

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

KANAUTICA ZAYRE-BROWN,

Plaintiff,

v.

NORTH CAROLINA DEPARTMENT
OF ADULT CORRECTION, *et al.*,

Defendants.

No. 3:22-cv-191

**PLAINTIFF'S REPLY BRIEF IN IN SUPPORT OF HER MOTION FOR
PARTIAL SUMMARY JUDGMENT**

Nothing in Defendants' opposition to Plaintiff's motion changes the fundamental dynamic in this case: every single health care provider in the record who has expertise in gender-affirming care, and every single health care provider who has personally examined Plaintiff, agrees that gender-affirming surgery is necessary to treat her gender dysphoria. Moreover, a non-incarcerated person in Plaintiff's shoes—which Defendants agree should be the standard—could undoubtedly obtain this treatment as a medically necessary, non-elective procedure. (*See* Doc. 63 at 6-7.)

Defendants' opposition largely boils down to this: Plaintiff has not experienced enough pain to need surgery. If only she had greater outward signs of distress or made greater efforts to harm herself, Defendants might change their minds. That view, however, finds zero support in any clinical criteria or standard of care. Under

the only standard of care recognized by the Fourth Circuit and the medical community, to qualify for surgery, a patient must have persistent gender dysphoria that does not abate with other therapies—Plaintiff’s situation exactly. Nor does Defendants’ view comport with the Eighth Amendment. Prison officials may not “withhold treatment from an inmate who suffers from a serious, chronic disease until the inmate’s condition significantly deteriorates.” *Gordon v. Schilling*, 937 F.3d 348, 359 (4th Cir. 2019).

When assessing all this evidence, a reasonable trier of fact would have to side with Plaintiff. It would take an *unreasonable* trier of fact to side with Defendants. Therefore, Plaintiff’s motion should be granted.¹

¹ On claims for equitable relief, the court is usually the trier of fact. There is no right to a jury trial for equitable relief, “which only the court can award.” *Hanwha Azdel, Inc. v. C & D Zodiac, Inc.*, No. 6:12-cv.00023, 2013 WL 3989147, at *1 (W.D. Va. Aug. 2, 2013). At summary judgment, district courts can make credibility determinations on such claims because they would otherwise still be resolved by the court in a bench trial. *E.g.*, *Porter v. Clarke*, 290 F. Supp. 3d 518, 531 n.10 (E.D. Va. 2018) (granting plaintiffs summary judgment on Eighth Amendment claim after weighing the “competing experts’ opinions” in a way that “would be left to the Court” at a bench trial), *aff’d*, 923 F.3d 348 (4th Cir. 2019).

Defendants have demanded a jury trial, but they only have a right to a jury trial on Plaintiff’s state constitutional claim for damages. *See Johnson v. Randle*, No. 10-cv-0135-SCW, 2013 WL 5647142, at *4 (S.D. Ill. Oct. 15, 2013) (bench trial was held on Eighth Amendment claim for injunctive relief and jury trial on damages claim). And as described below, the factual issues on Plaintiff’s Eighth Amendment injunctive-relief claim and state damages claim are different: The former concerns whether Defendants are being deliberately indifferent *now*; the latter whether Defendants were deliberately indifferent when they denied surgery in February 2022, and if so, the amount of damages owed. Therefore, if necessary, the Court can resolve any factual disputes at this stage to resolve Plaintiff’s claims for injunctive relief.

I. Plaintiff's Medical Records and Testimony Establish an Objectively Serious Medical Need.

“The objective component of a deliberate indifference claim is satisfied by a serious medical condition. And a medical condition is serious when it has been diagnosed by a physician as mandating treatment or is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.” *Id.* at 356 (citation and quotation marks omitted). Here, no one disputes that multiple doctors have diagnosed Plaintiff with gender dysphoria, prescribed treatment, and recognized the risks of harm she faces without adequate treatment. This uncontradicted evidence satisfies the objective prong of Plaintiff’s Eighth Amendment claim.

Defendants disagree, but cannot cite a single case holding that gender dysphoria is not an objectively serious condition, or even that a reasonable trier of fact could reach that conclusion. (*See* Doc. 64 at 24-26.) They instead spend much of their opposition parsing Plaintiff’s medical records. (*Id.* at 2-9.) Defendants say that these records “do not demonstrate any significant history of anxiety, depression, loss of interest, hopelessness, or other indications of significant or worsening symptoms, including suicidal ideation or thoughts of self-harm.” (*Id.* at 3.)

Not so. Plaintiff’s medical records, and the testimony of providers who treated Plaintiff directly, speak for themselves.² Much like the defendants in a recent case granting summary judgment to a plaintiff seeking gender-affirming surgery,

² Plaintiff’s other briefing discusses this evidence in greater detail. (*See* Doc. 63 at 10-20; Doc. 66 at 9 & n.2.)

Defendants here focus exclusively on “occasional reports of feeling better” while ignoring “the many reports showing [Plaintiff] was suffering and demanding adequate treatment for her mental health condition.” *Clark v. Quiros*, No. 3:19-cv-00575-VLB, 2023 WL 6050160, at *19 (D. Conn. Sept. 15, 2023).

Defendants also take issue with Plaintiff’s testimony describing her painful symptoms. They say that her second declaration (Doc. 62-24) offers “personal beliefs, opinion, or conclusory statements” and contradicts her prior testimony. (Doc. 64 at 32.) That is wrong. Plaintiff is not offering opinions but sharing her personal experience. And tellingly, Defendants do not explain why that declaration contradicts her verified complaint, first declaration, and deposition testimony—all of which detail her ongoing pain and repeated pleas for Defendants to help her. (See Doc. 13-2, First Zayre-Brown Decl. ¶¶20, 25-30, 33-34, 45, 49, 51-54; Doc. 62-3, Zayre-Brown Dep. 143:20–144:20, 151:1-14, 156:9-157:7, 161:7-162:3, 164:12-22, 169:9-12, 170:5-171:10.)

Plaintiff has therefore satisfied the objective prong of her Eighth Amendment claim as a matter of law.

I. Defendants Know About Plaintiff’s Need for Surgery but Continue to Deny That Care for Medically Unsound Reasons.

On the subjective prong of Plaintiff’s Eighth Amendment claim, the records show conclusively that Defendants are “intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.” *Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976). That action has “unnecessarily prolonged [Plaintiff’s] pain.” *Sharpe v. S.C. Dep’t of Corr.*, 621 Fed. App’x 732, 734 (4th Cir.

2015) (quotation marks omitted). Defendants’ opposition is meritless.

A. The standard for injunctive relief is what Defendants know now—not what they perceived in the past.

Defendants continue to frame their Eighth Amendment argument in the past tense, asserting that they “were not subjectively aware of an excessive risk of harm that they consciously disregarded” (Doc. 64 at 16; *see also id.* at 14 n.4 (facts in Figler, Caraccio, and Dula declarations “were not known to, and thus could not have been considered by, Defendants, at the time they made their determination”).)

As Plaintiff has explained, that is not the standard for injunctive relief. The test is what Defendants know right now—if “the evidence before a district court establishes that an inmate faces an objectively intolerable risk of serious injury, the defendants could not plausibly persist in claiming lack of awareness[.]” *Farmer v. Brennan*, 511 U.S. 825, 846 n.9 (1994). Therefore, by virtue of the vast record before the Court, Defendants cannot persist in claiming ignorance.

B. Defendants and their experts are not qualified to assess Plaintiff’s need for gender-affirming surgery.

When prison officials make medical decisions without adequate qualifications, they may violate the Eighth Amendment. For example, in *Edmo v. Corizon, Inc.*, which affirmed judgment for the plaintiff, the court explained that the defendants’ experts “lack[ed] meaningful experience directly treating people with gender dysphoria,” and “the more relevant experience for determining the medical necessity of [gender-affirming surgery] is having treated individuals with gender dysphoria, having evaluated individuals for [such surgery], and having treated them post-

operatively.” 935 F.3d 757, 787-88 (9th 2019).

Here, Plaintiff’s opening brief explains that even the Defendants who are doctors have never evaluated a patient for gender-affirming surgery and otherwise have minimal experience with gender-affirming medicine. (Doc. 63 at 9.) In response, Defendants do not argue otherwise. This uncontested dearth of qualifications strongly supports Plaintiff.

Defendants instead rely on expert reports from Dr. Sara Boyd, Dr. Joseph Penn, and Dr. Fan Li. However, as explained in Plaintiff’s contemporaneously filed *Daubert* motions, their testimony is inadmissible under Federal Rule of Evidence 702. Like Defendants, Drs. Boyd, Penn, and Li have never evaluated a patient for gender-affirming surgery, have no expertise in gender-affirming care more generally, and offer opinions that are irrelevant or unreliable. Such inadmissible evidence cannot create a disputed fact issue precluding summary judgment. *See* Fed. R. Civ. P. 56(c)(2) (providing that “material cited to support or dispute a fact cannot be presented in a form that would be admissible in evidence”); *Kadell v. Folwell* 620 F. Supp. 3d 339, 392 (M.D.N.C. 2022) (striking defense expert testimony and granting summary judgment to plaintiffs).³

Even if Dr. Boyd’s testimony is admissible, it helps Plaintiff, not Defendants. Defendants say that Dr. Boyd “absolutely does not agree that surgery is necessary to ‘cure’ Plaintiff’s GD.” (Doc. 64 at 19.) But here is her sworn testimony:

³ Nor could these expert reports support Defendants’ own motion for summary judgment, as Defendants did not rely on these reports in support of that motion. (*See* Docs. 60, 61.)

Q. Do you have any reason to think that Mrs. Zayre-Brown can be cured of her gender dysphoria while she still has a penis or a phallus as she calls it?

A. Based on her statements, I think not.

...

Q. Okay. You mentioned the -- the phrase necessary but not sufficient a little while ago. [] Would you say that removing her phallus and having genital surgery would be necessary but not necessarily sufficient to cure her gender dysphoria?

A. Ultimately, yes. The question of the timing, I think, is a separate issue, but in the long-term sense, yes.

(Doc. 62-1, Boyd Dep. 166:21-25, 167:12-21.)

That testimony is consistent with Plaintiff's argument. Surgery—*in addition* to hormone therapy, psychotherapy, and social transitioning—is necessary to cure or significantly ameliorate her gender dysphoria. Therefore, denying surgery is not “adequate to address the prisoner’s serious medical need.” *De'lonta v. Johnson*, 708 F.3d 520, 526 (4th Cir. 2013).

Defendants also point out Dr. Boyd's opinion that surgery is not necessary as an “immediate intervention.” (Doc. 64 at 19.) Dr. Boyd testified that Plaintiff would likely benefit from surgery while incarcerated, but the procedure would ideally happen outside of prison. (Doc. 62-1, Boyd Dep. 181:12-23.) No court has ever held, however, that prison officials may simply wait out the clock on a prisoner's sentence to avoid providing medical care. *See Mitchell v. Kallas*, 895 F.3d 492, 496 (7th Cir. 2018) (“Prison staff cannot bide their time and wait for an inmate's sentence to expire before providing necessary treatments.”). Moreover, Dr. Boyd's concerns were

specifically about undergoing surgery in the prison environment. (Doc. 65-1, Boyd Rep. at 27, 31; Doc. 65-12, Boyd Dep. 108:4-112:10.) Though still incarcerated, Plaintiff is in a community transition center, not prison, making this particular concern especially irrelevant. (Doc. 62-24, 2nd Zayre-Brown Decl. ¶¶3-4.)

Dr. Ettner's rebuttal report further explains why this assertion does not make sense: "If an individual requires treatment, provision of treatment will be therapeutic regardless of where the patient resides. Would Dr. Boyd similarly claim that a diabetic patient who requires insulin should forego that treatment while incarcerated to receive the greatest benefit?" (Ex. 1, Ettner Reb. Rep. ¶13.)

All told, no one on Defendants' side of this case is remotely qualified to opine on the discrete medical question before the Court. Everyone who *is* qualified supports Plaintiff. Defendants try to diminish those opinions, but their efforts fall short.

Start with the UNC specialists. Defendants discount their opinions because DAC "did not refer Plaintiff to UNC for a medical necessity determination—that determination is for the Department to make." (Doc. 64 at 13.) Whether Defendants requested the evaluation or not, these providers—upon reviewing Plaintiff's medical records and personally evaluating her—saw that their patient was not receiving adequate care and needed surgery. (Doc. 62-17, Figler Decl. ¶10; Doc. 62-18, Caraccio Decl. ¶11; Doc. 62-16, Croft Decl. ¶18.) Simply because Defendants might not have wanted this information does not make it less true or compelling.

