been educated on the surgical interventions by the UNC Transhealth Program and identified a preference for a vulvoplasty if performed. The patient had completed other gender-affirming surgeries (orchiectomy, breast implants) prior to incarceration and has been on hormone replacement therapy since 2012. Mental health and behavioral health case reviews indicated no current evidence of any significant comorbid mental health issues. Patient continues to demonstrate emotional and psychological stability with evidence of adequate coping skills. The patient's mood and anxiety symptoms appear well-controlled by psychiatric interventions, however, recent progress notes from supportive counseling and therapy sessions indicate the patient has been heavily focused on the status of the final decision regarding her requested/desired surgery and experiencing related anxiety/frustrated mood.

Offender Brown has been housed in a female prison since 8/2019 and her adjustment to being housed in a female prison has been generally acceptable apart from a period of time in the fall / winter of 2020 related to reports of this offender having engaged in assaultive and extortive behavior against female offenders. Although she has largely adapted well to her current facility assignment, continued vigilance is necessary in order to ensure the offender's continued stability and to protect other offenders.

**MEDICAL ANALYSIS:**

This offender has received and continues to receive extensive treatment while incarcerated. As with all treatments in medicine, ongoing re-evaluations are conducted and regimens adjusted based on the clinical course, with further interventions based on findings from those reevaluations.

Medical analysis for this case included a comprehensive review of the offender's medical and behavioral health history, as well as a comprehensive literature review. When treatments are considered for any patient, the most important imperative for physicians is to base recommendations on evidence-based medicine and consideration of that

information in the context of the individual patient. Although the offender has clearly communicated a desire for further

Offender Name: [REDACTED] Off #: 0618705  
Date of Birth: [REDACTED] 1981 Sex: F Facility: ANSO  
Date: 04/26/2022 12:00 Provider: Peiper, Lewis J Ph.D Dir. of

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gender-affirming surgery, there is insufficient medical evidence to indicate such a complex and irreversible surgical intervention is medically necessary for her at this time.

Based on this review, it is the determination of the medical authority that gender reassignment surgery (GRS) as requested by this offender is not medically necessary.

**Co-Pay Required:** [REDACTED] No **Cosign Required:** No

**Telephone/Verbal Order:** No

**Standing Order:** No

Completed by Peiper, Lewis J Ph.D Dir. of Beh. Health on 04/26/2022 12:12

Requested to be reviewed by Dula, Jennifer L MSW Clinical Social Worker.

Review documentation will be displayed on the following page.



# EXHIBIT B

██████████ (Kanautica Zayre-Brown, 0618705), referred to as offender and/or patient below

- admitted to prison 10/10/2017
- current projected release date 11/2/2024
- Anson CI (transferred from Warren on 8/15/2019)
- Medium Custody (promoted from Close on 1/4/2022)

**Surgery Request and Case Summary:**

- 2/20/2020, DTARC recommended receiving a consult from a specialist experienced in performing vaginoplasty surgeries to obtain information to further evaluate treatment options and required course going forward.
- 8/4/2020, patient participated in telehealth appointment with Kristia Vasilof from UNC Transhealth Program as part of initial review for consult referral
- 8/27/2020, DTARC reviewed and recommended UR approval for in-person consult with UNC Transhealth Program
- 2/25/2021, DTARC reviewed information regarding need to meet with UNC Transhealth Program Manager prior to scheduling in-person appointment.
- 5/25/2021, Katherine Croft (Transhealth Program Manager) completed a telehealth consult with Offender Brown as part of the planned surgical consult with the UNC Transhealth program. The consult noted "no primary concerns were identified that would interfere with surgery except for weight, which the patient indicated she was intending to lose for surgery."
- 7/12/2021, patient was transported for an in-person consultation with Dr. Figler with the UNC Transhealth Program on 7/12/2021. The consultation documentation was received on 7/20/2021 at Anson and entered into the offender's document manager. The consultation indicated the patient's desire for vulvoplasty (not vaginoplasty) and need for weight loss from the recorded weight of 288 at the time down to a maximum of 250 with an identified weight goal of 210.
- 7/29/2021, Dr. Peiper informed by UNC Telehealth Program that they will need two referral letters related to WPATH criteria
- 10/4/2021, new updated Transgender Accommodation Summary completed as part of the referral letter requirement summarizing history of transition, patient's continued commitment to surgery, current and recent psychological stability, absence of uncontrolled comorbid mental health conditions, and that the patient met appropriate criteria for surgery.

**DTARC Review 2/17/2022:**

Patient has maintained the minimum weight goal identified by UNC Transhealth program. Weight has been below 240 since 11/15/2021 and at the time of the DTARC was most recently (2/11) at 236. Patient is now eligible for review related to DTARC recommendation on requested vulvoplasty surgery.

Mental health and behavioral health case reviews indicated no current evidence of any significant comorbid mental health issues. Review of patient's related mental health and behavioral health record indicates the criteria identified by UNC Transhealth Program for appropriateness for surgery have been met. The patient has a well-documented, persistent transgender identity with a commitment for "bottom surgery." The patient has been educated on the surgical interventions by the UNC Transhealth Program and identified a preference for a vulvoplasty if performed. The patient has lived as a female in the community prior to this incarceration and has been housed in a female prison since 8/2019. The

patient has completed other gender-affirming surgeries (orchiectomy, breast implants) and has been on hormone replacement therapy since 2012. The patient's mood and anxiety symptoms appear well-controlled by psychiatric interventions, however, recent progress notes from supportive counseling and therapy sessions indicate the patient has been heavily focused on the status of the final decision regarding her requested/desired surgery and experiencing related anxiety/frustrated mood.

#### MEDICAL ANALYSIS:

Medical analysis for this case included a comprehensive review of the offender's medical and behavioral health history, as well as a comprehensive literature review. When treatments are considered for any patient, the most important imperative for physicians is to base recommendations on evidence-based medicine and consideration of that information in the context of the individual patient.

Based on this review, it is the determination of medical authority that gender reassignment surgery (GRS) as requested by this offender is not medically necessary. The rationale for this determination is several fold, particularly when the requested treatment for this offender (vulvoplasty), is compared to what are considered "medically necessary" surgeries for other medical conditions.

First, medically necessary treatments, and this is particularly true of surgical procedures, consist of a single, or at most a very discrete subset of surgeries. This is entirely not the case in the context of GRS, where there are a wide range of treatments, most notably absent surgery, but also including surgeries, which are presented as "options" in treatment, and are largely determined by the patient's desires. This would not be the case were the procedure truly "necessary", defined as treatment required in order to protect life, to prevent significant disability, or to alleviate pain. In these cases, barring any individual contraindications to surgery, almost all individuals suffering with these symptoms would indeed consent to surgery. This is clearly not the case with GRS, as, according to NIH data (2019), only 25-35% of transgender individuals ever undergo any form of GCS. ([Demographic and temporal trends in transgender identities and gender confirming surgery \(nih.gov\)](#)). This would not be true of any other "medically necessary" procedure in this country.

Almost universally, medically necessary procedures are by definition covered by insurance carriers. This too is not the case with GRS. In fact, 64% (32 States) of U.S. States' Medicaid programs do not offer coverage for GRS. ([Issue brief: Health insurance coverage for gender-affirming care of transgender patients \(ama-assn.org\)](#)). In fact, in N.C. the State Employees Health Plan, as with the majority of other US State health plans similarly do not cover the cost of GCS. This absolutely would not be the case were the procedure indeed "medically necessary".

Medically necessary treatments must be based on standards of practice, must be evidence-based, peer-reviewed and without bias or conflict of interest among the researchers or agency providing the recommendations, and there is almost always consensus among the medical community as to not only the necessity of the treatment/ procedure, but further, the preferred treatment. These factors establish standard of care, and physicians are derelict in their duties when they stray from these critical considerations. Unfortunately, in the case of GRS in the treatment of gender dysphoria, none of these factors are true. Most notably, the entity most often referred to for guidance regarding treatment of gender dysphoria, namely WPATH (World Professional Association for Transgender Health), simply does not meet these criteria.

WPATH remains under increasing scrutiny and continues to be mired in controversy for the very reasons cited above, calling into question its objectivity and the very real concern that it is not the typical professional organization that develops reliable clinical practice guidelines. WPATH is considered by many to instead be a hybrid professional and activist organization, where activists have become voting members, and even move on to lead the organization. In fact, it is argued by many that WPATH is “activist-led” rather than “evidence-led”, and therefore are not a reliable agency in medical decision making for our patients.

Conflicts of interest among the organization are also of significant concern. The overwhelming majority of WPATH Committee members either receive income based on recommendations in the guidelines, work at clinics or universities who receive funds from advocacy groups, foundations, or pharmaceutical companies who heavily favor a certain treatment paradigm, or have received grants and published papers or research in transgender care.

The majority of the members of the WPATH Committee are from the U.S., and six of them have affiliations with the same university—the University of Minnesota Program in Sexuality, which is primarily funded by a transgender advocacy organization (Tawani Foundation).

As if the factors above were not concerning enough, the situation becomes more concerning when we consider another source we as practitioners use to develop treatment plans for our patients, namely specialty societies. In the case of WPATH, three of the same committee members for the WPATH Guidelines also served on the Endocrine Society guideline committee, which raises intellectual conflict of interest concerns, as recommendations based on faulty conclusions in the WPATH guidelines could potentially have been duplicated in the Endocrine Society guidelines.

When, as clinicians we encounter concerns related to objectivity or conflict of interest, for instance, a study recommending a particular pharmacologic treatment or prosthetic device wherein the study was funded by the pharmaceutical company or prosthetic manufacturer, we are then obligated to expand our research and consider other studies. To do otherwise as medical professionals would be negligent; we simply cannot rely solely on a single organization with these concerns at the forefront in making decisions for our patients. This is precisely the case here, where there is significant concern for objectivity and conflict of interest among WPATH, as well as the US Endocrine Society.

When further research is conducted, as we have done in this case, it becomes even more apparent why there is indeed not consensus among the medical community in the treatment of gender dysphoria, and particularly GCS.

Perhaps one of the most important considerations in developing treatment plans for our patients is the long term prognosis following the treatment. Most critically, the imperative “*Primum non nocere*”, (“First do no harm”) must be at the forefront of consideration. This imperative is the underpinning of the oath all physicians take. In order to ensure the most appropriate, effective, and safest care to patients, clinicians must exercise due diligence in evaluating all available information in formulating recommendations to patients. The evidence regarding GRS does not provide sufficient confidence that the procedures should be undertaken without concern for having violated that oath.