As for Dr. Ettner, Defendants cite Dr. Boyd's criticisms that psychologists are generally not qualified to make medical-necessity determinations. (Doc. 64 at 19.) But

Defendants do not argue that Dr. Ettner is unqualified as an expert witness under Rule 702. And multiple courts have expressly found that Dr. Ettner is qualified to opine on the medical necessity of gender-affirming care, including surgery. *See, e.g., Edmo*, 935 F.3d at 787 (“Dr. Ettner . . . [is] well-qualified to opine on the medical necessity of [gender-affirming surgery]”); *C.P. by and through Pritchard v. Blue Cross Blue Shield of Illinois*, 3:20-cv-06145-RJB, 2022 WL 17092846, at *2-3 (W.D. Wash. Nov. 21, 2022) (finding Ettner qualified as “an expert to testify about the medical necessity of gender-affirming care”); *see also Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1192 (N.D. Cal. 2015) (relying on Ettner’s expert testimony in granting a preliminary injunction ordering gender-affirming surgery).

For these reasons, Defendants have not presented any admissible evidence that could tip the scales of this totally one-sided record.

C. Defendants’ bases for denying surgery are medically unsound.

Defendants maintain that refusing surgery was justified for two reasons: Plaintiff was “doing well” and mentally stable, and the evidence on the efficacy of gender-affirming surgery is mixed. On their face, both reasons are medically unsound.

i. Plaintiff “doing well” and being mentally stable

Defendants first maintain that surgery is not necessary because Plaintiff was “doing well” and mentally stable. On the issue of mental stability, Defendants say they denied surgery based on the “presentation of GD symptoms,” and not “stability of any existing significant mental health conditions.” (Doc. 64 at 14 (citations

omitted).)

This explanation is not persuasive. First, Defendants do not attempt to justify their reasoning under any clinical criteria, guidelines, standards of care, or professional experience with gender-affirming medicine. Rather, Defendants invoke their own personal criteria, and reject the recommendations of specialists who were applying the standard of care broadly accepted in North Carolina and elsewhere. That is strong evidence of deliberate indifference. *See Edmo*, 935 F.3d at 792 (defendants’ “decision was based on inexplicable criteria far afield from the recognized standards of care”).

Moreover, even if Plaintiff’s gender dysphoria symptoms are “stable”—i.e., not getting worse—Defendants concede that does not mean she is well or has been getting better. (Doc. 62-5, Campbell 30(b)(6) Dep. 183:23-24 (“Q: Does stable imply good?” “A: No, it does not.”). The evidence shows that Plaintiff continues to experience deep psychological pain and face longer term risks without gender-affirming surgery. (Doc. 66 at 9 n.2; Doc. 62-19, Dula Decl. ¶¶8-12; Doc. 61-2, Ettner Rep. ¶¶75-79, 133-35.) Moreover, under the WPATH SOC, a patient does not have to be on the brink of a mental breakdown to need surgery. The essential test is persistent gender dysphoria after other treatments prove ineffective. (Doc. 61-2, Ettner Rep. ¶¶48-50; Doc 62-17 Figler Decl. ¶¶9-10.)

In the end, it appears Defendants simply think that Plaintiff has not experienced enough pain to need surgery. Defendants also say, however, they are “not withholding treatment until Plaintiff’s condition worsens.” (Doc. 64 at 15.) But that

is *precisely* what Defendants are doing. In the very next sentence, Defendants say they could “approve [surgery] as medically necessary if conditions changed or the other treatments could no longer manage her condition.” (*Id.*) And Defendants have repeatedly suggested that if Plaintiff suffered greater mental instability or made more efforts to harm herself, perhaps they might approve surgery. (*See* Doc. 18 at 10 (distinguishing *Edmo* “because it involved multiple known self-castration attempts and other physical forms of self-harm”); Doc. 66-1 at 1 (making same argument at hearing).)

Of course, that is not the law. The Supreme Court has held that “a remedy for unsafe conditions need not await a tragic event.” *Helling v. McKinney*, 509 U.S. 25, 33 (1993). A reasonable trier of fact could not accept this medically unsound rationale for denying treatment.

i. “Low Quality” Evidence

Defendants further try to justify withholding surgery by arguing that the literature on its efficacy is “mixed” and lacks “[h]igh-[q]uality [r]esearch.” (Doc. 64 at 28.) Multiple courts have rejected this misleading argument. This Court should too.

For starters, this argument is irrelevant to the specific facts of this case. Defendants concede that, despite their opinions on the research, surgery can be medically necessary for some patients. (*See* Doc. 60 at 5; Doc. 10-1, EMTO Policy at 7.) And they offer zero evidence that surgery would be dangerous or ineffective *for Plaintiff*. Plaintiff’s providers, on the other hand, do not speak in generalities, but detail why she herself needs surgery. (Doc. 61-2, Ettner Rep. ¶¶133-35; Ex. 1, Ettner

Reb. Rep. ¶¶25, 27; Doc. 62-17, Figler Decl. ¶¶10-11; Doc. 62-19, Dula Decl. ¶¶10-13.)

Defendants rely on the expert report of Dr. Fan Li, a statistician, to argue that studies cited by Dr. Ettner and WPATH “fail to provide rigorous and consistent statistical evidence on the benefits in quality of life and well-being of” gender-affirming surgery. (Doc. 64 at 29.) Dr. Li focuses on the research being “low quality” and lacking randomized control trials. (Doc. 65-15, Li. Rep. at 4.) Dr. Penn’s report makes similar points. (Doc. 65-13, Penn Rep. at 24 n. 6, 32-34.)

Plaintiff explains in her contemporaneously filed *Daubert* motions why these reports and testimony are inadmissible under Rule of Evidence 702. But even if admissible, Plaintiff’s rebuttal reports explain why these opinions are deeply misleading.

Dr. Armand Antommara is a medical doctor and bioethicist. (Ex. 2, Antommara Rep. ¶¶4, 8.) His rebuttal report explains why Dr. Li has imposed inappropriately high standards on the kinds of research that informs medical treatment decisions:

Recommendations in clinical practice guidelines are not based solely on the quality of the evidence, or on “high” quality evidence. Recommendations may appropriately be justified by observational studies. While observational studies are characterized as “low” quality evidence, “low” is a relative term describing the different levels of evidence and should not be misinterpreted as meaning “poor or inadequate.” While a statistician may hold randomized controlled trials up as the “gold standard” of for evidence (Li Report at 8), clinicians must make decisions based on the best, currently available evidence, which includes other types of studies. They cannot tell their patients to come back later after randomized controlled trials have been conducted. Furthermore, there are sound reasons why

randomized controlled trials may not be available or, if available, may not provide “high” quality evidence in particular circumstances. In practice, only a minority of clinical practice guideline recommendations are based on “high” quality evidence. The lack of randomized controlled trials and reliance on “low” quality evidence does not mean that there is not reasonable support for a clinical practice guideline recommendation or that a treatment is not medically necessary.

(*Id.* ¶18.)

Dr. Ettner’s rebuttal report addresses this issue as well: “[L]ess than one in ten medical treatments are supported by rigorous scientific research. . . . Despite a lack of strong evidence and based on national guidelines and clinical recommendation, surgeries such as rotator cuff repair and arthroscopic knee repair are routinely performed. Even vitamin D and aspirin lack what is referred to as ‘high quality’ evidence.” (Ex. 1, Ettner Reb. Rep. ¶19.)

Courts have recognized this reality, rejecting the same misleading argument that Defendants make here. See *Flack v. Wisconsin Dep’t of Health Servs.*, 395 F. Supp. 3d 1001, 1014 (W.D. Wis. 2019) (rejecting “low-quality evidence” argument because it “does not change the fact that the larger medical community considers these treatments to be acceptable”); *Dekker v. Weida*, No. 4:22cv325-RH-MAF, 2023 WL 4102243, at *15 (N.D. Fla. June 21, 2023) (same); *Brandt v. Rutledge*, No. 4:21CV00450 JM, 2023 WL 40373727, at *17 (E.D. Ark. June 20, 2023) (same).

For all these reasons, Plaintiff has established the subjective component of her Eighth Amendment claim as a matter of law.

II. Plaintiff Could Not Allege the Facts in This Case in the North Carolina Industrial Commission.

Defendants maintain that “Plaintiff could seek relief based on [her] contentions in the North Carolina Industrial Commission, and therefore has an adequate state remedy and cannot pursue a State constitutional claim under *Corum*.” (Doc. 64 at 34.) Apparently, Defendants think that Plaintiff could take her complaint in this case, simply call her claims “negligence” instead of constitutional violations, and file that document in the Industrial Commission where she could potentially recover damages.

Plaintiff has explained elsewhere why that is wrong. (Doc. 63 at 30-31; Doc. 66 at 22.) In short, the Industrial Commission lacks jurisdiction over torts that have a *mens rea* greater than ordinary negligence—that is, “allegations of gross negligence and wanton, reckless and malicious conduct[.]” *Collins v. N.C. Parole Comm’n*, 456 S.E.2d 333, 336 (N.C. Ct. App. 1995). Those are precisely what Plaintiff has alleged here: Defendants have intentionally or recklessly denied her medically necessary care. Therefore, a restyled complaint alleging the same facts would be dismissed for lack of jurisdiction. *See id.* (holding that “the Industrial Commission does not have jurisdiction to hear and award damages on plaintiff’s claims” of gross negligence and malicious conduct).

For these reasons, Plaintiff may bring her state constitutional claim. The record establishes Defendants’ liability on that claim as a matter of law. Unlike Plaintiff’s claim for injunctive relief, what Defendants knew in the past is relevant here. And the record shows conclusively that when Defendants denied surgery in

February 2022, they did so (1) having reviewed medical records that demonstrated Plaintiff experiencing persistent gender dysphoria despite her prior treatments, (2) having sent Plaintiff to be evaluated by specialists at UNC specifically for gender-affirming surgery, (3) having reviewed the conclusions of those specialists and Plaintiff's other providers that she needed gender-affirming surgery, and (4) having knowledge of Plaintiff's repeated, urgent pleas for help. (*See* Doc. 63 at 16-19.) A reasonable trier of fact could only conclude that Defendants knew there was a substantial risk that Plaintiff would continue to experience painful symptoms of gender dysphoria.

III. The Record Shows that Plaintiff Was Denied Surgery Because of Her Disability.

Defendants argue that Plaintiff cannot prove that she is “qualified for a government benefit or service[] but . . . was excluded from that benefit or service on the basis of her disability.” (Doc. 64 at 34.) Not so.

First, medical care provided by a prison is obviously a government service. “State prisons fall squarely within the statutory definition of ‘public entity,’ and thus, must provide ‘services, programs, or activities’ in accordance with the ADA’s requirements.” *Doe v. Pennsylvania Department of Corrections*, 2021 WL 1583556, at *12 (W.D. Pa. Feb. 19, 2021) (quoting *Pa. Dep’t of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998)), *report and recommendation adopted*, 2021 WL 1115373 (W.D. Pa. Mar. 24, 2021). Gender-affirming surgery is another form of government-provided medical care expressly contemplated by Defendants’ policy for transgender accommodations. (Doc. 10-1, EMTO Policy at 7.)

Second, Plaintiff qualifies for that service for all the reasons she has given in support of her Eighth Amendment claim: she will continue to suffer the painful effects of gender dysphoria without it.

Third, at least one of the reasons Defendants have refused that service is “because of” the disability itself. *See Baird ex rel. Baird v. Rose*, 192 F.3d 462, 468 (4th Cir. 1999) (discussing ADA causation requirements). The record shows that Defendants have provided gender-affirming surgery to other prisoners—including genital reconstruction—just not to treat gender dysphoria. (Doc. 62-5, Campbell 30(b)(6) Dep. 144:2-19; Doc. 62-19; Dula Decl. ¶16 (patient was denied hysterectomy when recommended for treatment of gender dysphoria, but provided hysterectomy when recommended to treat uterine fibroids).) Indeed, Defendants have *never* approved gender-affirming surgery for gender dysphoria. (Doc. 62-5, Campbell 30(b)(6) Dep. 135:18-136:10.)

Moreover, the Case Summary explaining why Plaintiff should not receive surgery states: “The evidence regarding [gender-affirming surgery] does not provide sufficient confidence that the procedures should be undertaken without concern for having violated [the Hippocratic] oath.” (Doc. 61-2, Ettner Rep., App’x G at 3.) Defendant Campbell—DAC’s chief medical officer—wrote a position statement in March 2022 that “gender reassignment surgery (GRS), as a treatment for gender dysphoria, is not medically necessary.” (*Id.* App’x H at 2.) He provided no exceptions to this rule. And the DTARC Defendants, Defendant Junker, and Defendant Harris

ultimately deferred to Dr. Campbell. (Doc. 62-8, Catlett Dep. 47:7-15; Doc. 62-22, Peiper Dep. 103:20-105:7, 116:1-20; Doc. 62-13, Sheitman Dep. 131:7-18.)

Defendants' arguments here simply rehash their Eighth Amendment arguments that surgery was not medically necessary, and Plaintiff was receiving *some* accommodation, just not the one she wanted. (Doc. 64 at 34.) The first point fails for all the reasons Plaintiff has offered in her briefing. The second point fails because denying a specific treatment may violate the ADA if doing so was discriminatory or a failure to provide a reasonable accommodation. *See Lewis v. N.C. Dep't of Pub. Safety*, No. 1:15-CV-284-FDW, 2018 WL 310142, at *11 (W.D.N.C. Jan. 4, 2018) (denial of specific hepatitis C medication may violate ADA).

Defendants also argue that the case law on this subject is not persuasive because it mostly deals with motions to dismiss. (Doc. 64 at 34.) The subject matter in this ADA claim is indeed relatively new, but the case law shows what kinds of facts, if proven, would establish an ADA violation. Plaintiff has proven those facts here: Defendants provide gender-affirming surgeries to some prisoners, but not to prisoners like Plaintiff who need it to treat gender dysphoria.

Finally, Defendants have not addressed Plaintiff's other ADA claim that surgery is a reasonable accommodation that DAC has failed to provide. (Doc. 1 ¶174 ("DPS is failing to make reasonable modifications to its rules, policies, or practices, necessary to accommodate [Plaintiff's disability].")) Defendants briefly addressed this claim in their opening brief in support of summary judgment, but did not argue that providing surgery would present an "undue hardship" in the form of administrative

or security concerns. (*See* Doc. 60 at 32, 34-35.) They only gave the conclusory statement that “Plaintiff cannot show that the requested surgery was necessary to allow her ‘equal access to prison life.’” (*Id.* at 31.) The record demonstrates otherwise.

A critical aspect of being in DAC custody is rehabilitation. The evidence shows that Plaintiff has been fixated on obtaining medically necessary care, which has inhibited her rehabilitation. (Doc. 62-25, Penn Dep. 210:18-211:4 (“What I would testify to is that she is totally a hundred percent focused on this one surgery to the neglect of her other lifelong issues.”); Doc. 62-3, Zayre-Brown Dep. 153:7-20, Doc. 62-1, Boyd Dep. 181:18-182:20; Doc. 62-23, Bowman Dep. 89:20-91:5; 118:5-21.)

Accordingly, a reasonable trier of fact could only find that Plaintiff was denied gender-affirming surgery because she sought that accommodation for gender dysphoria, and that providing surgery would be a reasonable accommodation.

CONCLUSION

Last year, the Court denied Plaintiff’s motion for a preliminary injunction because granting it “would effectively end this case without the benefit of a factual record,” and a “well-developed record” was necessary to consider Plaintiff’s claims. (Doc. 15 at 4-5.) After nearly a year of discovery, the production of thousands of pages of documents, fourteen depositions, and a Rule 35 examination, that record is now before the Court—and it overwhelmingly favors Plaintiff.

Consequently, Plaintiff’s motion for partial summary judgment should be granted. The Court should immediately order Defendants to provide access to gender-affirming surgery as prescribed by Plaintiff’s treating physicians at UNC. The Court

should also find Defendants liable under Plaintiff's state constitutional claim with the amount of damages to be determined at trial.

Respectfully submitted this 26th day of October 2023.

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CERTIFICATE OF SERVICE

I certify that on October 26, 2023, I electronically filed the foregoing document using the ECF system which will send notification of such filing to all counsel of record.

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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.

Civil Action No. 3:22-cv-00191

EXPERT REBUTTAL REPORT OF DR. RANDI C. ETTNER, PH.D.

1. As stated in my Expert Report dated February 2, 2023 (“Expert Report”) that was previously submitted in this action, I am a clinical and forensic psychologist with expertise concerning the diagnosis and treatment of gender dysphoria. I have actual knowledge of the matters stated herein and could and would so testify if called as a witness.

2. I have been asked by counsel for Plaintiff Kanautica Zayre-Brown (“Mrs. Zayre-Brown” or “Plaintiff”) to provide the Court with my expert opinions addressing the expert reports of Sara Boyd, Ph.D. (“Dr. Boyd”) and Joseph Penn, M.D. (“Dr. Penn”) submitted by defendants in Mrs. Zayre-Brown’s lawsuit seeking gender-affirming surgery. While this expert rebuttal report

does not address all of the deficiencies in the expert reports of Dr. Boyd and Dr. Penn, I have tried to highlight below the most serious errors in them.

3. In preparing this expert rebuttal report, I reviewed the Expert Reports of Sara Boyd, Ph.D., Joseph Penn, M.D., and Fan Li, Ph.D. that were served on Plaintiff's counsel in this action. I also reviewed Dr. Boyd's and Dr. Penn's affidavits in support of Defendants' response to Plaintiff's motion for a preliminary injunction, Dr. Boyd's recorded interview of Mrs. Zayre-Brown and the literature cited in this expert rebuttal report.

4. Both Dr. Boyd and Dr. Penn attempt to diminish the conclusions I set forth in my Expert Report because I am not a medical provider. Their criticism is not warranted. My role is accurately described in *Fields v. Smith*, 712 F. Supp. 2d 830, 838 (E.D. Wisc. 2010): "As part of her role as clinician for clients with GID, Dr. R. Ettner examines clients, and recommends necessary medical treatments.... Her role is to collaborate with medical caregivers, endocrinologists, and surgeons who implement the treatment.... Dr. R. Ettner assesses the intensity of the GID in a given individual, and determines whether or not a particular treatment would be medically necessary." Given my extensive experience evaluating, diagnosing, and treating thousands of individuals with gender dysphoria and mental health issues related to gender dysphoria, my publication of several books related to the treatment of individuals with gender dysphoria, including the medical text *Principles of Transgender Medicine and Surgery* (co-editors Monstrey & Eyler; Routledge

2007) and the 2nd edition (co-editors Monstrey & Coleman), and my other experience detailed in my Expert Report, I am more than qualified to provide the conclusions in my Expert Report, including with regard to the medical necessity of providing gender-affirming surgery to transgender individuals such as Mrs. Zayre-Brown. Courts have expressly so found. *See, e.g., Edmo v. Corizon, Inc.*, 935 F.3d 757, 788 (9th Cir. 2019) (“Dr. Ettner ... [is] well-qualified to opine on the medical necessity of [gender-affirming surgery]”); *C.P. by and through Pritchard v. Blue Cross Blue Shield of Illinois*, 2022 WL 17092846 (W.D. Wash. Nov. 21, 2022) (finding me qualified as “an expert[] to testify about the medical necessity of gender-affirming care”); *see also Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1187-88, 1190, 1192 (relying on my expert testimony in granting a preliminary injunction requiring prison officials to provide an incarcerated individual gender-affirming surgery). I have never been found by a Court to not be qualified to opine on an issue concerning treatment for gender dysphoria, and I have been a court-appointed expert in a matter regarding surgery for an incarcerated transgender woman (*Soneeya v. Bender*, Case No. 07-12325-DPW (D. Mass.)).

REBUTTAL TO THE EXPERT REPORT OF DR. BOYD

5. Dr. Boyd attempts to buttress her qualifications with new assertions regarding her experience, not delineated in her prior declaration in opposition to Plaintiff’s motion for a preliminary injunction. Dr. Boyd states that she performs mental health assessments on incarcerated gender dysphoric

and transgender patients, some for the purpose of assessing gender-affirming care. Glaringly, however, she neglects to specify the nature of the gender-affirming care she recommends. Given her emphatic view that psychologists cannot make “medical” recommendations (Boyd Expert Report, p. 5), one is left to conclude that Dr. Boyd has never recommended surgery for any gender dysphoric patient. Indeed, she does not disclose whether she has ever authored the surgical referral letters qualified mental health professionals transmit to surgeons, nor how many patients she has followed post-surgery, nor how many patients she has assessed who have undergone vulvoplasty (all of which I have done on numerous occasions).

6. Since Dr. Boyd is, by her own admission, unable to opine on the medical necessity of Mrs. Zayre-Brown receiving gender-affirming surgery (Boyd Expert Report, pp. 2, 5), her opinions fall back on generic psychological statements, such as asserting that “The source of Mrs. Zayre-Brown’s Gender Dysphoria appears multifaceted, with psychosocial, cultural, identity, environmental and interpersonal factors...” and that Mrs. Zayre-Brown’s need for treatment is “significantly dependent on the setting where she is residing.” The source of Mrs. Zayre-Brown’s gender dysphoria is her status as a woman with a phallus. This remains an incontrovertible, distressing fact—in all settings in which she may reside. Despite Dr. Boyd’s assertion that she is unable to opine on the necessity for surgical treatment, no compunction appears to prevent her from opining at pp. 3, 23, and 34 of her expert report that Mrs.-

Zayre Brown should wait for her release from prison to obtain surgery, without considering the harms and risks to Mrs. Zayre-Brown of such a delay.

7. Dr. Boyd appears to believe that psychologists can opine on treatment for gender dysphoria being psychologically necessary, but not on it being medically necessary. This is a false dichotomy with regard to gender dysphoria treatments. By analogy, would she say that treatment of disfiguring facial burn wounds is “psychologically necessary” but not medically necessary, and the patient doesn’t require skin grafting? If significant distress arises from an underlying medical condition, only adequate treatment of the medical condition provides relief. This explains why neither psychotropic drugs nor talk therapy alone are efficacious in treating gender dysphoria.

8. In the area of gender dysphoria, psychologists are not prohibited from making recommendations concerning medical necessity, and to my knowledge, historically have always done so. Dr. Boyd has cherry picked some statements from the WPATH Standards of Care (“SOC”), but what she asserts reveals that she lacks familiarity with the document’s guidelines. The SOC outlines the tasks of mental health professionals working with adults who present with gender dysphoria which include that they “assess eligibility, prepare, and refer for hormone therapy” and “[i]f applicable, assess eligibility, prepare and refer for surgery.” SOC 7, pp. 25, 26. The guidelines have addressed the role of the mental health professional since first promulgated in 1979. I am an author of the two most recent SOC iterations (the 7th and 8th versions).

9. Much of Dr. Boyd's report is a critique of my assessment of Mrs. Zayre-Brown. Dr. Boyd is critical of the instruments I use, and instead administered personality tests to Mrs. Zayre-Brown, including the Minnesota Multi-Phasic Personality Inventory (MMPI). Psychologists who work with this population do not administer personality tests when assessing treatment needs, as such tests have no probative value regarding that assessment. A systematic review of the administration of psychometric tests in transgender individuals requesting surgical treatment questioned the utility in this patient population (Lehmann & Leavey, 2020). As Keo-Meier and Fitzgerald explain:

"The most widely used personality instrument is the MMPI.... It is commonly used in evaluations that have an impact on personnel selection and custody hearings, areas where transgender people are typically discriminated against.... Those who are using assessment instruments [such as the MMPI] to help answer the question of whether or not a client is ready for medical transition are using tools that were not created for the purposes they are used for. This is akin to attempting to screw on a lightbulb with a hammer."

The only probative information in the personality tests administered by Dr. Boyd is that they show that Mrs. Zayre-Brown is not malingering. (Boyd Expert Report, p. 18.)