Case in point is the 2016 CMS (Centers for Medicaid and Medicare) Decision Memo which summarizes the following: “Based on a thorough review of the clinical evidence available at this time, there is not

enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria". Further in the report, "When considering even the 'best studies', the conclusion was that there is no evidence of 'clinically significant changes' after sex reassignment surgery." ([NCA - Gender Dysphoria and Gender Reassignment Surgery \(CAG-00446N\) - Proposed Decision Memo \(cms.gov\)](#))

No studies conclusively demonstrate that GCS improves quality of life or sufficiently addresses gender dysphoria. In fact, in the largest and most thorough long term study looking at quality of life after GCS [Sweden; 324 individuals over a 30 year period (1973-2003)] ([Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden \(plos.org\)](#)), found evidence to the contrary. Specifically, 1-15 years after surgical reassignment, the suicide rate of those who had undergone sex reassignment surgery rose to 20 times that of comparable peers; there was notable increased mortality and psychiatric hospitalization (which was 2.8 times greater than in controls). As/ more interesting was the finding that death due to neoplasm and cardiovascular disease was increased 2-2.5 times in the surgical group, and this increased mortality was not realized for some 10 years after surgery.

There is a growing body of research into what seems to be an increasing number of transgender individuals who at some point "de-transition", or go back to living as their sex assigned at birth (or at least discontinue some or all aspects of gender affirmation).

The phenomenon of de-transition is critically important in considering treatment options for patients, particularly when treatment involves either irreversible or incredibly difficult/ poor outcomes, such as surgeries. This consideration is of even greater concern when the veracity of the patient is in question or there are other factors such as secondary gain to be considered.

A study recently (June 2021) published by the National Institutes for Health (National Center for Biotechnology Information-NCBI) found that among individuals who had undergone transition, more than 13% had undergone de-transition. [Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis \(nih.gov\)](#)

Further analysis of this data demonstrated that of those who de-transitioned, 38% did so because transitioning had failed to resolve their psychological issues, so they concluded that "gender dysphoria wasn't the cause"; another 23% did so because they came to understand that they had in fact been struggling with sexual orientation issues rather than gender dysphoria. [Why Some Transpersons Decide to Detransition | Psychology Today](#)

A large sample, peer-reviewed study conducted in 2021 found that 70% of those who detransitioned did so after they realized their gender dysphoria was "related to other issues" and 50% did so because transition had failed to alleviate their dysphoria. Interestingly, 43% endorsed a "change in political views" as a reason for detransition. Importantly, 43% of those who detransitioned had previously undergone GCS. [Full article: Detransition-Related Needs and Support: A Cross-Sectional Online Survey \(tandfonline.com\)](#)

Another more recent study (Oct 2021) found that 70% were dissatisfied with their decision to transition. 61% of those who detransitioned had returned to their identifying with their birth sex, 14% identified as nonbinary, and 8% identified as transgender. The study goes on to emphasize the need for "alternative,

non-invasive approaches for gender dysphoria management in young people”.

Growing Focus on Detransition | SEGM

Having taken all these factors into consideration, it remains my medical determination that the surgical procedure requested by this offender is not medically necessary. Further, there is increasing evidence that GRS does not represent the definitive treatment for gender dysphoria, nor does the literature provide the confidence in long-term success required in order to undertake invasive procedures. There simply is not consensus among the medical community that GRS represents THE only acceptable nor THE most recommended treatment for gender dysphoria. In no other context would surgery be considered for a patient if at least one of these factors were not considered to be consensus among the medical community.

# EXHIBIT C

**Division Transgender Accommodations Review Committee (DTARC)**  
**Position Statement**  
**Gender Reassignment Surgery**  
**NCDPS-Prisons**

23 March 2022

Dr Arthur L Campbell, III, M.D.

Chief Medical Officer, NC Prisons

## SUMMARY POSITION STATEMENT:

*As with all treatments, including procedures and surgeries provided to offenders, the first consideration is whether the treatment is medically necessary. This consideration is precisely the same as that utilized by every managed care system and health insurance agency in the Country.*

*After extensive and objective review and analysis of hundreds of studies and other publications, it has been determined that gender reassignment surgery (GRS), as a treatment for gender dysphoria, is not medically necessary.*

*When GRS is considered with and compared to other procedures and surgeries which are broadly considered medically necessary, GRS procedures fail to satisfy the criteria and characteristics evidenced by those broadly accepted procedures. Specifically, there are concerns that the risk, as defined by failure of the procedure to correct the underlying problem or the need for subsequent reversal of the procedure outweigh any potential benefit of the procedure. GRS simply does not represent an objective "standard of care" and there are grave concerns with significant conflict of interest and the lack of evidence-based, peer-reviewed criteria utilized in developing criteria.*

## ANALYSIS/ DISCUSSION

There continue to be variable, and at times discrepant definitions of “medical necessity” between medical professionals, insurance providers, legislators, legal authorities, and activists. Across the country, the Courts continue to be somewhat inconsistent in their interpretations of what constitutes “medical necessity”. These discrepancies become even more complex in the context of medical care for the prison population.

Broadly speaking, at the most basic level, a medically necessary procedure is one which is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. More specifically, there are fairly standard characteristics which most in the medical community would agree either constitute or are associated with a “medically necessary” treatment or procedure, and in the context of gender reassignment surgery (GRS), these characteristics can be applied to reach a determination.

Some prominent characteristics of “medically necessary” procedures include:

- The risk to the patient of not performing the surgery exceed the potential risks of the surgery itself (includes intraoperative, postoperative and long term risks).
- The procedure has been determined to constitute “standard of care”, which leads to the following:
  - Overwhelming majority of individuals with the condition undergo the procedure
  - Majority of health insurance carriers provide coverage for the procedure, particularly when the procedure is not costlier than an alternative service or sequence of treatments that are at least as likely to produce equivalent therapeutic results.
- Treatment recommendations are developed through evidence-based medicine/ practice and are modified based on findings from continuous future studies.

When gender reassignment surgery is considered utilizing the general principles outlined above, it becomes apparent that the procedure(s) are indeed not “medically necessary”. What follows is a summary analysis and explanation.

- **For medically necessary procedures, the risk to the patient of not performing the surgery exceeds the potential risks of the surgery itself.**

*From the definition above, it follows that for a “medically necessary” procedure, the consensus among the medical community would be that not undertaking the procedure (surgery) will of course fail to alleviate the symptoms associated with the condition, but most importantly, could also result in one/ more of the following: (1) Death, (2) Severe disability, or (3) Significant worsening of the condition. A procedure which is unlikely to improve symptoms, carries with it increased risk of worsening symptoms, or those that disproportionately jeopardize a patient’s well-being would not be considered “medically necessary”. In fact, they would instead likely not be recommended at all.*

In the case of GRS, it is far from consensus among the medical community that individuals with gender dysphoria who do not undergo the procedure(s) are at increased risk of any of the sequelae outlined above. In fact, there are studies which cause great concern that a not insignificant portion of individuals who undergo the procedure(s) not only fail to improve, but in many cases, experience worse symptoms with quite concerning consequences.

One example: The largest and longest term study looking at quality of life after GCS, conducted in Sweden with 324 individuals over 30 years (1973-2003), actually demonstrated a 20-fold increase in suicides and 2.8 times greater rate of psychiatric hospitalization. Individuals also had a 2-2.5 times greater rate of neoplasm and cardiovascular disease. Importantly, many of these quite concerning outcomes did not occur until 10 years or more after surgery. [1]

Studies demonstrating findings such as those above are not isolated. Another study in 2017, incidentally sponsored by a group that was clearly pro-transition, found that “suicide attempts were lower before transition than over most other periods”. For example, the study found that suicidal ideation was 50.6% after transition compared with a 36.1% rate before transition. [2]

Another important consideration in any surgical treatment is outcomes, including analysis of the need for further surgeries, etc. There is a growing body of research into what seems to be an increasing number of transgender individuals who at some point “de-transition”, the act of stopping or reversing gender transition, often going back to living as their sex assigned at birth.

This phenomenon of de-transition is critically important in considering treatment options for patients, particularly when treatment involves either irreversible or incredibly difficult/ poor outcomes, such as surgeries.

A study published in the Archives of Sexual Behavior in October 2021 found a 24% rate of de-transition. This study uncovered some interesting, and frankly concerning statistics. For example, 60% of those who de-transitioned did so at least partly because they had become more comfortable with their natal(birth) sex. A quite significant amount (49%) did so as a result of concerns about the potential medical complications from transitioning. Perhaps most

significantly, 55% expressed concerns that they had “not received adequate evaluations from a doctor or mental health professional before starting transition”. [3]

Further analysis of this data and other studies demonstrated that of those who de-transitioned, 38% did so because transitioning had failed to resolve their psychological issues, so they concluded that “gender dysphoria wasn’t the cause”; another 23% did so because they came to understand that they had in fact been struggling with sexual orientation issues rather than gender dysphoria. [4]

A large sample, peer-reviewed study conducted in 2021 found that 70% of those who de-transitioned did so after they realized their gender dysphoria was “related to other issues” and 50% did so because transition had failed to alleviate their dysphoria. Interestingly, 43% endorsed a “change in political views” as a reason for de-transition. Importantly, 43% of those who de-transitioned had previously undergone GCS. [5]

Another more recent study (Oct 2021) found that among individuals who de-transitioned, 70% did so due to being dissatisfied with their decision to transition. 61% of those who de-transitioned had returned to their identifying with their birth sex, 14% identified as non-binary, and 8% identified as transgender. The study goes on to emphasize the need for “alternative, non-invasive approaches for gender dysphoria management in young people”. [6]

Findings such as these raise serious concerns and tip the “risk-benefit” analysis away from the support for surgery among objective medical observers, thereby refuting its “medical necessity”.

- **“Medically necessary” procedures are by definition considered to constitute “standard of care”.**

*If a procedure (surgery in this case) were the “standard of care”, there would be a single, or at most a discrete subset of procedures which have been determined by the medical community to be most appropriate to treat the condition.*

- *There are specific criteria which indicate not only the “qualification” for surgery, but also the specific procedure or approach would be best*
- *There are specific criteria which determine relative or absolute contraindications to surgery*
- *Based on these standards, the overwhelming expectation would be that (excluding patients who decline surgery against medical advice), that virtually every patient with this condition (and without contraindications) would indeed be provided the procedure.*
- *Majority of health insurance carriers provide coverage for the procedure, particularly when the procedure is not costlier than an alternative service or sequence of treatments that are at least as likely to produce equivalent therapeutic results.*

When evaluating and researching these factors in the context of GRS, it becomes readily apparent that GRS indeed does not satisfy the requirements necessary for it to be considered “standard of care”.