10. Most baffling is Dr. Boyd's lengthy discussion of informed consent. Dr. Boyd appears to be conflating the procedure-specific informed consent process that occurs between provider and patient (which includes discussion and the provision written materials outlining, among other things, potential risks, benefits, alternatives, and pre-procedure and post-procedure

instructions regarding a particular treatment, in accordance with AMA guidelines) with what is referred to as “the informed consent model of gender-affirming care.” Dr. Boyd drastically misunderstands the latter. The informed consent model of gender-affirming care is offered in some clinics to *broaden* access to care for transgender patients. The model was created in the early 2000’s to eliminate the necessity of mental health assessment, which some perceive as a barrier to care. Clinics such as Callan Lourde in New York City, Howard Brown Health Center in Chicago. and Fenway Clinic in Boston are examples of facilities that provide hormones to transgender patients eighteen years and older, typically at low cost, upon their consent and without the kind of mental health assessment required by WPATH. For example, Dr. Scott Mosser, a San Francisco surgeon, describes the implementation of the model:

“Dr. Mosser follows the informed consent model and generally does not require letters for FTM/N or MTF/N top surgery, or other body masculinization or feminization procedures (except in the case of individuals 17 years of age or younger).... So, letters are welcome and valuable but often not required for surgery. If you are an insightful, mature individual 18 years or older, with an adequate support system and are capable of informed consent based on an educated experience of the risks and benefits of surgery, Dr. Mosser does not require a therapist letter.”

https://www.genderconfirmation.com/about_us/. Ironically, Dr. Boyd uses the Cavanaugh, Hopwood, & Lambert article, to buttress her flawed argument. However, the authors, who are affiliated with the Fenway Clinic, use this very article to endorse the informed consent model, as it “seeks to acknowledge and better support the patient's right to, and capability for, personal autonomy in

choosing care options without the required involvement of a mental health professional.” In other words, under the informed consent model, surgical intervention is an option if the patient deems it necessary—which is not the approach WPATH or I follow.

11. Despite her protracted discourse regarding informed consent, Dr. Boyd ultimately concludes that Mrs. Zayre-Brown understands her options, the risks and benefits, and the potential functionality and cosmesis (resulting appearance) of surgically reconstructed genitalia. However, she asserts (at p. 31 of her expert report) that Mrs. Zayre-Brown has less than realistic expectations regarding post-surgical care in prison. This is not an indication of Mrs. Zayre-Brown’s naivete, but rather, it is indicative of Dr. Boyd’s lack of knowledge of what vulvoplasty surgery entails. The post-surgical care for vulvoplasty is simple wound care that prisons regularly are and should be able to easily provide: cleaning, changing of dressings, and surveillance, as with any surgical procedure.

12. Dr. Boyd repeatedly asserts unsupported conclusions as to what I did or did not consider (as well as what Dr. Figler discussed with Mrs. Zayre-Brown). For example, Dr. Boyd criticizes me for not referencing Mrs. Zayre-Brown’s medical records, “one of which was serious enough to send her to an emergency room.” I reviewed and considered all of Mrs. Zayre-Brown’s medical records. My report acknowledges the telltale suicidal ideation and thoughts of surgical self-treatment known to portend risk in incarcerated patients. In

conflict with Dr. Boyd's recognition of the seriousness of Mrs. Zayre-Brown's condition requiring that she go to the emergency room, Dr. Penn dismisses this same incident as inconsequential. This is but one example of the "Catch-22" paradox of defendants' expert rebuttals: They ignore Mrs. Zayre-Brown's acute distress, insisting she is stable, even though stability is one of the criteria for providing gender-affirming surgery. I have described in detail in my Expert Report my opinions regarding Mrs. Zayre-Brown and the bases for them, and Dr. Boyd's viewpoint in no way alters or diminishes my opinions and conclusions.

13. Dr. Boyd's assertion that Mrs. Zayre-Brown "would not derive the greatest psychological benefit from delivering the surgical intervention in the carceral setting" is nonsensical. If an individual requires treatment, provision of treatment will be therapeutic regardless of where the patient resides. Would Dr. Boyd similarly claim that a diabetic patient who requires insulin should forego that treatment while incarcerated to receive the greatest benefit?

14. The SOC 8 makes clear (at S106) the importance of not withholding surgical care:

"(Transgender) people with Gender Dysphoria should have an appropriate treatment plan to provide medically necessary surgical treatments with similar elements to those who reside outside institutions (Brown 2009; Adams v. Federal Bureau of Prisons, No. 09-10272 [D. MO June 7, 2010]; Edmo v. Idaho Department of Corrections, 2020). The consequences of denial or lack of access to gender affirming surgeries for residents of institutions who cannot access such care outside of their institutions may be serious, including substantial worsening of gender dysphoria symptoms, depression, anxiety, suicidality, and

the possibility of surgical self-treatment (e.g., autocastration or autopenectomy; Brown, 2010, Maruri, 2011; Edmo v. Idaho Department of Corrections, 2020). It is not uncommon for residents of institutions to be denied access to evaluation for gender affirming surgery as well as denial of the treatment itself, even when medically necessary (Kosilek v. Massachusetts/Dennehy, 2012; Edmo v. Idaho Department of Corrections, 2020). The denial of medically necessary evaluations for, and the provision of, gender affirming surgical treatments and necessary aftercare is inappropriate and inconsistent with these Standards of Care.”

The WPATH SOC promote the highest standards of health care for individuals, based on the best available science and expert professional consensus. All major medical professional associations endorse treatment in accordance with the WPATH SOC. Notably, neither Dr. Boyd nor Dr. Penn assert that Mrs. Zayre-Brown does not meet these standards.

15. Having worked with thousands of gender dysphoric patients since 1978, having followed hundreds of patients pre- and post-surgery, and having had access to follow up data on patients at hospitals where I have been on staff or provide consultation, I can attest that surgical removal of primary sex characteristics inconsistent with an individual’s gender identity is medically necessary for some individuals and can be curative for gender dysphoria.

REBUTTAL TO THE EXPERT REPORT OF DR. PENN

16. Like Dr. Boyd, Dr. Penn’s report contains additional experiences he has not previously disclosed. Despite this amplification, there is no indication that Dr. Penn has ever evaluated and supported any incarcerated or non-incarcerated transgender person’s need for surgical intervention, nor does

he state having provided referral letters to, or consulting with, surgeons regarding patient surgical procedures or collaborating in post-surgical care, as instructed in the NCCHC guidelines to which Dr. Penn provides a link.

17. Dr. Penn's critique that I do "not work in correctional settings" is of no relevance, given that I have evaluated a large number of gender dysphoric prisoners in jails, state correctional facilities throughout the US, immigration detention centers, federal prisons, US. Army correctional facilities, and custodial facilities for the criminally insane. I also have been a consultant to carceral institutions developing or revising policies for the care of transgender prisoners. In addition, I am the author of the SOC 8 chapter on Institutionalized Persons and the Chair of the WPATH committee on Incarcerated Persons.

18. Dr. Penn's prior declaration, submitted in opposition to Plaintiff's motion for a preliminary injunction, raised objections based on cost, security concerns, and post-surgical care. In his Expert Report, however, he appears to abandon those arguments, instead raising new issues in a kitchen-sink attempt to support his forgone conclusion.

19. Dr. Penn asserts the flawed premise that the determination of medical necessity depends on whether a proposed treatment "is supported by rigorous scientific evidence." (Penn Expert Report, pp. 8, 33.) In fact, less than one in ten medical treatments are supported by rigorous scientific research. In a sample of 1,567 interventions studied within Cochrane reviews, Journal of Clinical Epidemiology found 94% were not supported by rigorous scientific

evidence.¹ Despite a lack of strong evidence and based on national guidelines and clinical recommendation, surgeries such as rotator cuff repair and arthroscopic knee repair are routinely performed. Even vitamin D and aspirin lack what is referred to as “high quality” evidence. Dr. Penn’s assertion that high levels of evidence must undergird medical recommendations completely discounts clinical judgment and is even in opposition to the NCCHC 2020 position statement on transgender healthcare advising reliance on “*clinical decision making*” to initiate or advance hormone medication treatment or candidacy for surgical interventions” (emphasis added) and indicating that such decisions should be made on a case-by-case basis.² Providers have relied on their training and clinical judgment to provide case-by-case recommendations regarding medical treatment long before the GRADE assessment rating system was established and continue to do so.

20. Ultimately, Dr. Penn belies his expertise in gender dysphoria treatment by his offensive and dismissive comparison of genital surgery to, among other things, the removal of a mole or droopy eyelids (Penn Expert Report, p. 26). This egregious lack of understanding of the seriousness of gender

¹ Howick, J., Koletski, D., Joannidis, J. et al., Most healthcare interventions tested in Cochrane Reviews are not effective according to high quality evidence: a systematic review and meta-analysis. *Journal of Clinical Epidemiology*, 148; 2022.

² <https://www.ncchc.org/transgender-and-gender-diverse-health-care-in-correctional-settings-2020-2/>, at p. 3.

dysphoria, the consequences of failure to treat the condition adequately, and the suffering of individuals afflicted, is a priori evidence of Dr. Penn's lack of meaningful experience with this population.

21. Dr. Penn's assertion that the definition of medical necessity differs based on how a procedure is paid for or whether an individual is incarcerated (Penn Expert Report, pp. 21-23) is incorrect. The need for and efficacy of surgery is the same regardless of these factors. Dr. Penn also is incorrect in the accusation (at p. 23 of his expert report) that the WPATH positions regarding medical necessity are "dismissive of the need of an individual evaluation of each patient" or the patient's informed consent, both of which the SOC require. Dr. Figler, Dr. Caraccio, Dr. Umesi, MSW Dula, and I all used the appropriate medical necessity criteria in reaching conclusions regarding the provision of gender-affirming surgery for Mrs. Zayre-Brown. As I have pointed out previously, Dr. Penn ignores the recommendations of these providers and their use of this criteria. Moreover, the Federal Bureau of Prisons and numerous state prisons also rely on these same criteria when implementing gender-affirming surgery.³

22. Dr. Penn resorts to rhetorical strategy in criticizing my use of the descriptor "severe." This is a fatuous argument, given that this determination

³ See *Iglesias v. Federal Bureau of Prisons*, 2021 WL 6112790, at *3 (S.D. Ill. Dec. 27, 2021); *Monroe v. Baldwin*, 424 F. Supp. 3d 526, 532-33 (S.D. Ill. 2019); *Edmo v. Idaho Dept. of Corrections*, 358 F. Supp. 3d 1103, 1115-16 (D. Idaho 2018); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1171-72, 1176 (N.D. Cal. 2015).

is common among those who evaluate and treat gender dysphoria (and some other conditions, as well). Brown, in Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder writes: “With no other viable options, *severe gender dysphoria* in prisons that do not provide transgender health care may lead to desperate measures of self-treatment through permanent removal of the testes and/or penis in the absence of comorbid psychosis or substance use disorders” (italics added) (2010). Dr. Penn himself uses the term to describe Mrs. Zayre-Brown’s condition as “not severe.” A study of phenomenology of gender dysphoric patients published in *Clinical Psychology Review* found: “for some participants, this feeling of disgust towards their body led to suicidal thoughts or self-harm; individuals felt that death was preferable to continuing to live in their body.” It is not surprising that clinicians would characterize these feelings as “severe.”

23. Dr. Penn’s critique that my expert report rested on whether “the contemplated intervention could provide [only] some therapeutic benefit to the patient” (Penn Expert Report pp. 8, 25-26) is wrong. Instead, it rests on the seriousness of Mrs. Zayre-Brown’s gender dysphoria, the failure of prior treatments to attenuate that gender dysphoria, and the utility of surgical treatment in achieving this outcome.

24. It is troubling that Dr. Penn objects to treatment suggesting that there may be other stressors in prison. This is not justification for withholding treatment that will alleviate an existing condition regardless of those stressors

nor is it a justification for prolonging the suffering of Mrs. Zayre-Brown or other individuals with her condition.

25. It is not true that “there was a lack of any clinical indication that without the vulvoplasty Plaintiff was at serious risk of some severe distress, harm, or disability.” (Penn Expert Report, pp. 28-29). For example, in addition to my own clinical assessment of Mrs. Zayre-Brown and that of Drs. Figler, Carcaccio, Umesi, and MSW Dula (all of whom were chosen by the defendants in this lawsuit to evaluate and/or treat Mrs. Zayre-Brown), medical records indicate that in December 2020, Mrs. Zayre-Brown was hospitalized for a month, resulting from voicing suicidal ideation and a desire to amputate her penis. In April of 2021, Mrs. Zayre-Brown informed her DPS mental health provider that she had a band tied around her penis that had been in place for more than a week. Dr. Penn brushes aside these incidents because they are self-reported and did not result in genital injury or completed suicide. Would he similarly brush aside a patient who describes panic disorder because the behavior is self-reported, and the patient did not sustain bodily harm when the alleged attack caused sensations of chest pain and feelings of choking?

26. Although Dr. Penn is correct in delineating the criteria for *diagnosing* gender dysphoria (i.e., clinically significant distress that impairs some aspect of functioning), there is no controversy regarding Mrs. Zayre-Brown’s *diagnosis*. At issue is her current *treatment* requirements. Mrs. Zayre-Brown had a ligature strangulating the blood supply to the penis, in order to

facilitate amputation. Dr. Penn ignores this and other indicia of harm, instead asserting that Mrs. Zayre-Brown's harmonious family relations and her ability to work in the commissary are a priori evidence that her suffering is insignificant—a conclusion that cannot be justified.

27. Dr. Boyd's and Dr. Penn's critiques notwithstanding, it is my opinion that the benefit to Mrs. Zayre-Brown of undergoing gender-affirming surgery is great, and far outweighs the very minimal risk of surgery. Given the suffering she has experienced—an anguish known to intensify with age—it is medically necessary for her to undergo surgery now, rather than prolonging the suffering she experiences as a woman with detested male genitalia.

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

Executed this 26 day of July, 2023.

Dr. Randi Ettner Ph.D.
Dr. Randi Ettner, Ph.D.

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

Kanautica Zayre-Brown,

Plaintiff,

v.

The North Carolina Department of Public
Safety, et al.,

Defendants.

CIVIL ACTION

Case No. 3:22-CV-00191-MOC-DCK

**EXPERT REBUTTAL REPORT OF
ARMAND H. MATHENY AN TOMM MARIA, MD, PhD, FAAP, HEC-C**

I, Armand H. Matheny Antomm aria, hereby declare and state as follows:

1. I have been retained by counsel for Plaintiff as a rebuttal expert in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated herein.

3. In preparing this declaration, I reviewed the expert reports by Randi C. Ettner, PhD, and Fan Li, PhD. Dr. Ettner's report contains copies of the Division Transgender Accommodations Review Committee's Position Statement: Gender Reassignment Surgery and Case Summary: Offender #0618705, which I also reviewed. In addition to these expert reports and the materials cited herein, I have also relied on my years of research and other experience, as set out in my curriculum vitae (Exhibit A), in forming my opinions. The materials I have relied upon in preparing this expert rebuttal

report are the same types of materials that experts in my fields of study regularly rely upon when forming opinions on subjects. I may wish to supplement these opinions or the bases for them due to new scientific research or publications, or in response to statements and issues that may arise in my area of expertise.

OVERVIEW

4. I am a pediatrician and bioethicist with extensive clinical and research experience. I am the author of 42 peer-reviewed articles, which have been published in high-impact journals including the *Journal of the American Medical Association* and *Annals of Internal Medicine*, and I direct the Ethics Center at Cincinnati Children's Hospital Medical Center. This expert rebuttal report sets forth my reasons for my disagreement with and my concerns about the conclusions Dr. Li reaches in her expert report.

5. Dr. Ettner explains that gender-affirming genital surgery is a medically necessary treatment for Mrs. Zayre-Brown (Paragraphs 132-137). Dr. Li claims that evidence cited by Dr. Ettner and by the World Professional Association for Transgender Health (WPATH) does not provide reasonable support for Dr. Ettner's and WPATH's conclusions (Page 4).

6. Dr. Li mischaracterizes the level of evidence necessary for making treatment recommendations. Treatment recommendations are not required to be based on randomized controlled trials. Widely accepted methods for developing clinical practice guidelines state that treatment recommendations may be based on "low" or "very low"

quality evidence.¹ In fact, a significant portion of treatment recommendations across the spectrum of medical interventions rely on this level of evidence. Dr. Li also fails to acknowledge the constraints on conducting randomized controlled trials for many medical treatments, including gender-affirming genital surgery and other forms of gender-affirming medical care.

BACKGROUND AND QUALIFICATIONS

7. I am the Director of the Ethics Center, the Lee Ault Carter Chair of Pediatric Ethics, and an Attending Physician in the Division of Hospital Medicine at Cincinnati Children’s Hospital Medical Center (“Cincinnati Children’s”). I am also a Professor in the Departments of Pediatrics and Surgery at the University of Cincinnati College of Medicine.

8. I received my medical degree from Washington University School of Medicine in St. Louis, Missouri in 2000. I received my PhD in Religious Ethics from The University of Chicago Divinity School in 2000. I completed my pediatrics residency at the University of Utah in 2003.

9. I have been licensed to practice medicine since 2001 and am currently licensed to practice medicine in Ohio. I have been Board Certified in General Pediatrics since 2004 and in Pediatric Hospital Medicine since the inception of this certification in 2019. I have been certified as a Healthcare Ethics Consultant since the inception of this certification in 2019.

¹ As explained below, “low” and “very low” are relative terms used to describe two of the four levels of evidence. They should not be misinterpreted as meaning “poor or inadequate” evidence.

10. I have extensive experience as a pediatrician and as a bioethicist. I have been in clinical practice since 2003 and 30% of my current effort is dedicated to caring for hospitalized patients. I provide evidence-based medical care to my patients and teach evidence-based medicine to the trainees that I supervise. This includes using clinical practice guidelines and teaching trainees how they are developed. I was Chair of the Ethics Committee at Primary Children's Medical Center in Salt Lake City, Utah from 2005 to 2012 and have been Director of the Ethics Center at Cincinnati Children's since 2012. I regularly consult on the care of patients in the Transgender Health Clinic at Cincinnati Children's and participate in the Clinic's monthly multidisciplinary team meetings. I remain current with the medical and bioethics literature regarding the treatment of individuals with gender dysphoria. I chair Cincinnati Children's Fetal Care Center's Oversight Committee, which provides the Center recommendations on the use of innovative treatments and experimental interventions.

11. I am a member of the American Academy of Pediatrics (AAP), the American Society for Bioethics and Humanities (ASBH), the Association of Bioethics Program Directors, and the Society for Pediatric Research. I was a member of the AAP Committee on Bioethics from 2005 to 2011. I have also served as a member of the ASBH's Clinical Ethics Consultation Affairs Committee from 2009 to 2014 and currently serve on its Healthcare Ethics Consultant Certification Commission.

12. I am the author of 42 peer-reviewed journal articles, 11 non-peer-reviewed journal articles, 6 book chapters, and 28 commentaries. My peer-reviewed journal articles have been published in high-impact journals, including the *Journal of the American*

Medical Association and *Annals of Internal Medicine*. I am also an author of 17 policy statements and technical reports, including 4 as lead author, by the AAP.

13. I am a member of the Executive Editorial Board and the Associate Editor for Ethics Rounds of *Pediatrics*. I am an active peer reviewer for many medical journals, including the *American Journal of Bioethics* and the *Journal of Pediatrics*. I also review abstracts for meetings of professional organizations, including the Pediatric Academic Societies and ASBH. I was previously a member of the editorial boards of the *Journal of Clinical Ethics* and the *Journal of Medical Humanities*.

14. In summary, as an academic pediatric hospitalist, I practice and teach evidence-based medicine, including the use and development of clinical practice guidelines. As a bioethicist, I help patients, parents, and health care providers address ethical dilemmas and resolve ethical conflicts. This involves analyzing the evidence and reasons supporting different treatment options.

15. I have previously testified at deposition and trial in *Brandt v. Rutledge*, United States District Court, Eastern District of Arkansas, Case No. 5:21-CV-00450-JM-1; and at deposition and trial in *Dekker v. Weida*, United States District Court, Northern District of Florida, Case No. 4:22-cv-00325-RH-MAF. I have also previously testified in the preliminary injunction phase in *Doe v. Abbott*, District Court of Travis County, Texas 353rd Judicial District, Case No. D-1-GN-22-000977; and in the preliminary injunction phase and at deposition in *Boe v. Marshall*, United States District Court, Northern District of Alabama, No. 22-cv-184.

16. I am being compensated at a rate of \$400 per hour for my work in this matter. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

DR. LI'S EXPERT REPORT

17. Dr. Li contends that the evidence cited by Dr. Ettner and WPATH does not provide reasonable support for Dr. Ettner's and WPATH's conclusions regarding the effectiveness of gender-affirming medical care to treat gender dysphoria. What Dr. Li considers reasonable is clarified by her statement that "Among the dozens of studies reviewed, there is not a single randomized controlled trial. Most of the studies cited in support of those assertions are of low quality in terms of study design and statistical methodology (Dr. Fan Li Expert Report ("Li Report") at 4; see also *id.* at 25)." A substantial portion of Dr. Li's report provides her assessment of the research cited by Dr. Ettner and WPATH (Li Report at 11-24) and she frequently repeats her claims about reasonable support, randomized controlled trials, and "low" quality evidence (Li Report at 12, 14, 15, 16, 17, 18, 19, 21, 22, and 24). Dr. Li's characterization of the studies being subject to confounding, selection, nonresponse, and recall bias is part of her justification for labeling them as "low" quality.

18. The primary problem with Dr. Li's opinions is not her characterization of individual studies. While not conceding Dr. Li's characterization of each individual study, there are few randomized controlled trials of gender-affirming medical care and the body of evidence is currently appropriately characterized as "low" or "very low" quality. The primary problem with Dr. Li's opinions is that the standard that she relies on for

determining whether Dr. Ettner's and WPATH's conclusions are reasonable is inappropriately high. Recommendations in clinical practice guidelines are not based solely on the quality of the evidence, or on "high" quality evidence. Recommendations may appropriately be justified by observational studies. While observational studies are characterized as "low" quality evidence, "low" is a relative term describing the different levels of evidence and should not be misinterpreted as meaning "poor or inadequate." While a statistician may hold randomized controlled trials up as the "gold standard" of for evidence (Li Report at 8), clinicians must make decisions based on the best, currently available evidence, which includes other types of studies. They cannot tell their patients to come back later after randomized controlled trials have been conducted. Furthermore, there are sound reasons why randomized controlled trials may not be available or, if available, may not provide "high" quality evidence in particular circumstances. In practice, only a minority of clinical practice guideline recommendations are based on "high" quality evidence. The lack of randomized controlled trials and reliance on "low" quality evidence does not mean that there is not reasonable support for a clinical practice guideline recommendation or that a treatment is not medically necessary.

CLINICAL PRACTICE GUIDELINES

19. Given the breadth of the existing medical literature and its ever-increasing size, medical professionals may have difficulty finding useful information to inform

decision-making and treatment recommendations. The optimal resource, if one is available, is a clinical practice guideline.²

20. Medical professional organizations develop clinical practice guidelines to provide clinicians with helpful, evidence-based recommendations and improve patient care and outcomes. Clinical practice guidelines are developed using systematic reviews of the literature—systematic processes to select and review relevant scientific evidence. Systematic reviews evaluate the evidence, but do not make treatment recommendations.³ Clinical practice guidelines both evaluate the evidence and make recommendations.⁴ One widely used method for rating the quality of evidence and the strength of recommendations is the Grades of Recommendation Assessment, Development and Evaluation (GRADE) system.⁵

Quality of the Evidence

21. In clinical practice guidelines, the quality of evidence has been defined as “the extent of our confidence that the estimates of an effect are adequate to support a particular decision or recommendation.”⁶ Quality of evidence is based on five factors: risk

² Guyatt G, Rennie D, Meade MO, et al., eds. *Users' Guide to the Medical Literature: A Manual for Evidence-Based Clinical Practice*. 3rd ed. McGraw Hill Education; 2015.

³ National Heart, Lung, and Blood Institute. About systematic evidence reviews and clinical practice guidelines. Accessed July 30, 2023. Available at <https://www.nhlbi.nih.gov/node/80397>.

⁴ Qaseem A, Kansagara D, Lin JS, et al. The development of clinical guidelines and guidance statements by the Clinical Guidelines Committee of the American College of Physicians: Update of methods. *Ann Intern Med*. 2019;170(12):863-870.

⁵ Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490; Guyatt G, Oxman AD, Akl EA, et al. GRADE guidelines: 1. Introduction-GRADE evidence profiles and summary of findings tables. *J Clin Epidemiol*. 2011;64(4):383-394.