The justification used by those who advocate for surgeries is that they are “necessary” in order to alleviate the “dysphoria” associated with the condition. However, unlike other “medically necessary” surgeries, where there is single or at most a very discrete set of established procedures, in the case of GRS, there is a wide spectrum of continually expanding surgical options designed to treat gender dysphoria.

While not all inclusive, these potential surgical options include (not all inclusive) mastectomy, mammoplasty, orchiectomy, penectomy, metoidioplasty, scrotoplasty, vulvoplasty, vaginoplasty, phalloplasty, voice feminization surgery (anterior glottal web formation; cricothyroid approximation; laser reduction glottoplasty), chondrolaryngoplasty, facial feminization/ masculinization surgery, hip augmentation/ enhancement, gluteal augmentation/ reduction, body contouring and fat transfer, and others.

What this list makes very evident is that there is clearly no established specific (or even series of surgeries) which is the “standard” in the treatment of gender dysphoria. Instead, clinicians and advocates involved in the care of patients with gender dysphoria believe that the extent, type and number of surgeries an individual “needs” (“upper” and/ or “lower”) are quite literally determined by what makes the patient feel “complete” (or what they “choose”). Unlike pre-operative evaluations for other surgeries (such as a CT scan, MRI, biopsy, etc), in the case of gender dysphoria, there are no objective studies of any kind that can be performed to either determine indications for surgery or to develop specific surgical recommendations; these

determinations are purely subjective on the part of the individual. These facts alone make it clear that none of these surgeries can in any way be considered “necessary”.

Over time, for most every surgical procedure, criteria and pre-operative evaluations are continually refined in order to ensure the procedures are offered only to those patients who are most likely to benefit from the procedure. Data is collected continuously and that data helps to not only identify the best candidates for a particular surgery, but also to determine those who are not likely to benefit, and most importantly, those who have risk factors which would contraindicate the surgery.

In the case of GRS, the opposite is true. Treatment advocacy groups continue to significantly relax criteria to the point where it is simply a matter of the individual “asking” for the procedure(s). In fact, their approach to individuals with gender dysphoria has just recently been updated to an “informed consent model”/ “affirmation only” model, which “seeks to better acknowledge and support patient’s right of, and their capability for, personal autonomy in choosing care options without the requirement of external evaluations or therapy by mental health professionals” [7]

Another important consideration is the fact that for traditional “medically necessary” surgeries, the overwhelming majority of patients with the condition (unless there are specific contraindications or the patient declines), will indeed end up undergoing the procedure. This too is not the case at all with GRS. In fact, only 25-35% of individuals with gender dysphoria ever undergo any GRS. [8]. This further substantiates the case that GRS for the treatment of gender dysphoria is indeed not “medically necessary”, as the vast majority of individuals never undergo these procedures. That is not the case at any truly “medically necessary” surgeries.

Another factor with “medically necessary” procedures (again, which equates to being the “standard of care”) is that due to these procedures being established as the “standard of care”, the majority of health insurance carriers provide coverage for the procedure, particularly when the procedure is not costlier than an alternative service or sequence of treatments that are at least as likely to produce equivalent therapeutic results. This too is not true when evaluating the current state of health insurance coverage for GCS.

At the federal level, CMS (Centers for Medicare and Medicaid), after an exhaustive review of hundreds of studies in 2016, concluded that the procedures would not be mandated as part of Medicare plans due to the conclusion that there is a “lack of evidence that the procedures benefits patients”. More specifically, the Decision Memo stated the following: “Based on a thorough review of the clinical evidence available at this time, there is not enough evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria”, and went on to conclude that there is no evidence of “clinically significant changes” after GRS. [9]

Similarly, at the State level, while there are expected variations, 64% (32) of States’ Medicaid Programs also do not provide GRS coverage. [10] Further, most State Employees’ Health Plans (including North Carolina) do not provide coverage for GRS.

When specifically considering GRS in prisons, it is important to note that there have been no Federal inmates who have received GRS and only two states to date have provided for the procedure, both of which were very discrete circumstances in court settlements. Were GRS indeed “medically necessary”, not providing the procedure would bolster court cases regarding the 8<sup>th</sup> Amendment to the US Constitution. However, this has not been the case. Recent court rulings on this have been inconsistent to say the least. In fact, cases in both the First and Fifth Circuit Courts of Appeal have concluded that the State prison systems did not violate inmate’s rights (did not inflict “cruel and unusual punishment”) by declining provision of GRS for inmates.

More specifically, in the Fifth Circuit Court of Appeals case (March 2019; *Gibson v Collier*), in its findings, the Court confirmed that *“it is indisputable that the necessity and efficacy of sex reassignment surgery is a matter of significant disagreement within the medical community. As the First Circuit has noted—and counsel here does not dispute—respected medical experts fiercely question whether sex reassignment surgery, rather than counseling and hormone therapy, is the best treatment for gender dysphoria.”*

Further, the Court provided the following explanation:

*“Under established precedent, it can be cruel and unusual punishment to deny essential medical care to an inmate. But that does not mean prisons must provide whatever care an inmate wants. Rather, the Eighth Amendment “proscribes only medical care so unconscionable as to fall below society’s minimum standards of decency.”* Interestingly, the Court went on to point out that something (in this case, GRS) cannot be “unusual” if doing so is not the “usual” treatment, which is clearly the case in the context of GRS in either prisons or across the country as a whole. [11]

None of these would be the case were GRS indeed the “standard of care” and the procedures were “medically necessary”, which further bolsters the case that these procedures are indeed not medically necessary.

- **Treatment recommendations are developed through evidence-based medicine/ practice and are modified based on findings from continuous future studies.**

*Surgical procedures are determined using evidence-based, peer-reviewed medical studies which are free of bias or conflict of interest, leading to near consensus among the medical community as to not only the necessity of the treatment/ procedure, but further, the preferred treatment.*

- *Critically important is that these studies continually evaluate (and modify based on the data obtained) the pre-operative, intra-operative, post-operative, and long term approaches and prognosis associated with the procedure.*

This factor associated with evaluating medical necessity for any procedure is critical in order to ensure the best care for our patients, and in the case of GRS, is perhaps one of the most concerning factors. Unfortunately, in the case of GRS in the treatment of gender dysphoria, this level of scrutiny is simply not present. Most notably, the entity most often referred to for guidance regarding treatment of gender dysphoria, namely WPATH (World Professional Association for Transgender Health), simply does not utilize these criteria in developing their "standards of care". This realization has led to individuals/groups, who are supportive of treatments for gender dysphoria but who lack confidence in WPATH, establishing other organizations in order to ensure the level of scrutiny needed in undertaking these procedures.

For example, the Society for Evidence-Based Gender Medicine (SEGM) has recently been established by a physician in Oregon who has grown increasingly concerned with the lack of objectivity displayed by WPATH, stating that the organization "remains captured by activists". "We need a serious organization to take a sober look at the evidence and that is why we have established the Society for Evidence-Based Gender Medicine [SEGM]," she noted. "This is what we do — we are looking at all of the evidence. "She specifically recommends the WPATH SOC not be "the new gold standard going forward, primarily because it is not evidence-based". Instead, she points out that "WPATH utilizes the 'Delphi consensus process' to determine their recommendations, but this process is designed for use with a panel of experts when evidence is lacking". Instead of a panel of experts, she and an increasing number of other physicians across the country view WPATH as a "panel of activists" instead of a panel of experts. [12]

Medically necessary treatments must be based on standards of practice, must be evidence-based, peer-reviewed and without bias or conflict of interest among the researchers or agency providing the recommendations, and there is almost always consensus among the medical community as to not only the necessity of the treatment/ procedure, but further, the preferred treatment. These factors establish standard of care, and physicians are derelict in their duties when they stray from these critical considerations.

Unfortunately, the literature often relied upon is fraught with study design problems, including convenience sampling, lack of controls, cross-sectional design, small sample sizes, short study lengths, and enormously high drop-out rates among participants. Very few studies on transition escape these issues. For example, a 2018 systematic review of quality-of-life studies of transitioned adults rated only two out of twenty-nine studies as high-quality. [13]

WPATH remains under increasing scrutiny and continues to be mired in controversy for the very reasons cited above, calling into question its objectivity and the very real concern that it is not the typical professional organization that develops reliable clinical practice guidelines. WPATH is considered by many to instead be a hybrid professional and activist organization, where activists have become voting members, and even move on to lead the organization. In fact, it is argued by many that WPATH is “activist-led” rather than “evidence-led”, and therefore are not a reliable agency in medical decision making for our patients.

Conflicts of interest among the organization are also of significant concern. The overwhelming majority of WPATH Committee members either receive income based on recommendations in the guidelines, work at clinics or universities who receive funds from advocacy groups, foundations, or pharmaceutical companies who heavily favor a certain treatment paradigm, or have received grants and published papers or research in transgender care. [14]

The majority of the members of the WPATH Committee are from the U.S., and six of them have affiliations with the same university—the University of Minnesota Program in Sexuality, which is primarily funded by a transgender advocacy organization (Tawani Foundation). In fact, the current chairman of WPATH has his very position at the University of Minnesota funded by Jennifer Pritzer, a trans person and head of Tawani. In fact, there are press releases of Eli Coleman in 2017 thanking Jennifer Pritzer profusely for a generous donation, which adds up to 6.5 million dollars that Tawani has given to the university. Tawani also funded WPATH SOC development. Another advocacy group, Gender Identity Research and Education Society (GIREs) funded the translation of the SOC into various languages. [14]

As if the factors above were not concerning enough, the situation becomes more concerning when we consider another source we as practitioners use to develop treatment plans for our patients, namely specialty societies. In the case of WPATH, three of the same committee members for the WPATH Guidelines also served on the Endocrine Society guideline committee, which raises intellectual conflict of interest concerns, as recommendations based on faulty conclusions in the WPATH guidelines could potentially have been duplicated in the Endocrine Society guidelines.

This concern is supported by the fact that ECRI (Emergency Care Research Institute), the DHHS-appointed Agency for Healthcare Research and Quality (AHRQ) for the National Guideline Clearinghouse (NGC), has failed to provide Trust Ratings for either WPATH or the Endocrine Society guidelines for the treatment of gender dysphoria. The reason for this lack of inclusion was because “only a few of the recommendations were supported by the systematic review; the majority were not”, and that the agencies “did not use a systematic review process” in developing their guidelines. [14]

When, as clinicians we encounter concerns related to objectivity or conflict of interest, for instance, a study recommending a particular pharmacologic treatment or prosthetic device wherein the study was funded by the pharmaceutical company or prosthetic manufacturer, we are then obligated to expand our research and consider other studies. To do otherwise as medical professionals would be negligent; we simply cannot rely solely on a single organization with these concerns at the forefront in making decisions for our patients. This is precisely the

case here, where there is significant concern for objectivity and conflict of interest among WPATH, as well as the US Endocrine Society.

When further research is conducted, as we have done in this case, it becomes even more apparent why there is indeed not consensus among the medical community in the treatment of gender dysphoria, and particularly GCS.

In summary, based on the extensive and objective review of hundreds of studies and other publications, it is quite clear that gender reassignment surgery as a course of treatment for gender dysphoria is indeed not a medical necessity. When GRS is considered with and compared to other procedures and surgeries which are broadly considered medically necessary, the procedures fail to satisfy the criteria and characteristics evidenced by those procedures. Specifically, there are concerns that the risk, as defined by failure of the procedure to correct the underlying problem or the need for subsequent reversal of the procedure outweigh the potential benefit of the procedure. GRS simply does not represent an objective "standard of care" and there are grave concerns with significant conflict of interest and the lack of evidence-based, peer-reviewed criteria utilized in developing criteria.

Accordingly, to support these procedures given all these concerns would be in conflict with the most critical imperative in medicine, "*Primum non nocere*" (First, do no harm"). This imperative is the underpinning of the oath all physicians take. In order to ensure the most appropriate, effective, and safest care to patients, clinicians must exercise due diligence in evaluating all available information in formulating recommendations to patients. The evidence regarding GCS does not provide sufficient confidence that the procedures should be undertaken without concern for having violated that oath.

## CITATIONS

- [1] [Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden \(plos.org\)](#)
- [2] [Varied Reports of Adult Transgender Suicidality: Synthesizing and Describing the Peer-Reviewed and Gray Literature | Transgender Health \(liebertpub.com\)](#)
- [3] [Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners | SpringerLink](#)
- [4] [Factors Leading to “Detransition” Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis - PMC \(nih.gov\)](#)
- [5] [Why Some Transpersons Decide to Detransition | Psychology Today](#)
- [6] [Full article: Detransition-Related Needs and Support: A Cross-Sectional Online Survey \(tandfonline.com\)](#)
- [7] [Demographic and temporal trends in transgender identities and gender confirming surgery \(nih.gov\)](#)
- [8] [Growing Focus on Detransition | SEGM](#)
- [9] [Informed Consent in the Medical Care of Transgender and Gender-Nonconforming Patients | Journal of Ethics | American Medical Association \(ama-assn.org\)](#)
- [10] [NCA - Gender Dysphoria and Gender Reassignment Surgery \(CAG-00446N\) - Proposed Decision Memo \(cms.gov\)](#)
- [11] [Issue brief: Health insurance coverage for gender-affirming care of transgender patients \(ama-assn.org\)](#)
- [12] [Gibson v. Collier, No. 16-51148 \(5th Cir. 2019\) :: Justia](#)
- [13] [WPATH Draft on Gender Dysphoria 'Skewed and Misses Urgent Issues' \(medscape.com\)](#)
- [14] [Quality of life of treatment-seeking transgender adults: A systematic review and meta-analysis | SpringerLink](#)
- [15] [Bias, not evidence dominates WPATH transgender standard of care - CANADIAN GENDER REPORT](#)

# EXHIBIT D

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

**PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANTS'  
RENEWED MOTION FOR RULE 35 EXAMINATIONS  
OF PLAINTIFFS SUSAN DOE AND K.F.**

The controversy in this case centers on whether the Challenged Exclusion's premise that gender-affirming medical care is experimental is valid and lawful. Plaintiffs, two adult and two adolescent transgender Medicaid beneficiaries, challenge Defendants' adoption of a rule, Florida Administrative Code 59G-1.050(7), prohibiting Medicaid coverage of services for the treatment of gender dysphoria, *regardless of individual medical necessity* (hereinafter the "Challenged Exclusion"). The Challenged Exclusion *categorically* bans coverage of gender-affirming medical care on the grounds that the care is *never* medically necessary. It makes no exception based on a particular patient's individual circumstances or condition. Accordingly, this Court has indicated that "the controlling substantive

issue” in the case is “whether [the] treatments at issue are experimental.” ECF 80 at 2.<sup>1</sup>

Yet, notwithstanding the categorical nature of the Challenged Exclusion and the nature of the controlling issues in the case, Defendants seek psychiatric examinations of only two of the Plaintiffs, selectively choosing to target the Minor Plaintiffs (Susan Doe and K.F.) for such an invasive intrusion. But Defendants have not—and cannot—meet their stringent burden under Federal Rule of Civil Procedure 35, nor survive the “discriminating” scrutiny the Court must employ in considering their request. Given the categorical nature of the Challenged Exclusion, the validity of an individual Plaintiff’s diagnosis, or their individual need for a particular gender-affirming treatment, is not at issue.

As the Supreme Court has held:

[T]he ‘in controversy’ and ‘good cause’ requirements of Rule 35 ... are not met by mere conclusory allegations of the pleadings—nor by mere relevance to the case—but require an affirmative showing by the movant that each condition as to which the examination is sought is really and genuinely in controversy and that good cause exists for ordering each particular examination.

*Schlagenhauf v. Holder*, 379 U.S. 104, 118 (1964). Defendants cannot show that the Minor Plaintiffs’ mental condition is “in controversy” nor that they have “good cause” for the examinations. Instead, their purpose in requesting these examinations

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<sup>1</sup> The Court has also zeroed in on whether the process was fair and reasonable. *See, e.g.*, ECF 62 at 90:1-91:3.

is to harass and intimidate the Minor Plaintiffs. Not only have Defendants failed to make the requisite affirmative showing under Rule 35, but Defendants' proposed examiner is not qualified and does not meet this Court's instruction that the examiner not be a "transgender denier or skeptic."

For these and following reasons, the Court should deny Defendants' Renewed Motion for Rule 35 Examinations.

### **LEGAL STANDARD**

Rule 35 "requires discriminating application by the trial judge, who must decide, as an initial matter in every case, whether the party requesting a mental or physical examination or examinations has adequately demonstrated the existence of the Rule's requirements of 'in controversy' and 'good cause.'" *Schlagenhauf*, 379 U.S. at 118–19. "The 'good cause' and 'in controversy' requirements of Rule 35 make it very apparent that sweeping examinations of a party who has not affirmatively put into issue his own mental or physical condition are not to be automatically ordered." *Id.* at 121.<sup>2</sup>

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<sup>2</sup> Defendants cite a district court case for the mistaken proposition that "Rule 35(a) is to be construed liberally in favor of granting discovery." ECF 88 at 3 (quoting *Cody v. Marriott Corp.*, 103 F.R.D. 421, 422 (D. Mass. 1984)). This ignores unequivocal guidance from the Supreme Court that "Mental and physical examinations are only to be ordered upon a discriminating application by the district judge of the limitations prescribed by the Rule" and that having "such examinations [] be ordered routinely" would be "an untoward result." *Schlagenhauf*, 379 U.S. at 121–22.

The “in controversy” and “good cause” requirements “are distinct and implicate different concerns.” *Winstead v. Lafayette Cnty. Bd. of Cnty. Commissioners*, 315 F.R.D. 612, 616 (N.D. Fla. 2016).

## **ARGUMENT**

### **I. The Minor Plaintiffs’ mental condition is not in controversy.**

Rule 35 demands “an affirmative showing by the movant that *each condition* as to which the examination is sought is *really and genuinely in controversy*.” *Schlagenhauf*, 379 U.S. at 118 (emphasis added). “[M]ost courts agree that for a plaintiff’s mental status to be ‘in controversy’ requires more than ‘garden variety’ emotional distress allegations that are part and parcel of the plaintiff’s underlying claim.” *Bowen v. Parking Auth. of City of Camden*, 214 F.R.D. 188, 193 (D.N.J. 2003). As such, the collective view of courts, including this Court, is that:

A court will order plaintiffs to undergo mental examinations when, in addition to a claim of emotional distress, one or more of the following elements are present: (1) a cause of action for intentional or negligent infliction of emotional distress; (2) an allegation of specific mental or psychiatric injury or disorder; (3) a claim of unusually severe emotional distress; (4) plaintiff’s offer of expert testimony to support a claim of emotional distress; and/or (5) plaintiff’s concession that his or her mental condition is ‘in controversy within the meaning of Rule 35(a).

*Winstead*, 315 F.R.D. at 614 (quoting *Bowen*, 214 F.R.D. at 193) (cleaned up));<sup>3</sup> *see also Peltier v. Charter Day Sch., Inc.*, No. 7:16-CV-30-H(2), 2017 WL 4582459, at \*1 (E.D.N.C. Jan. 6, 2017). “The ultimate question is whether a plaintiff is making a claim for damages related to emotional distress that differs substantially from the typical claim in similar cases.” *Winstead*, 315 F.R.D. at 615.

Here, Defendants have not offered—and cannot offer—any plausible basis for the Court to find that the Minor Plaintiffs’ mental condition is sufficiently “in controversy” to meet the high threshold for a Rule 35 mental examination.

Defendants hinge their request for intrusive, invasive, and harassing examinations of the Minor Plaintiffs on the allegations in the Complaint that the Minor Plaintiffs have gender dysphoria and suffered from anxiety in the past but “[a] claimant’s medical condition is not necessarily placed in controversy simply by the language of the pleadings.” *E.E.O.C. v. Maha Prabhu, Inc.*, 2008 WL 2559417, at \*3 (W.D.N.C. June 23, 2008). Defendants point to the *parents’* fear of the *possible* repercussions of the Minor Plaintiffs not being able to access the care that their doctors have recommended. But that is not enough.

Defendants cannot hang their request for a compelled mental examination of the minor Plaintiffs on so slender a thread. Neither the pleadings nor the fears

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<sup>3</sup> These factors, which have been adopted by most federal courts were first articulated in *Turner v. Imperial Stores*, 161 F.R.D. 89 (S.D. Cal. 1995). This Court adopted these factors in *Winstead*, 315 F.R.D. at 614.

articulated in the parents' declarations relied upon by Defendants are sufficient to place the Minor Plaintiffs' mental condition "in controversy."