⁶ Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):403.

of bias, inconsistency, indirectness, imprecision, and publication bias. Dr. Li focuses on the risk of bias, including confounding, selection, nonresponse, and recall bias, as well as the inconsistency of results. The GRADE system distinguishes four levels of evidence: “high,” “moderate,” “low,” and “very low.” These levels are relative to one another and “low” does not necessarily mean “poor or inadequate.” As discussed below, a recommendation in a clinical practice guideline may be based on “low,” or “very low” quality evidence, not just “high” or “moderate” quality evidence.⁷

22. With respect to study design, randomized trials are initially assigned to the “high” category.⁸ In a randomized trial, participants are randomly assigned to a treatment or a comparison group. As Dr. Li describes (Li Report at 8), the major benefit of a randomized trial is that it decreases the likelihood that any differences in the outcomes between the groups is the result of baseline differences between the groups rather than the result of the intervention.⁹ In addition to randomization, randomized controlled trials also frequently use “blinding” or “masking.” In a “double-masked” trial, neither the investigators nor the participants know whether the participant was randomized to the treatment or comparison group. Masking reduces the effect of individuals’ biases on the

⁷ Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490; Guyatt G, Oxman AD, Akl EA, et al. GRADE guidelines: 1. Introduction-GRADE evidence profiles and summary of findings tables. *J Clin Epidemiol*. 2011;64(4):383-394. The guidelines initially defined the quality of the evidence based on four factors; a fifth was added in a subsequent revision.

⁸ Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490; Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.

⁹ See also Browner WS, Newman TB, Cummings SR, et al. *Designing Clinical Research*. 5th ed. Wolters Kluwer; 2023.

ascertainment of the outcomes. For example, if investigators were biased in favor of the treatment and knew which participants were randomized to the treatment group, they might unconsciously report more favorable outcomes for them.¹⁰ While randomized controlled trials are initially assigned to the “high” category, their final rating may be lowered based on the aforementioned factors.¹¹

23. By comparison, observational studies are initially assigned to the “low” category.¹² Observational studies include cross-sectional and longitudinal studies. In cross-sectional studies, investigators collect data at a single point in time. Cross-sectional design permits investigators to examine potential associations between factors, but it cannot prove one factor caused the other. In longitudinal studies, researchers follow individuals over time, making continuous or repeated measures.¹³ Observational studies’ final rating may be increased if any of several factors, e.g., a large effect size, is present.¹⁴

24. The labels “high” and “low” quality evidence can be misleading if interpreted in the colloquial sense of “excellent or necessary” or “poor or inadequate,” respectively. While randomized controlled trials are described in the medical literature as “high” quality

¹⁰ Browner WS, Newman TB, Cummings SR, et al. *Designing Clinical Research*. 5th ed. Wolters Kluwer; 2023.

¹¹ Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490; Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.

¹² Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490; Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.

¹³ Browner WS, Newman TB, Cummings SR, et al. *Designing Clinical Research*. 5th ed. Wolters Kluwer; 2023.

¹⁴ Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490; Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol*. 2011;64(4):401-406.

evidence and observational studies as “low” quality evidence, as described below, “low” quality evidence can be sufficient to justify treatment recommendations. Indeed, clinical practice guidelines regularly rely on “low” quality evidence. A trial or study having methodological limitations does not mean that it is irrelevant.

25. In some contexts, randomized controlled trials may be unavailable, may not be ethical or feasible, or may have intrinsic methodological limitations. There are significant barriers to randomized controlled trials, including their high cost and the lack of funding, the complexity of regulations and trial procedures, and difficulties recruiting sufficient participants.¹⁵ Randomized controlled trials, therefore, are less common than observational studies and may be unavailable for some treatments. Systematic reviews typically find “low” or “very low”-quality evidence for most medical interventions. Padhraig S. Fleming and colleagues conducted a review of systematic reviews published on the Cochrane Database of Systematic Reviews between January 1, 2013, and June 30, 2014. They focused on those that incorporated the GRADE approach and examined the quality of evidence for the first listed primary outcome. Of the 608 reviews, 82 (13.5%) reported “high,” 197 (30.8%) “moderate,” 193 (31.7%) “low,” and 126 (24%) “very low”-

¹⁵ Duley L, Antman K, Arena J, et al. Specific barriers to the conduct of randomized trials. *Clin Trials*. 2008;5(1):40-48; Bothwell LE, Greene JA, Podolsky SH, Jones DS. Assessing the gold standard—Lessons from the history of RCTs. *N Engl J Med*. 2016;374(22):2175-2181.

quality evidence.¹⁶ In a subsequent study, a related group of authors found that updated reviews did not consistently demonstrate an improvement in the quality of the evidence.¹⁷

26. At times, it may be unethical to conduct randomized trials. For randomized trials to be ethical, there must be clinical equipoise. Clinical equipoise is uncertainty within the scientific community about whether the intervention or the control is more efficacious. If clinical equipoise does not exist, it is unethical to knowingly expose trial participants to an inferior intervention or control. Trials must also be feasible: it would also be unethical to expose individuals to the risks of trial participation without the benefit of the trial generating generalizable knowledge. A randomized trial that is unlikely to find enough people to participate because they believe they might be randomized to an inferior intervention, for example, would be unethical because it could not produce generalizable knowledge due to an inadequate sample size.¹⁸

27. Even if randomized controlled trials can be conducted ethically, they may not provide “high” quality of evidence due to intrinsic design limitations. For example, if participants enrolled but were dissatisfied with the group to which they were randomized, they might seek treatment outside of the trial or not follow up. This crossover or loss to

¹⁶ Fleming PS, Koletsi D, Ioannidis JP, Pandis N. High quality of the evidence for medical and other health-related interventions was uncommon in Cochrane systematic reviews. *J Clin Epidemiol.* 2016;78:34-42. *See also* Howick J, Koletsi D, Ioannidis JPA, et al. Most healthcare interventions tested in Cochrane Reviews are not effective according to high quality evidence: A systematic review and meta-analysis. *J Clin Epidemiol.* 2022;148:160-169, which found that only 10.1% of interventions (158 of 1,567) had “high” quality evidence supporting their benefits.

¹⁷ Howick J, Koletsi D, Pandis N, et al. The quality of evidence for medical interventions does not improve or worsen: A metaepidemiological study of Cochrane reviews. *J Clin Epidemiol.* 2020;126:154-159.

¹⁸ Emanuel EJ, Wendler D, Grady C. What makes clinical research ethical? *JAMA.* 2000;283(20):2701-2711.

follow-up could negatively affect the trial. Surgical trials face additional issues: it may be difficult to control for the learning curve (changes in outcomes as a surgeon gains experience with a technique), different surgeon's skill levels, and differences or changes in the surgical technique.¹⁹

28. Observational studies are especially important when randomized controlled trials are unavailable, are not ethical or feasible, or have intrinsic methodological limitations.²⁰

Strength of Recommendations

29. When making recommendations, the authors of guidelines consider a variety of factors; the quality of the evidence is only one factor considered in making recommendations. Other considerations include the balance between desirable and undesirable outcomes, confidence and variability in patients' values and preferences, and resource use.²¹ The GRADE system distinguishes "strong" and "weak" recommendations; "guideline authors make a strong recommendation when they believe that all or almost all informed people would make the recommended choice" and a "weak" recommendation when most would but an appreciable number would not. GRADE acknowledges that "weak" recommendations can be confused with weak evidence or misinterpreted as

¹⁹ Love JW. Drugs and operations. Some important differences. *JAMA*. 1975;232(1):37-38; Gelijns AC, Ascheim DD, Parides MK, Kent KC, Moskowitz AJ. Randomized trials in surgery. *Surgery*. 2009;145(6):581-587.

²⁰ Browner WS, Newman TB, Cummings SR, et al. *Designing Clinical Research*. 5th ed. Wolters Kluwer; 2023.

²¹ Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490; Andrews JC, Schunemann HJ, Oxman AD, et al. GRADE guidelines: 15. Going from evidence to recommendation-determinants of a recommendation's direction and strength. *J Clin Epidemiol*. 2013;66(7):726-735.

ignorable or uncertain recommendations. It offers “conditional,” “discretionary” and “qualified” as alternatives to “weak.”²² The larger the differences between the desirable and undesirable outcomes, and the lesser the variability in patient values and preferences, the more likely a “strong” recommendation is warranted.²³ “Low” quality evidence may be sufficient to make a “strong” recommendation.²⁴ Dr. Li ignores altogether this aspect of medical decision making.

30. Recommendations made by professional associations in guidelines are infrequently based on well-designed and conducted randomized controlled trials. Instead, recommendations are frequently based on observational studies or, if such studies are unavailable, expert opinion. The medical use of the term “expert opinion” in this context refers to the consensus of experts in the relevant field(s) when studies are not available.

31. For example, Jonathan M. Hazelhurst and colleagues reviewed the guidelines produced by five endocrinology associations that graded the quality of the evidence. The 29 guidelines included 1,762 recommendations, only 191 (10.8%) of which were supported

²² Andrews J, Guyatt G, Oxman AD, et al. GRADE guidelines: 14. Going from evidence to recommendations: The significance and presentation of recommendations. *J Clin Epidemiol.* 2013;66(7):719-725.

²³ For example, among people with cancer of the lymphatic system, young people consistently value a longer life more than avoiding chemotherapy side effects, but some older individuals value avoiding side effects more. This justifies a “strong” recommendation in the younger age group and a “weak” recommendation in the older one. Andrews JC, Schunemann HJ, Oxman AD, et al. GRADE guidelines: 15. Going from evidence to recommendation-determinants of a recommendation's direction and strength. *J Clin Epidemiol.* 2013;66(7):726-735.

²⁴ Andrews JC, Schunemann HJ, Oxman AD, et al. GRADE guidelines: 15. Going from evidence to recommendation-determinants of a recommendation's direction and strength. *J Clin Epidemiol.* 2013;66(7):726-735.

by well-conducted, randomized, controlled trials.²⁵ Similar studies of recommendations in other medical specialties also demonstrate that the minority of recommendations (10.8-29%) are based on “high” quality evidence. See Table 1 (Exhibit B). Similar studies are not available in surgery. Studies of surgery, rather than examining the level of evidence in clinical practice guidelines, examine the level of evidence for procedures performed by a surgeon(s) during a particular timeframe.²⁶

Clinical Practice Guidelines for Gender-Affirming Medical Care

32. The level of evidence supporting clinical practice guidelines recommendations regarding gender-affirming medical care is comparable to the level of evidence supporting many other medical treatments, and gender-affirming medical care should not be held to a higher standard.

33. The Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, has published a clinical practice guideline for the treatment of gender-dysphoric/gender-incongruent persons, including pubertal suppression, sex hormone treatment, and surgery for gender confirmation.²⁷ WPATH’s Standards of Care for the Health of Transgender and Gender Diverse People, which is

²⁵ Hazlehurst JM, Armstrong MJ, Sherlock M, et al. A comparative quality assessment of evidence-based clinical guidelines in endocrinology. *Clin Endocrinol (Oxf)*. Feb 2013;78(2):183-90. While all of the associations graded the quality of the evidence, not all of the associations used the GRADE methodology.

²⁶ See, for example, Lee JS, Urschel DM, Urschel JD. Is general thoracic surgical practice evidence based? *Ann Thorac Surg*. 2000;70(2):429-431 and Howes N, Chagla L, Thorpe M, McCulloch P. Surgical practice is evidence based. *Br J Surg*. 1997;84(9):1220-1223.

²⁷ Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.

currently in its 8th version (“SOC-8”), also provides evidence-based guidelines for the provision of gender-affirming medical care.²⁸ The treatments outlined in these guidelines are also endorsed by other medical professional associations including the American Academy of Family Physicians,²⁹ the AAP,³⁰ the American College of Obstetricians and Gynecologists,³¹ the American Medical Association,³² the American Psychiatric

²⁸ Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, Version 8. *Int J Transgend Health*. 2022;23(Suppl 1):S1-S259.

²⁹ American Academy of Family Physicians. Care for the transgender and gender nonbinary patient. Accessed July 13, 2023. Available at <https://www.aafp.org/about/policies/all/transgender-nonbinary.html#:~:text=The%20American%20Academy%20of%20Family,patients%2C%20including%20children%20and%20adolescents>.

³⁰ Rafferty J, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, et al. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. *Pediatrics*. 2018;142(4):e20182162.