Moreover, while Defendants do not base their request on any claim for damages (and to be clear, Plaintiffs are not asserting any emotional distress damages),<sup>4</sup> no Plaintiff in this case is seeking to recover *damages* for any psychological or physical injury caused by Defendants, nor have they alleged any severe or particularized psychological harm because of Defendants' conduct. In fact, it is *only* the Defendants' adoption of the categorical Challenged Exclusion (i.e., the Defendants' conduct) that is at issue in this suit; there is no issue before this Court regarding the Minor Plaintiffs' diagnoses or any dispute that they were previously receiving necessary medical treatments as recommended by their treating providers.

The information sought through the requested mental examinations as to the Minor Plaintiffs' mental states is thus entirely irrelevant to the claims and defenses in this case, which may be decided on the merits as a matter of law: either the facially sex-based Challenged Exclusion violates the law, or it does not. Similarly, either

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<sup>4</sup> Plaintiffs seek no monetary compensation from the Defendants other than that which they can obtain under Section 1557 of the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 18116, which in this case is an award of nominal damages recognizing the violation of their civil rights and compensation for any out-of-pocket costs for their medical care that would have been covered by Medicaid but for the Challenged Exclusion. *Cf. Cummings v. Premier Rehab Keller, P.L.L.C.*, 142 S. Ct. 1562, *reh'g denied*, 142 S. Ct. 2853 (2022).

the Challenged Exclusion was reasonably adopted through a thoughtful and fair process or it was not. These issues do not implicate the Plaintiffs' diagnoses.

One need only briefly look to the *Turner* factors—something Defendants have not done—to see that the Minor Plaintiffs' mental condition is not in controversy.

1. *A cause of action for intentional or negligent infliction of emotional distress.*

This basis is inapplicable. None of the Plaintiffs have asserted a cause of action for intentional or negligent infliction of emotional distress. *See, e.g., Peltier*, 2017 WL 4582459, at \*1-2 (denying mental examination where plaintiffs asserted causes of action for sex-based discrimination in violation of the Fourteenth Amendment and Title IX of the Education Amendment of 1972, 20 U.S.C. § 1681 et seq., among others).

2. *An allegation of specific mental or psychiatric injury or disorder.*

This basis is similarly inapplicable. The Minor Plaintiffs have *never* alleged that Defendants' discriminatory actions caused a "specific mental or psychiatric injury or disorder," or that they have sought treatment for and/or were diagnosed with any "specific mental or psychiatric injury or disorder" *as a result of Defendants' conduct*. It is patently insufficient under Rule 35's "in controversy" requirement that the Minor Plaintiffs were *previously* diagnosed with gender dysphoria or other mental and physical health conditions. The relevant inquiry is whether they have sought compensatory damages for a "specific mental or

psychiatric injury or disorder” caused by Defendants’ conduct. As such, “[t]his case is similar to those in which courts have refused mental examinations in that there is no claim of *specific psychiatric injury*, but rather generalized feelings of distress.” *Maha Prabhu, Inc.*, 2008 WL 2559417, at \*3; *see also Winstead*, 315 F.R.D. at 615; *Peltier*, 2017 WL 4582459, at \*2 (denying mental examination of minor plaintiffs after finding they “have pled no cause of action placing their mental state at issue”).

3. *A claim of unusually severe emotional distress.*

This basis is likewise inapplicable. Defendants have not shown the Minor Plaintiffs have alleged that they have suffered unusually severe emotional distress as a result of Defendants’ actions. Indeed, no cause of action in the Complaint involves arises or involves compensation for “unusually severe emotional distress.” “Courts have consistently found that an allegation of ongoing mental distress exposes a plaintiff to *a Rule 35 examination only when the plaintiff intends to seek damages for symptoms or conditions that are more severe than general emotional distress.*” *Conforti v. St. Joseph’s Healthcare Sys., Inc.*, No. 2:17-CV-00050-CCC-CLW, 2020 WL 365100, at \*2 (D.N.J. Jan. 22, 2020) (emphasis added).<sup>5</sup> As such,

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<sup>5</sup> Like the case at hand, *Conforti* involved a transgender plaintiff with gender dysphoria who claimed, inter alia, discrimination on the basis of sex under Section 1557 of the ACA. In *Conforti*, the Court found that “Defendants similarly have not demonstrated that Plaintiff’s gender dysphoria diagnosis is ‘in controversy’ for purposes of adjudicating Plaintiff’s discrimination claims and Defendants’ affirmative defenses. ... Rather, the liability determination in this matter turns on

a “[p]laintiff does not place her mental condition in controversy by alleging that her psychological well being, as well as the psychological well being of all reasonable individuals exposed to like circumstances, is seriously affected by defendants’ behavior.” *Robinson v. Jacksonville Shipyards, Inc.*, 118 F.R.D. 525, 531 (M.D. Fla. 1988); *see also Turner*, 161 F.R.D. at 97 (“This court concludes that ‘emotional distress’ is not synonymous with the term ‘mental injury’ as used by the Supreme Court in *Schlagenhauf v. Holder* for purposes of ordering a mental examination of a party under Rule 35(a), and specifically disagrees ... that a claim for damages for emotional distress, without more, is sufficient to put mental condition ‘in controversy’ within the meaning of the Rule. If this were the law, then mental examinations could be ordered whenever a plaintiff claimed emotional distress or mental anguish.”).<sup>6</sup> Likewise, a “[p]laintiff’s history of depression and anxiety, no matter how extensive or complicated, cannot on its own sustain Defendants’ burden under Rule 35.” *Conforti*, 2020 WL 365100, at \*2. Nor can a parent’s fears of the consequences of the Minor Plaintiffs being denied care have bearing on the

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whether Defendants denied Plaintiff treatment for impermissible discriminatory reasons.” *Conforti*, 2020 WL 365100, at \*2.

<sup>6</sup> Even if there were a sufficient basis to determine that unusually severe emotional distress as a result of Defendants’ actions has been alleged (and there is not), “a claim of unusually severe emotional distress usually must be accompanied by another of the *Turner* factors in order to merit an independent examination.” *Maha Prabhu, Inc.*, 2008 WL 2559417, at \*3. Here, none of the factors are present.

“controlling” and much broader question in this case of whether the medical care targeted by the Challenged Exclusion is experimental.

4. Plaintiff’s offer of expert testimony to support a claim of emotional distress.

This basis is also inapplicable. Plaintiffs have not asserted a cause of action for emotional distress and therefore do not intend to submit expert testimony in support of such a claim. And presenting generalized expert testimony is insufficient to place a party’s mental condition in controversy. *See Peltier*, 2017 WL 4582459, at \*2.

5. Plaintiff’s concession that his or her mental condition is ‘in controversy within the meaning of Rule 35(a).

This factor likewise cannot be met. The Minor Plaintiffs clearly do not concede, and have never conceded, that their mental condition is in controversy.

In sum, Defendants have not shown that Plaintiffs’ mental conditions are in controversy in this case.

**II. Defendants have not shown good cause for the invasive psychiatric examination they request.**

“The law requires the party seeking a Rule 35 order to make an affirmative showing of good cause.” *Pearson v. Norfolk-S. Ry. Co.*, 178 F.R.D. 580, 582 (M.D. Ala. 1998). Rule 35’s “good-cause requirement is not a mere formality, but is a plainly expressed limitation on the use of that Rule.” *Schlagenhauf*, 379 U.S. at 118. It is distinct from, and more stringent than, the general “relevance” standard

contained in Rule 26. Thus, while “an allegation of emotional distress will make a plaintiff’s mental state relevant to the proceedings,” under Rule 35, a movant “must show necessity, which is the element that separates the procedures involving independent medical examinations and other tools of discovery.” *Maha Prabhu, Inc.*, 2008 WL 2559417, at \*2. Only “[w]here the average lay person would have difficulty evaluating *the nature, extent, and cause of the claimant’s injuries*, there is good cause for an independent medical evaluation.” *Id.* (emphasis added).

“To establish ‘good cause,’ the moving party generally must offer specific facts showing the examination is necessary and relevant to the case.” *Robinson v. HD Supply, Inc.*, No. 2:12-CV-604 GEB AC, 2013 WL 3815987, at \*6 (E.D. Cal. July 19, 2013). “The good cause analysis is fact-sensitive, and ‘what may be good cause for one type of examination may not be so for another.’” *Conforti*, 2020 WL 365100, at \*3 (quoting *Schlagenhauf*, 379 U.S. at 118). “Factors considered in assessing whether ‘good cause’ exists include, but are not limited to: (1) the possibility of obtaining desired information by other means; (2) whether plaintiff plans to prove her claim through testimony of expert witnesses; (3) whether the desired materials are relevant; and (4) whether plaintiff is claiming ongoing emotional distress.” *Robinson v. HD Supply*, 2013 WL 3815987, at \*6. Here, Defendants have not shown there is good cause for the intrusive psychiatric examinations they request.

*First*, Defendants have not explained why the desired information can only be obtained through intrusive psychiatric examinations of two young adolescents.

Defendants contend they are “*entitled* to confirm whether or not Plaintiffs suffer from gender dysphoria and whether Plaintiffs have undergone appropriate mental health treatment and whether reversal of their gender affirming treatment will negatively impact their mental health as alleged.” ECF 88 at 4. But not only is that not the case (again, the individual Plaintiffs’ diagnoses are not at issue), but Defendants have not shown *why* an independent psychiatric examination would be necessary in any event.

“One factor that is relevant to the determination of ‘good cause’ is the possibility of obtaining the desired information by other means.” *Marroni v. Matey*, 82 F.R.D. 371, 372 (E.D. Pa.1979) (citing *Schlagenhauf*, 379 U.S. at 118). “When the ‘desired information’ is in essence a treating physician/therapist/psychologist’s records and opinions about a party’s mental injuries, disclosure of those records and opinions—together with the opportunity to depose the party and perhaps the treater—offers a less intrusive means of obtaining similar (if not the same) information.” *Winstead*, 315 F.R.D. at 616; *see also Conforti*, 2020 WL 365100, at \*4. Here, Defendants have not even attempted to seek the information they claim to need through any of those means. Without conceding whether it is appropriate, it is important to note for the Court that Defendants have not sought to depose the Minor

Plaintiffs, depose the Minor Plaintiffs' parents, nor depose any of the Minor Plaintiffs' treating health care providers.

“Defendants have not sustained their burden of specifically demonstrating that the extraordinary remedy of a Rule 35 examination is necessary here.” *Conforti*, 2020 WL 365100, at \*4. Defendants have not utilized or even attempted less intrusive means, instead seeking to subject two young adolescents to intrusive and invasive psychiatric examinations as a matter of first resort.

*Second*, Defendants have not shown why the desired information is not only relevant, but necessary. “Whether good cause is established depends on both relevance and need.” *Pearson*, 178 F.R.D. at 582 (citing 7 Moore’s Federal Practice § 35.04 [1] (Matthew Bender 3d Ed.)); *see also Peters v. Nelson*, 153 F.R.D. 635 (N.D. Iowa 1994)). And as the Eleventh Circuit has explained, “[t]he scope of allowable discovery is determined by the claims (and defenses) raised in the case.” *Chudasama v. Mazda Motor Corp.*, 123 F.3d 1353, 1368 n.37 (11th Cir. 1997).

Indeed, this Court instructed Defendants that should they file a renewed motion, they should “address how any finding from an examination might affect a ruling on the controlling substantive issue of whether treatments at issue are experimental.” ECF 80 at 2. Defendants have failed to do so. They have not explained how an individual Plaintiff’s examination affects the controlling substantive issue before this Court.

By the Challenged Exclusion’s explicit terms and Defendants’ own admission, this case is not about whether medical treatment for gender dysphoria was necessary or appropriate for any plaintiff but rather the “controlling question of whether ‘current medical knowledge’ supports the State’s conclusion that certain treatments for gender dysphoria are experimental.” Defs.’ Opp. to Non-Parties Joint Mot. to Quash, *In re subpoenas served on: Am. Acad. of Pediatrics, et al.*, No. 1:23-mc-00004-CJN (D.D.C. filed on Jan. 20, 2023) (ECF 11), at 18, <https://tinyurl.com/2p8dp36n>. Whether any provider selected by Defendants agrees or disagrees with the gender dysphoria diagnoses of the Minor Plaintiffs (as diagnosed by their treating providers) is wholly irrelevant. Further, it is immaterial whether or not any individual physician believes that these treatments are medically necessary for any singular person or, alternatively, appropriate for any particular given situation. This case is about whether coverage for such treatments can be categorically banned—*i.e.*, whether coverage for such treatments can be prohibited ***without regard*** to the individual circumstances of any transgender patient. Nor can a two-hour examination of a single plaintiff show whether other covered medical treatments could sufficiently treat a plaintiffs’ gender dysphoria.<sup>7</sup>

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<sup>7</sup> In this regard Defendants’ proposed examiner has already reached a conclusion (see ECF 88-1 at ¶¶7, 9) making the examination all the more unnecessary.

In sum, psychiatric examinations of the Minor Plaintiffs cannot change the undeniable fact that the Minor Plaintiffs have been diagnosed with gender dysphoria by their medical providers, nor will such examination assist the Court in determining whether gender-affirming medical care is experimental or whether Defendants reasonably arrived at such determination.

*Third*, given the categorical nature of the Challenged Exclusion and the broad scope of the controlling question, Plaintiffs do not intend to present expert testimony specific to Plaintiffs in order to prove their claims.<sup>8</sup> Because expert testimony specific to the Minor Plaintiffs is not at issue, no psychiatric examinations of the Minor Plaintiffs are warranted or necessary. Both *Conforti* (involving a transgender plaintiff with gender dysphoria) and *Peltier* (involving minor plaintiffs alleging sex discrimination) are instructive on this point. In both cases, the plaintiffs sought to present generalized expert testimony, where the experts had not met with or examined the plaintiffs, did not opine that the plaintiffs had suffered particularized psychological injuries from the defendants' actions or policies, and did not opine on the clinical diagnoses of the plaintiffs. In both cases, the courts found that such expert testimony was insufficient to warrant Rule 35 psychiatric examinations. *See Conforti*, 2020 WL 365100, at \*2; *Peltier*, 2017 WL 4582459, at \*2.

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<sup>8</sup> To be sure, should the Court grant Defendants' request for independent psychiatric evaluations of the Minor Plaintiffs, Plaintiffs would then have their own experts meet with the Plaintiffs to ensure equal footing.

*Fourth*, Plaintiffs are not claiming, let alone asserting causes of action, for any ongoing emotional distress as a result of the Challenged Exclusion beyond what is typical in discrimination cases. “As a direct and proximate result of the discrimination” engendered by the Challenged Exclusion, Plaintiffs only allege that they have suffered “mental pain and suffering and emotional distress.” *See, e.g.*, ECF 1 at ¶265. Such allegations of ongoing distress require no further investigation by psychiatrist or psychologist as they are “not unique” to the Minor Plaintiffs and “can be understood by the lay person.” *Maha Prabhu, Inc.*, 2008 WL 2559417, at \*3–4; *see also Montana v. Cty. of Cape May Bd. of Freeholders*, No. 09-0755, 2013 WL 5724486, at \*4 (D.N.J. Oct. 18, 2013) (“Describing plaintiff’s character traits or stating that he experienced stress and anger after experiencing alleged harassment neither raises plaintiff’s emotional distress claims to a level of severe mental injury, nor does it highlight a specific mental injury.”). “This case is similar to those in which courts have refused mental examinations in that there is no claim of specific psychiatric injury, but rather generalized feelings of distress.” *Maha Prabhu, Inc.*, 2008 WL 2559417, at \*3; *accord Nathai v. Fla. Detroit Diesel-Allison, Inc.*, 268 F.R.D. 398, 401 (M.D. Fla. 2010) (“The only evidence available to the Court are the allegations of emotional distress and mental anguish within the complaint. Beyond these garden variety claims of emotional distress, there are no allegations that Plaintiff suffered any permanent or severe psychological damage.”).

*Fifth*, given that the good cause analysis is fact-sensitive, it is particularly relevant for the Court to understand the context of Defendants' request. As is evident on its face, Defendants' Rule 35 Motion (both the original and the renewed versions) targeted solely the two Minor Plaintiffs in the case; Defendants do not seek psychiatric examinations of the two Adult Plaintiffs. This discrepancy sheds light upon the harassing nature of the request.

Why is the information sought in this motion not necessary to obtain from the Adult Plaintiffs? The answer is simple: It is not necessary at all. And why target the more vulnerable and younger of the Plaintiffs for such intrusive examinations? Defendants do not explain such discrepancy, which one would think is necessary in order to carry their burden of demonstrating with specificity why there is good cause for the requested psychiatric examinations.

Indeed, Defendants' *own conduct* demonstrates that there is no need for psychiatric examinations of the Minor Plaintiffs and that their Motion is meant to harass rather than to elicit *relevant and necessary* information. In taking the depositions of the two Adult Plaintiffs, Defendants spent no more than 30 to 40 minutes examining each. That they have expended little to no time or effort seeking answers to the questions they contend necessitate the examinations of the Minor Plaintiffs significantly undercuts any argument that there is good cause for the examinations. And given that the possibility of obtaining desired information by

other means is a factor in determining good cause for a Rule 35 examination, the fact that Defendants have not attempted to ascertain even *some* of this information by other means (and have not sought to elicit similar information from the Adult Plaintiffs) demonstrates that there is no good cause here. *Accord Maha Prabhu, Inc.*, 2008 WL 2559417, at \*4 (“[T]his Court is not convinced that a wide-ranging intrusion into her privacy is merited especially where the opportunity to have questioned Ms. Sullivan through deposition and interrogatories has passed.”).

**III. Granting Defendants’ motion would be contrary to public policy and would chill the rights of all discrimination victims.**

Here, Plaintiffs are facially challenging as unlawful and unconstitutional a broad, categorical policy denying coverage for medical treatment for gender dysphoria, regardless of individual medical necessity. Defendants have failed to show that psychiatric examinations of the Minor Plaintiffs are warranted under the heightened requirements imposed by Rule 35, as Plaintiffs only assert generalized non-medical allegations of emotional distress and do not seek *any* compensation for any psychological injury caused by Defendants.

Yet, as Defendants would have it, any plaintiff bringing a standard discrimination claim with pre-existing mental health history could be forced to endure an invasive Rule 35 examination for merely exercising their right to seek redress in the judicial system for an act of discrimination. Such a warrantless expansion of a highly invasive discovery mechanism is precisely what the

heightened requirements under Rule 35 are intended to prevent, as it would chill victims of discrimination from coming forward to assert their rights in court and would make unnecessary and invasive medical discovery a routine aspect of civil rights litigation. *See T.C on Behalf of S.C. v. Metro. Gov't of Nashville & Davidson Cnty., Tennessee*, No. 3:17-CV-01098, 2018 WL 3348728, at \*10 (M.D. Tenn. July 9, 2018) (“Close adherence to Rule 35’s requirements is particularly necessary in the context of claims brought under anti-discrimination statutes, where the prospect of being required to undergo a physical or mental evaluation to vindicate protected rights might cause plaintiffs to abandon their claims.”).

Courts have recognized that these concerns are a “good reason for such restraint” in compelling a Rule 35 examination: “Extraordinarily intrusive as they invariably are, such orders would have an unwarranted chilling effect on persons who believe that they have been subjected to unlawful discrimination if they faced a physical or mental examination anytime they sought redress for such perceived discrimination.” *Benham v. Rice*, 2007 WL 8042488, at \*2 (D.D.C. Sept. 14, 2007) (reversing a magistrate judge’s order granting a motion for a Rule 35 examination and for medical records for a plaintiff who “makes a claim for the same type of distress or humiliation attendant to any ‘garden-variety’ claim of discrimination”); *see also Robinson v. Jacksonville Shipyards*, 118 F.R.D. at 531 (“Because claims in this area are measured against an objective standard, a ruling in favor of a mental

examination in this case would endorse mental examinations in every Title VII hostile work environment sexual harassment case.”). “This result is unacceptable and the price would be too high.” *Robinson v. Jacksonville Shipyards*, 118 F.R.D. at 531 (cleaned up); *cf. Schlagenhauf*, 379 U.S. at 122 (“The plain language of Rule 35 precludes such an untoward result.”); *Turner*, 161 F.R.D. at 97 (“Rule 35(a) was not meant to be applied in so broad a fashion.”).

Defendants have offered no compelling basis or specific facts that would warrant subjecting the Minor Plaintiffs to the “sweeping examinations” of Rule 35. *Schlagenhauf*, 379 U.S. at 121. Defendants vague and conclusory statements are insufficient under existing case law to find either that the Plaintiffs’ standard emotional distress allegations in the Complaint place their mental condition “in controversy” or that “good cause” was shown.