³¹ American College of Obstetricians and Gynecologists. ACOG Committee Opinion Number 823: Health care for transgender and gender diverse individuals. March 2021. Accessed July 13, 2023. Available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals/>; American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice and Committee on Health Care for Underserved Women. Health care for transgender and gender diverse individuals: ACOG Committee Opinion, Number 823. *Obstet Gynecol*. 2021;137(3):e75-e88.

³² American Medical Association. Removing financial barriers to care for transgender patients H-185.950. 2022. Accessed July 13, 2023. Available at <https://policysearch.ama-assn.org/policyfinder/detail/H-185.950?uri=%2FAMADoc%2FHOD.xml-0-1128.xml>; Madara JL to McBride B. April 26, 2021. Accessed July 13, 2023. Available at <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf>.

Association,³³ the American Psychological Association,³⁴ and the Pediatric Endocrine Society.³⁵

34. The Endocrine Society clinical practice guideline includes 28 recommendations: 3 (11%) are based on “moderate,” and 19 (68%) are based on “low” or “very low” quality evidence. The remaining 6 (21%) recommendations are Ungraded Good Practice Statements.³⁶ The quality of the evidence supporting these recommendations is similar to the quality of the evidence supporting the recommendations in other endocrine clinical practice guidelines described above.

35. WPATH’s clinical practice guideline makes 150 recommendations, including 11 recommendations in its chapter on Surgery and Postoperative Care. WPATH relies on a similar body of evidence to the Endocrine Society, with the addition of studies published after the Endocrine Society’s guideline.³⁷

36. There are limitations to the use of randomized controlled trials in gender-

³³ American Psychiatric Association. Position statement on treatment of transgender (trans) and gender diverse youth. July 2020. Accessed July 13, 2023. Available at <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Transgender-Gender-Diverse-Youth.pdf>.

³⁴ American Psychological Association. Transgender, gender identity, and gender expression non-discrimination. August 2008. Accessed July 13, 2023, Available at <https://www.apa.org/about/policy/transgender.pdf>.

³⁵ Endocrine Society and Pediatric Endocrine Society. Transgender health: Position Statement. December 2020. Accessed July 13, 2023. Available at <https://www.endocrine.org/advocacy/position-statements/transgender-health>; Anton BS. Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives. *Am Psychol*. 2009;64:372-453.

³⁶ Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.

³⁷ Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, Version 8. *Int J Transgend Health*. 2022;23(Suppl 1):S1-S259.

affirming medical care. As a result of the studies referenced by the Endocrine Society and WPATH, and healthcare providers' experience, randomized controlled trials comparing gender-affirming medical care to no medical care are currently unethical. Potential investigators do not have clinical equipoise between treatment and no treatment; they believe that treatment is superior. Therefore, it would be unethical to not provide treatment to the control group. It is also highly unlikely that enough participants would enroll in randomized controlled trials, knowing they might not receive treatment, for them to be informative.³⁸

37. Even if such studies could be conducted ethically, they would provide a lower quality of evidence because of intrinsic limitations in their design. In addition to the aforementioned limitations of randomized controlled trials in surgery, it would be impossible to blind surgeons or participants to whether the participants underwent gender-affirming surgery. This might bias their perception of the outcomes and lower the rating of the study's quality.³⁹

CONCLUSION

38. Dr. Li holds gender-affirming medical care to too high of a standard; she asserts that it must be supported by randomized controlled trials or, more accurately, "high"

³⁸ Chew D, Anderson J, Williams K, May T, Pang K. Hormonal treatment in young people with gender dysphoria: A systematic review. *Pediatrics*. 2018;141(4):e20173742; Reisner SL, Deutsch MB, Bhasin S, et al. Advancing methods for US transgender health research. *Curr Opin Endocrinol Diabetes Obes*. 2016;23(2):198-207.

³⁹ Browner WS, Newman TB, Cummings SR, et al. Designing Clinical Research. 5th ed. Wolters Kluwer; 2023; Atkins D, Best D, Briss PA, et al. Grading quality of evidence and strength of recommendations. *BMJ*. 2004;328(7454):1490.

quality evidence (because not all randomized controlled trials constitute “high” quality evidence). Medicine and its clinical practice guidelines do not hold recommendations to this standard and it is a standard that few recommendations meet. Only a minority of recommendations in clinical practice guidelines rely on “high” quality evidence. Treating individuals with gender dysphoria with gender-affirming medical care according to clinical practice guidelines, like the Endocrine Society’s and WPATH’s, is evidence-based. The level of evidence is reasonable to support the recommendations and is comparable to the level of evidence available in other fields of medicine.

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

Executed on August 7, 2023



ARMAND H. MATHENY ANTOMMARIA, MD, PhD

EXHIBIT A
Curriculum Vitae

Last Updated: July 12, 2023

PERSONAL DATA

Armand H. Matheny Antommara, MD, PhD, FAAP, HEC-C
Birth Place: Pittsburgh, Pennsylvania
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CONTACT INFORMATION

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EDUCATION

1983-1987	BSEE	Valparaiso University, with High Distinction Valparaiso, IN
1983-1987	BS	Valparaiso University (Chemistry), with High Distinction Valparaiso, IN
1987-1989	MD	Washington University School of Medicine Saint Louis, MO
1989-2000	PhD	The University of Chicago Divinity School (Religious Ethics) Chicago, IL
2000-2003	Resident	University of Utah (Pediatrics) Salt Lake City, UT
2005-2006	Certificate	Conflict Resolution Certificate Program, University of Utah Salt Lake City, UT

BOARD CERTIFICATION

2019 Pediatric Hospital Medicine, American Board of Pediatrics
2019 Healthcare Ethics Consultant-Certified, Healthcare Ethics Consultation
Certification Commission
2004 General Pediatrics, American Board of Pediatrics

PROFESSIONAL LICENSES

2012-Present	Doctor of Medicine, Ohio
2006-2010	Alternative Dispute Resolution Provider—Mediator, Utah
2001-2014	Physician and Surgeon, Utah
2001-2014	Physician and Surgeon Controlled Substance, Utah

PROFESSIONAL EXPERIENCE

Full Time Positions

- 2019-Present *Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Department of Surgery
- 2019-Present *Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Surgery
- 2017-Present *Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Division of Pediatric Hospital Medicine
- 2017-Present *Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics
- 2016-2017 *Associate Professor of Clinical-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics
- 2012-2017 *Associate Professor*
Cincinnati Children's Hospital Medical Center, Cincinnati, OH
Division of Pediatric Hospital Medicine
- 2012-Present *Lee Ault Carter Chair in Pediatric Ethics*
Cincinnati Children's Hospital Medical Center
- 2012-2016 *Associate Professor-Affiliated*
University of Cincinnati, Cincinnati, OH
Department of Pediatrics
- 2010-2012 *Associate Professor of Pediatrics (with Tenure)*
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics
- 2010-2012 *Adjunct Associate Professor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics and Humanities
- 2004-2010 *Assistant Professor of Pediatrics (Tenure Track)*
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics
- 2004-2010 *Adjunct Assistant Professor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics and Humanities
- 2003-2004 *Instructor of Pediatrics (Clinical Track)*
University of Utah School of Medicine, Salt Lake City, UT
Divisions of Inpatient Medicine and Medical Ethics
- 2003-2004 *Adjunct Instructor of Medicine*
University of Utah School of Medicine, Salt Lake City, UT
Division of Medical Ethics

Part Time Positions

- 2023-Present *Expert Witness*, Report
Poe, et al, v. Drummond, et al., United States District Court for the
Northern District of Oklahoma, Case No. 23-cv-00177-JFH-SH
- 2023-Present *Expert Witness*, Report
L.W., et al., v. Skrmetti, et al., United States District Court for the Middle
District of Tennessee, Case No. 3:23-cv-00376.
- 2022-Present *Expert Witness*, Reports, Deposition, and Testimony
Dekker, et al., v. Marstiller, et al., United States District Court for the
Northern District of Florida, Case No. 4:22-cv-oo325-RH-MAF
- 2022- Present *Expert Witness*, Report, Deposition, and Testimony
Eknes-Tucker, et al., v. Marshall, et al., United States District Court
Middle District of Alabama Northern Division, Case No. 2:22-cv0-184-
LCB.
- 2022-Present *Expert Witness*, Report and Testimony
Jane Doe, et al., v. Greg Abbott, et al., District Court of Travis County,
Texas 353rd Judicial District, Case No. D-1-GN-22-000977
- 2021-2022 *Expert Witness*, Reports, Deposition, and Testimony
Dylan Brandt, et al., v. Leslie Rutledge, et al., United States District
Court, Eastern District of Arkansas, Case No.: 5:21-CV-00450-JM-1
- 2021 *Consultant*
Proctor & Gamble, Cincinnati, OH
- 2019 *Consultant*
Sanofi Genzyme, Cambridge, MA
- 2018-Present *Consultant*
Center for Conflict Resolution in Healthcare, Memphis, TN
- 2017-2020 *Consultant*
Amicus Therapeutics, Cranbury, NJ
- 2017 *Consultant*
Sarepta Therapeutics, Cambridge, MA
- 2014 *Consultant*
Genzyme, A Sanofi Company, Cambridge, MA

Editorial Experience

Editorial Board

- 2020-Present *Pediatrics*, Associate Editor for Ethics Rounds and Member of the
Executive Editorial Board
- 2015-2020 *Journal of Clinical Ethics*
- 2009-2020 *Journal of Medical Humanities*

Guest Academic Editor

- 2017 *PLOS/ONE*

Ad Hoc Reviewer: *Academic Medicine, Academic Pediatrics, AJOB Primary Research, American Journal of Bioethics, American Journal of Law & Medicine, American Journal of Medical Genetics, American Journal of Transplantation, BMC Medical Ethics, BMJ Open, Canadian Journal of Bioethics, CHEST, Clinical Transplantation, European Journal of Human Genetics, European Journal of Pediatrics, Frontiers in Genetics, Hospital Medicine, International Journal of Health Policy and Management, International Journal of Nursing Studies, Journal of Adolescent and Young Adult Oncology, Journal of Clinical Ethics, Journal of Empirical Research on Human Research Ethics, Journal of General Internal Medicine, Journal of Healthcare Leadership, Journal of Hospital Medicine, Journal of the Kennedy Institute of Ethics, Journal of Law, Medicine & Ethics, Journal of Medical Ethics, Journal of Medical Humanities, Journal of Medicine and Life, Journal of Palliative Care, Journal of Pediatrics, Journal of Pediatric Surgery, Mayo Clinic Proceedings, Medicine, Healthcare and Philosophy, Molecular Diagnosis & Therapy, New England Journal of Medicine, Patient Preference and Adherence, Pediatrics, Pediatrics in Review, Personalized Medicine, PLOS/ONE, Risk Management and Healthcare Policy, Saudi Medical Journal, SSM - Qualitative Research in Health, and Theoretical Medicine and Bioethics*

SCHOLASTIC AND PROFESSIONAL HONORS

2023	<i>Digital Health Award, Bronze Medal in the Digital Health Media/Publications category for <i>Pediatric Collections: Ethics Rounds: A Casebook in Pediatric Bioethics Part II</i>, Health Information Resource Center, Libertyville, IL</i>
2021	<i>Hidden Gem Award, Cincinnati Children's Hospital Medical Center, Cincinnati, OH</i>
2019-2022	<i>Presidential Citation, American Society for Bioethics and Humanities, Chicago, IL</i>
2016	<i>Laura Mirkinson, MD, FAAP Lecturer, Section on Hospital Medicine, American Academy of Pediatrics, Elk Grove Village, IL</i>
2016, 2018	<i>Certificate of Excellence, American Society for Bioethics and Humanities, Glenview, IL</i>
2013, 2016	<i>Senior Resident Division Teaching Award, Cincinnati Children's Hospital Medical Center, Cincinnati, OH</i>
2012	<i>Role Model, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT</i>
2011	<i>Member, Society for Pediatric Research, The Woodlands, TX</i>
2011	<i>Presidential Citation, American Society for Bioethics and Humanities, Glenview, IL</i>
2009	<i>Role Model, Quality Review Committee, Primary Children's Medical Center, Salt Lake City, UT</i>

- 2008 *Nominee*, Physician of the Year, Primary Children's Medical Center, Salt Lake City, UT
- 2005-2006 *Fellow*, Medical Scholars Program, University of Utah School of Medicine, Salt Lake City, UT
- 1995-1997 *Doctoral Scholar*, Crossroads, A Program of Evangelicals for Social Action, Philadelphia PA
- 1989-1992 *Fellow*, The Pew Program in Medicine, Arts, and the Social Sciences, University of Chicago, Chicago, IL