#### **IV. Defendants’ chosen psychiatrist is not qualified to conduct the examination at issue and exhibits bias.**

Under Rule 35, a court may only order a party to submit to a Rule 35 examination conducted by a suitably licensed or certified examiner. A court has the “responsibility to determine the suitability of the examiner’s qualifications . . . even [for] a proposed examination by a physician”:

The court is thus expressly authorized to assess the credentials of the examiner to assure that no person is subjected to a court-ordered examination by an examiner whose testimony would be of such limited value that it would be unjust to require the person to undergo the invasion of privacy associated with the examination.

Fed. R. Civ. P. 35 advisory committee's note to 1991 amendment. A court order requiring a party to submit to a Rule 35 examination also "must specify the time, place, manner, conditions, and scope of the examination." Fed. R. Civ. P. 35(a)(2)(B). Thus, not only are neither the "in controversy" nor the "good cause" requirements met, but Defendants' proposed examiner, Dr. Joshua Sanderson, is also not qualified.

First, Dr. Sanderson, who has only six and half years of experience as a child and adolescent psychiatrist (ECF 88-1 at ¶3), has no real documented experience diagnosing and treating gender dysphoria. His claims in this regard seem to be intentionally misleading, if not outright false. Dr. Sanderson claims he has "examined *and treated* thousands of patients (of all ages) who either experience gender dysphoria or identify as something other than their gender assigned at birth." ECF 88-1 at ¶4. Such a claim is ludicrous.

Dr. Sanderson has spent the entirety of his medical studies and career in Louisiana. However, studies, based on data from the CDC's Behavior Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS), show that there are only 4,000 transgender youth (ages 13-17) and 15,700 transgender adults in the state of Louisiana. See Jody L. Herman, et al., Williams Inst., *How many adults and youth identify as transgender in the United States?* (June 2022), at 9, <https://tinyurl.com/33d6pduk>. Dr. Sanderson's claim that he has examined and

treated *thousands* of patients with gender dysphoria or who do not identify with their gender assigned at birth would mean that he has examined and treated over 1,000 such patients, which would represent at least 5% of the entire transgender population of Louisiana. This is simply not possible.

To put a finer point on it, Dr. Sanderson is the medical director of Acadania Treatment Center (“Acadania”), which is a treatment center that provides long-term residential care for adolescents (ages 12-17) who have a primary psychiatric diagnosis (such as schizophrenia, delusional disorder, or oppositional defiant disorder) and adolescents struggling with substance use disorders and addiction. *See* Acadania Treatment Programs & Levels of Care, Acadania Treatment Ctr., <https://www.acadianatreatmentcenter.com/programs> (accessed Feb. 2, 2023). Acadania has only 50 licensed beds. *See* Acadiana Treatment Ctr., Rehab.com, <https://tinyurl.com/2p8fc4m5> (accessed Feb. 3, 2023). And notably, Acadania does not list gender dysphoria amongst the conditions it treats, nor is it ever mentioned on its website. *See generally* <https://www.acadianatreatmentcenter.com/> (accessed Feb. 3, 2023). Pinecrest Supports and Services Center, where Dr. Sanderson provides some services, is a state-run 1,222 bed intermediate care facility for people with intellectual and developmental disabilities. *See* Pinecrest Supports and Servs. Ctr., La. Dep’t of Health, <https://ldh.la.gov/index.cfm/directory/detail/675> (accessed Feb. 3, 2023); Pinecrest Supports and Services Center, CareListings.com,

<https://tinyurl.com/2p89byh2> (accessed Feb. 3, 2023). Dr. Sanderson’s other work is forensic and not clinical in nature, meaning he does not diagnose and treat patients in his Deputy Coroner or Civil Court Testimony capacities. If one were to take the bed capacity at Acadania (50) and Pinecrest (1,222) and multiply each by: (1) the years Dr. Sanderson worked there (2 years at Acadania and 5 years at Pinecrest); (2) a factor of four (generously assuming a full turnover of the patient population every quarter); and (3) the proportion of the population ages 13 and up that is transgender (0.6%),<sup>9</sup> Dr. Sanderson could have *at most* encountered 150 transgender patients (assuming no other providers and not accounting for other variables).<sup>10</sup>

By contrast, Plaintiffs’ expert, Dr. Dan H. Karasic, has treated thousands of transgender patients over a career dedicated to this population and spanning over 30 years. ECF 11-3 at ¶7. Similarly, Dr. Randi C. Ettner, “a clinical psychologist with over 35 years of experience treating ... people, almost one third of whom were minors, with gender dysphoria and issues related to gender variance,” has worked with just “over 3,000 people.” *C.P. by & through Pritchard v. Blue Cross Blue*

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<sup>9</sup> See Herman, *supra*, at 1. To be sure, this is higher than the estimated proportion of the population that identifies as transgender in Louisiana, which is 0.44%. *Id.* at 9.

<sup>10</sup> For Acadania, 50 beds x 2 years x 4 (quarterly turnover) x 0.006 (proportion of pop. that is transgender) = 2.4 patients. For Pinecrest, 1,222 beds x 5 years x 4 (quarterly turnover) x 0.006 (proportion of pop. that is transgender) = 146.64 patients.

*Shield of Illinois*, No. 3:20-CV-06145-RJB, 2022 WL 17092846, at \*2 (W.D. Wash. Nov. 21, 2022). And Dr. Aron Janssen, a child and adolescent psychiatrist with over 12 years of experience, had seen approximately 300 transgender patients as of 2020. Expert Decl. of Aron Janssen, M.D., *D.H. v. Snyder*, No. 4:20-cv-00335-SHR (D. Ariz. filed Aug. 6, 2020) (ECF 5-4), at, <https://tinyurl.com/46k3ct7f>. It is thus not credible that Dr. Sanderson, whose practice *does not* focus on this population, has examined and treated *thousands* of patients with gender dysphoria or who do not identify with their gender assigned at birth. Such a falsehood shows his lack of credibility and competency to meet the rigorous and discriminating standard required for a Rule 35 examination.

Second, and equally as important, this Court has already noted that “no individual will be required to submit to an examination by a transgender denier or skeptic.” ECF 67 at 2; ECF 80 at 2. Nonetheless, Defendants have proposed a psychiatrist who is just that. While Dr. Sanderson states in a self-serving manner: “I am not a ‘gender dysphoria denier or skeptic,’” ECF 88-1 at ¶6, that is not the requirement the Court set forth and even then he goes on to make categorical statements that call his self-serving proclamation into question.<sup>11</sup> Dr. Sanderson

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<sup>11</sup> Notably, Dr. Sanderson does not affirm that he is not a “transgender denier or skeptic,” instead misquoting this Court’s language by affirming only that he is not a “gender dysphoria denier or skeptic.” This intentional use of language that deviates from this Court’s prior orders leaves open the possibility that he accepts the

categorically *believes* medical and surgical care should not be provided to *anyone* with gender dysphoria “until adulthood,” regardless of whether they have a valid gender dysphoria diagnosis or the severity of their dysphoria. *Id.* at ¶7. Dr. Sanderson also *believes* “the focus of care for individuals with gender dysphoria should be to engage them in exploratory therapy,” regardless of age or individual needs/circumstances. *Id.* Notably, Dr. Sanderson cites no authority for this *belief* because there is none to cite. To be sure, Dr. Sanderson forthrightly notes that he is outside the mainstream of medical opinion. *Id.* at ¶6 (“I disagree with the medical and surgical transition guidelines for gender dysphoria treatment.”).

What is more, so-called “gender exploratory therapy” is an “underdefined paradigm” for which there is “scarce” “discussions of the parameters of this therapeutic mode.” Florence Ashley (2022), Interrogating Gender-Exploratory Therapy, *Perspectives on Psychological Science* 0(0), at 2, 7, <https://doi.org/10.1177/17456916221102325>. It is built on “the premise that trans identities are suspect and often rooted in pathology” and opposes *both* social and medical transition for transgender youth. *Id.* at 1, 7. Indeed, the so-called “Gender Exploratory Therapy Association” submitted comments to the U.S. Department of Education opposing rules interpreting Title IX’s sex discrimination prohibition to

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diagnosis of gender dysphoria but denies or is skeptical about the experiences of transgender people.

encompass gender identity in large part on the basis that it would allow transgender adolescents to be socially affirmed in schools and therefore “severely undermine[] the goals of exploratory therapy” such as “coming to terms with their sexed body.” Letter from Lisa Marchiano, et al., Gender Exploratory Therapy Association, to Office of Civil Rights, U.S. Dep’t of Educ., regarding Nondiscrimination on the Basis of Sex in Education Programs or Activities Receiving Federal Financial Assistance, at 7 (Sept. 11, 2022), <https://www.regulations.gov/comment/ED-2021-OCR-0166-195294>. As such, so-called “gender exploratory therapy” has been critiqued as “indistinguishable from conversion [therapy] practices.” Ashley, *supra*, at 7.<sup>12</sup>

Having no documented experience working with this population except for an incredulous (and demonstrably false) claim based on his *ipse dixit* and having done no published research or peer-reviewed writing on the subject, Dr. Sanderson nevertheless opines categorically that “treatments for gender dysphoria—puberty blockers, cross-sex hormones, surgeries, etc.—are experimental.” *Id.* at ¶9.

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<sup>12</sup> In this context, conversion therapy refers to “interventions aimed at altering an individual’s ... gender identity, an/or gender nonconforming expression in order to promote ... a gender expression/identity aligning with sex anatomy,” “under the premise that a specific ... gender identity, and/or gender expression is pathological.” Am. Acad. of Child and Adolescent Psychiatry, Fact Sheet – Conversion Therapy (Sept. 2019), at 1, 3, <https://tinyurl.com/2n5yk9xn>.

Based on his own statements, Dr. Sanderson is both a “gender dysphoria denier or skeptic” and/or a “transgender denier or skeptic.”

In sum, Defendants bear the burden of satisfying Rule 35’s discriminating standard, including by proposing a suitably qualified examiner. They have not met their burden. Dr. Sanderson’s qualifications, given his fantastical claims of experience, are questionable, if not wholly lacking, and his proffered categorical disagreements with the mainstream of medical opinion demonstrate his status as a “denier or skeptic.” Simply put, Defendants have not shown that Dr. Sanderson can be trusted with conducting an intrusive and invasive examination of any of the Plaintiffs, let alone the two Minor Plaintiffs for which Defendants seek the examinations.

**V. Defendants’ motion is facially deficient.**

Rule 35(a) requires that an order for examination “specify the time, place, manner, conditions, and scope of the examination.” Defendants’ motion fails to specify the time and conditions in which the examinations of the two Minor Plaintiffs would occur and provides vague and insufficient descriptions of the manner and scope of the proposed examinations.

As to the conditions, the motion offers no information, though it states it would “take place remotely.” ECF 88 at 6. This lack of information is fatal. And

Plaintiffs would contend, that as to conditions, safeguards should be put in place to allow the two Minor Plaintiffs to feel safe. *See* Section VII, *infra*.

As to the manner and scope of the examination, Defendants vaguely assert that the examinations would occur “in a manner consistent with generally accepted psychiatric methods of evaluation and testing.” ECF 88 at 6. What are those methods? The motion provides no guidance. Moreover, Dr. Sanderson has explicitly stated that he “disagree[s] with the medical and surgical transition guidelines for gender dysphoria treatment.” ECF 88-1 at ¶6. Yet, “medical care for gender dysphoria has been confirmed as standard care by every relevant medical organization in the United States, including the American Academy of Pediatrics, the American Psychological Association, and the American Academy of Child and Adolescent Psychiatry.” Meredith McNamara, et al., *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria* (July 8, 2022), at 5, <https://perma.cc/XZV3-PBEA>; *see also generally* ECF 34-1. So given his disagreement, what does Dr. Sanderson consider to be “generally accepted”?

The motion further states that the examinations will involve “comprehensive psychiatric evaluation” but does not specify if any psychological testing will be applied and if so, what those tests would be. The motion states that “clinical scales *may* be used that are appropriate measures for gender dysphoria” but does not specify which scales.

Furthermore, the motion states that examinations will involve “a discussion surrounding understanding of consent for medical gender transition.” ECF 88 at 6. But the Minor Plaintiffs are 13 years old. By law, minors that age cannot consent to medical treatment. Consent is provided by a minor’s legal parent or guardian, and Rule 35 does not permit an examination of a minor plaintiffs’ parent. *See P.S. v. The Farm, Inc.*, No. 07-2210-JWL-DJW, 2008 WL 4198597, at \*3 (D. Kan. Sept. 11, 2008) (holding that Defendant cannot rely on Fed. R. Civ. P. 35 to force parent to provide information to medical examiner); *Caban ex rel. Crespo v. 600 E. 21st St. Co.*, 200 F.R.D. 176, 181 (E.D.N.Y. 2001) (“This Court therefore declines to expand the scope of Rule 35 to include representatives and natural guardians of infant-plaintiffs, particularly where a proposal to expand the Rule to encompass ‘agents’ was rejected.”). It is therefore unclear what a discussion involving consent would entail or why it would be appropriate.

In sum, the motion lacks the necessary information *required* by Rule 35 and is therefore facially deficient.

**VI. Defendants’ motion is untimely and would cause undue prejudice to Plaintiffs.**

The Court should also deny Defendants’ motion because it is untimely and would cause undue prejudice to Plaintiffs. Defendants indicated they would seek Rule 35 examinations as far back as mid-October. *See* ECF 66 at 2, 5 (noting that Defendants intended to pursue Rule 35 motions, and the conference where they

indicated as such took place on October 17, 2022). Nonetheless, Defendants waited until January 17, 2023 to first file a Rule 35 motion. *See* ECF 79. Their proposed examiner was so deficient that the Court denied the motion the next day, without prejudice. *See* ECF 80. Defendants then waited an additional two weeks before filing their renewed motion. The renewed motion comes two weeks before the deadline for expert reports. *See* ECF 71.

Notwithstanding their stated intention to seek Rule 35 examinations, Defendants have waited until days before the close of fact discovery and for Rule 26(a)(2) disclosures, as well as weeks after the deadline to serve written discovery (December 21, 2022, as per ECF 67), before making such a request. Should this Court allow Rule 35 examinations of any Plaintiff (which Plaintiffs strongly contend it should not do as neither the “in controversy” nor “good cause” requirements are met), Plaintiffs should have the opportunity to have their own experts meet with the Plaintiffs as well as to conduct written discovery regarding Defendants’ proposed examiner. But the deadline for expert reports is coming in just a few days (February 14, 2023) and the deadline for written discovery requests (December 21, 2022) has long since passed. Moreover, delay of the case, which is set for trial for May 9, 2023, would cause undue hardship to Plaintiffs and prolong the irreparable harms they are experiencing.

Plaintiffs urge the Court to not countenance Defendants' eleventh-hour tactics, especially not for examinations that are not meant to elicit information that is relevant, let alone necessary, to answer the ultimate questions in this case.

**VII. Should the Court allow the Rule 35 examinations—which it should not—it should order conditions in which they would occur that protect the Minor Plaintiffs' safety.**

As noted above, Defendants have not specified the conditions in which the Rule 35 examinations would take place, which should on its own be grounds to deny the motion. However, should the Court be inclined to allow Defendants' Rule 35 examinations of the Minor Plaintiffs (which it should not), Plaintiffs request that the Court order certain conditions:

1. The Minor Plaintiffs should be accompanied by their parents.

Not only would this occur normally during the course of routine treatment for minors the age of the Minor Plaintiffs, but Florida's rules regarding such examinations, which should be instructive, specify that:

“Any minor required to submit to examination pursuant to this rule shall have the right to be accompanied by a parent or guardian at all times during the examination, except upon a showing that the presence of a parent or guardian is likely to have a material, negative impact on the minor's examination.”

Fla. R. Civ. P. 1.360(a)(1)(C). This condition would also permit the Minor Plaintiffs to feel safe and supported during an examination.

2. The examiner must respect the Minor Plaintiffs gender identity and refer to them by the pronouns consistent with that identity.

Should the Court be inclined to permit Defendants' requested examinations to proceed, Plaintiffs request that the Court instruct that such examination be conducted in a "trans-affirmative" manner, respecting the Minor Plaintiffs' gender identity including by using their pronouns (she/her for Susan Doe and he/him for K.F.). *See* Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 AMERICAN PSYCHOLOGIST 832, 837 (2015), <https://www.apa.org/practice/guidelines/transgender.pdf> ("Services that psychologists provide to TGNC people require a basic understanding of the population and its needs, as well as the ability to respectfully interact in a trans-affirmative manner."). Courts have imposed such conditions in the context of Rule 35 examinations. *See Eller v. Prince George's Cnty. Pub. Sch.*, No. CV TDC-18-3649, 2019 WL 13108488, at \*2 n.2 (D. Md. Oct. 18, 2019) ("The Court directs that Dr. Cephus's examination shall be conducted in a 'trans-affirmative' manner and that Ms. Eller's gender identity be respected through the use of female pronouns.").

3. Additional Conditions may be necessary.

Aside from having the parents present, additional conditions may be necessary to protect the safety and comfort of the Minor Plaintiffs. For example, whether the Minor Plaintiffs' therapists should be also present. And similarly, whether the examination should in any way be recorded are questions that would need to be

addressed and resolved. Such conditions may be appropriate in this case considering Dr. Sanderson's, at best, exaggerations about his experience, his testimony that he deploys a treatment paradigm that has been critiqued as conversion therapy, and that he has already spelled out in his declaration his preconceived notions about the care appropriate for the Minor Plaintiffs.

Courts have permitted third-party observers in examinations of minor plaintiffs when appropriate. *See, e.g., C.F.B. by & through Baker v. Hayden*, No. 16-CV-2645-CM-GLR, 2018 WL 420030, at \*3 (D. Kan. Jan. 16, 2018); *Vreeland v. Ethan Allen, Inc.*, 151 F.R.D. 551, 551 (S.D.N.Y. 1993). Courts have similarly permitted the recording of psychiatric examinations. *See, e.g., Sidari v. Orleans Cnty.*, 174 F.R.D. 275, 291 (W.D.N.Y. 1996) (“Being an interpersonal exchange between two persons, there is by definition, a subjective component to a psychiatric examination. Thus, although it may not be required as a matter of law, the Court will direct that the mental examination be recorded by a mechanical audio tape recorder.”); *Di Bari v. Incaica Cia Armadora, S.A.*, 126 F.R.D. 12, 14 (E.D.N.Y. 1989) (“The undersigned agrees with plaintiff’s counsel that a psychiatric examination by defendant’s doctor is in reality adversarial in nature. . . . As such, the plaintiff will be allowed to have a court reporter present during the examination.”); *Zabkowicz v. W. Bend Co.*, 585 F. Supp. 635, 636 (E.D. Wis. 1984) (“The defendants’ expert is being engaged to advance the interests of the defendants;

clearly, the doctor cannot be considered a neutral in the case. ... In sum, I do not believe that the role of the defendants' expert in the truth-seeking process is sufficiently impartial to justify the license sought by the defendants. Accordingly, the plaintiffs, at their option, are entitled to have a third party (including counsel) or a recording device at the examination.”).

### **CONCLUSION**

Defendants are not entitled to Rule 35 examinations of any Plaintiff. And such examinations are not routine. To the contrary, they are to be allowed under the most stringent of circumstances after a discriminating review. Defendants have not their stringent burden here. They have not shown that the Minor Plaintiffs' mental condition is “in controversy” or that they have “good cause” for the examinations. What is more, their proposed examiner is not qualified based on his demonstrably false representations and the fact that he is, in fact, a transgender denier or skeptic.

For all the aforementioned reasons, Plaintiffs respectfully request that the Court deny Defendants' Renewed Motion for Rule 35 Examinations.

Dated this 4<sup>th</sup> day of February 2023.

Respectfully Submitted,

/s/ Omar Gonzalez-Pagan

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**CERTIFICATE OF SERVICE**

I hereby certify that on this 4th day of February 2023, a true copy of the foregoing has been filed with the Court utilizing its CM/ECF system, which will transmit a notice of electronic filing to counsel of record for all parties in this matter registered with the Court for this purpose.

**CERTIFICATE OF WORD COUNT**

As required by Local Rule 7.1(F), I certify that this Motion contains 7,991 words.

/s/ Omar Gonzalez-Pagan  
Omar Gonzalez-Pagan

Counsel for Plaintiffs

# EXHIBIT E

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

AUGUST DEKKER et al.,

Plaintiffs,

v.

CASE NO. 4:22cv325-RH-MAF

JASON WEIDA et al.,

Defendants.

\_\_\_\_\_ /

**ORDER DENYING THE MOTION  
FOR RULE 35 EXAMINATIONS**

For the reasons set out on the record of the hearing on February 6, 2023,

IT IS ORDERED:

The defendants' renewed motion to compel Rule 35 examinations, ECF  
No. 88, is denied.

SO ORDERED on February 6, 2023.

s/Robert L. Hinkle

United States District Judge