ADMINISTRATIVE EXPERIENCE

Administrative Duties

- 2023-Present *Chair*, Literature Selection Technical Review Committee, National Library of Medicine, Bethesda, MD
- 2019-Present *Chair*, Oversight Committee, Cincinnati Fetal Center, Cincinnati, OH
- 2014-Present *Chair*, Ethics Committee, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
- 2012-Present *Director*, Ethics Center, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
- 2012-Present *Chair*, Ethics Consultation Subcommittee, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
- 2010 *Co-Chair*, Ethics Subcommittee, Work Group for Emergency Mass Critical Care in Pediatrics, Centers for Disease Control and Prevention, Atlanta, GA
- 2009 *Chair*, Ethics Working Group, H1N1 and Winter Surge, Primary Children's Medical Center, Salt Lake City, UT
- 2005-2012 *Chair*, Ethics Committee, Primary Children's Medical Center, Salt Lake City, UT
- 2005-2012 *Chair*, Ethics Consultation Subcommittee, Primary Children's Medical Center, Salt Lake City, UT
- 2003-4 *Chair*, Clinical Pertinence Committee, Primary Children's Medical Center, Salt Lake City, UT

Professional & Scientific Committees

Committees

- 2023-Present *Member*, Expert Committee, Humanitarian Access Program, Alnylam Pharmaceuticals, Cambridge, MA
- 2021 *Member*, EMCO Capacity Collaboration, Ohio Hospital Association, Columbus, OH
- 2020-2021 *Member*, Allocation of Scarce Resources Work Group, Ohio Hospital Association, Columbus, OH
- 2020-Present *Member*, Literature Selection Technical Review Committee, National Library of Medicine, Bethesda, MD
- 2020 *Member*, Crisis Standards of Care Workgroup, The Health Collaborative,

- Cincinnati, OH
- 2019-Present *Member*, Healthcare Ethics Consultant Certification Commission, Oak Park, IL
- 2019 *Member*, Expert Panel, Pediatric Oncology End-of-Life Care Quality Markers, Institute for Cancer Outcomes & Survivorship, University of Alabama at Birmingham, Birmingham, AL
- 2018 *Member*, Resource Planning and Allocation Team Implementation Task Force, Ohio Department of Health, Columbus, OH
- 2012-Present *Member*, Gaucher Initiative Medical Expert Committee, Project HOPE, Millwood, VA
- 2009-2014 *Member*, Clinical Ethics Consultation Affairs Committee, American Society for Bioethics and Humanities, Glenview, IL
- 2005-2011 *Member*, Committee on Bioethics, American Academy of Pediatrics, Oak Park, IL

Data Safety and Monitoring Boards

- 2019-Present *Member*, Data and Safety Monitoring Board, Sickle Cell Domestic Trials, National Heart, Lung, and Blood Institute, Bethesda, MD
- 2018-2019 *Member*, Standing Safety Committee for P-188-NF (Carmeseal-MD™) in Duchenne Muscular Dystrophy, Phrixus Pharmaceuticals, Inc., Ann Arbor, MI
- 2017-Present *Member*, Observational Study Monitoring Board, Sickle Cell Disease Observational Monitoring Board, National Heart, Lung, and Blood Institute, Bethesda, MD
- 2016-2018 *Member*, Observational Study Monitoring Board, Long Term Effects of Hydroxyurea in Children with Sickle Cell Anemia, National Heart, Lung, and Blood Institute, Bethesda, MD

Reviewer

- 2020-Present *Abstract Reviewer*, American Society for Bioethics and Humanities Annual Meeting
- 2020 *Grant Reviewer*, The Croatian Science Foundation, Hrvatska zaklada za znanost (HRZZ)
- 2018 *Book Proposal Reviewer*, Elsevier
- 2018-2019 *Category Leader*, Religion, Culture, and Social Sciences, American Society for Bioethics and Humanities Annual Meeting
- 2017 *Timekeeper*, American Society for Bioethics and Humanities Annual Meeting
- 2017-Present *Abstract Reviewer*, Pediatric Academic Societies Annual Meeting
- 2016-2021 *Workshop Reviewer*, Pediatric Academic Societies Annual Meeting
- 2016 *Grant Reviewer*, Innovation Research Incentives Scheme, The Netherlands Organisation for Health Research and Development
- 2016-2017 *Abstract Reviewer*, American Society for Bioethics and Humanities

Annual Meeting
2014, 2016 *External Peer Reviewer*, PSI Foundation, Toronto, Ontario, Canada
2014 *Member*, Scientific Committee, International Conference on Clinical
Ethics and Consultation
2013 *Abstract Reviewer*, American Society for Bioethics and Humanities
Annual Meeting
2013 *Reviewer*, Open Research Area Plus, Agence Nationale de la Recherche,
Deutsche Forschungsgemeinschaft, Economic and Social Research
Council, National Science Foundation, and Organization for Scientific
Research
2011-2012 *Abstract Reviewer*, Pediatric Academic Societies Annual Meeting
2011-2013 *Workshop Reviewer*, Pediatric Academic Societies Annual Meeting
2011-2014 *Abstract Reviewer*, Pediatric Hospital Medicine Annual Meeting
2011-2012 *Religious Studies Subcommittee Leader*, Program Committee, American
Society for Bioethics and Humanities Annual Meeting
2010 *Abstract Reviewer*, American Society for Bioethics and Humanities
Annual Meeting

Other

2023 *Member*, Student Paper Committee, American Society for Bioethics and
Humanities
2021 *Timekeeper*, American Society for Bioethics and Humanities Annual
Meeting
2021 *Mentor*, Early Career Advisor Professional Development Track,
American Society for Bioethics and Humanities.
2021 *Mentor*, Early Career Advisor Paper or Project Track, American Society
for Bioethics and Humanities.
2109 *Mentor*, Early Career Advising Program, American Society for Bioethics
and Humanities
2018 *Passing Point Determination*, Healthcare Ethics Consultant-Certified
Examination, Healthcare Ethics Consultant Certification Commission
2018 *Member*, Examination Committee, Healthcare Ethics Consultant-Certified
Examination, Healthcare Ethics Consultant Certification Commission
2018 *Item Writer*, Healthcare Ethics Consultant-Certified Examination,
Healthcare Ethics Consultant Certification Commission

UNIVERSITY COMMUNITY ACTIVITIES

Cincinnati Children's Hospital Medical Center

2023-Present *Member*, Executive Committee, Discover Together Biobank
2020-Present *Member*, Faculty Diversity and Inclusion Steering Committee
2020-Present *Member*, Medical Management of COVID-19 Committee
2020-2021 *Member*, Caregiver Refusal Team
2020-2021 *Member*, COVID-19 Vaccine Allocation Committee

2020 *Member, Personal Protective Equipment Subcommittee of the COVID-19 Steering Committee*

2018-2019 *Member, Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference*

2017-Present *Member, Donor Selection Committee*

2017-2020 *Member, Employee Emergency Fund Review Committee*

2017 *Member, Root Cause Analysis Team*

2016-2017 *Member, Planning Committee, Center for Clinical & Translational Science & Training Research Ethics Conference*

2015-2019 *Member, Destination Excellence Medical Advisory Committee*

2015-Present *Member, Disorders of Sexual Development Case Review Committee*

2015-2019 *Member, Destination Excellence Case Review Committee*

2014-2018 *Member, Genomics Review Group, Institutional Review Board*

2014-2017 *Member, Center for Pediatric Genomics Leadership Committee*

2013-2017 *Member, Genetic Testing Subcommittee, Health Network*

2013-2016 *Member, Schwartz Center Rounds Planning Committee*

2013-2014 *Member, Genomics Ad Hoc Subcommittee, Board of Directors*

2012-Present *Member, Cincinnati Fetal Center Oversight Committee*

2012-Present *Member, Ethics Committee*

2012-Present *Member, G-23*

2012-2016 *Member, Integrated Solid Organ Transplant Steering Committee*

University of Utah

2009-2012 *Member, Consolidated Hearing Committee*

University of Utah School of Medicine

2010-2012 *Member, Medical Ethics, Humanities, and Cultural Competence Thread Committee*

2008-2010 *Member, Fourth Year Curriculum Committee*

University of Utah Department of Pediatrics

2010-2011 *Member, Planning Committee, 25th Annual Biological Basis of Children's Health Conference, "Sex, Gender, and Sexuality"*

2009-2012 *Member, Medical Executive Committee*

2005-2012 *Member, Retention, Promotion, and Tenure Committee*

2004-2012 *Interviewer, Residency Program*

2003-2012 *Member, Education Committee*

Intermountain Healthcare

2009-2012 *Member, System-Wide Bioethics Resource Service*

2009-2012 *Member, Pediatric Guidance Council*

Primary Children's Medical Center

2012-2012 *Member*, Shared Accountability Organization Steering Committee
2009 *Member*, H1N1 and Winter Surge Executive Planning Team
2005-2010 *Member*, Continuing Medical Education Committee
2005-2010 *Member*, Grand Rounds Planning Committee
2003-2012 *Member*, Ethics Committee

ACTIVE MEMBERSHIPS IN PROFESSIONAL SOCIETIES

2012-Present Association of Bioethics Program Directors
2011-Present Society for Pediatric Research
2000-Present American Academy of Pediatrics
1999-Present American Society of Bioethics and Humanities

FUNDING

Past Grants

2015-2019 “Better Outcomes for Children: Promoting Excellence in Healthcare Genomics to Inform Policy.”
Percent Effort: 9%
National Human Genome Research Institute
Grant Number: 1U01 HG008666-01
Role: Investigator

2015-2016 “Ethics of Informed Consent for Youth in Foster Care”
Direct Costs: \$10,000
Ethics Grant, Center for Clinical and Translational Science and Training
University of Cincinnati Academic Health Center
Role: Co-Investigator

2014-2015 “Extreme Personal Exposure Biomarker Levels: Engaging Community Physicians and Ethicists for Guidance”
Direct Costs: \$11,640
Center for Environmental Genetics
University of Cincinnati College of Medicine
Role: Investigator

2014-2015 “Child, Adolescent, and Parent Opinions on Disclosure Policies for Incidental Findings in Clinical Whole Exome Sequencing”
Direct Costs: \$4,434
Ethics Grant, Center for Clinical and Translational Science and Training,
University of Cincinnati Academic Health Center
Role: Principal Investigator

- 2013-2014 “Better Outcomes for Children: GWAS & PheWAS in eMERGEII
Percent Effort: 5%
National Human Genome Research Institute
Grant Number: 3U01HG006828-0251
Role: Investigator
- 2004-2005 "Potential Patients' Knowledge, Attitudes, and Beliefs Regarding
Participating in Medical Education: Can They be Interpreted in Terms of
Presumed Consent?"
Direct Costs: \$8,000
Interdisciplinary Research in Applied Ethics and Human Values, University
Research Committee, University of Utah
Role: Principal Investigator

TEACHING RESPONSIBILITIES/ASSIGNMENTS

Course and Curriculum Development

- 2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of
Medicine, Taught 1 time per year, Taken by medical students, Enrollment
100

Course Lectures

- 2018, 2021 Introduction to Biotechnology, “Ethics and Biotechnology” and “Clinical
Ethics,” BIOL 3027, University of Cincinnati, Taught 1 time per year,
Taken by undergraduate students, Enrollment 25.
- 2018-Present Biomedical Ethics, “Conscientious Objection in Healthcare” and “Ethical
Issues in the Care of Transgender Adolescents,” MEDS 4035 & MEDS
4036, University of Cincinnati College of Medicine, Taught 1 time per
year, Taken by senior undergraduate students, Enrollment 52.
- 2016 Foundations of Healthcare Ethics and Law, “Clinical Ethics,” HESA 390,
Xavier University.
- 2014-Present Physicians and Society, “Transfusion and the Jehovah’s Witness Faith,”
“Obesity Management: Ethics, Policy, and Physician Implicit Bias,”
“Embryos and Ethics: The Ethics of Designer Babies,” “Ethics and
Genetic Testing,” and “Ethics and Direct to Consumer Genetic Testing,”
26950112 and 26950116, University of Cincinnati School of Medicine,
Taken by first and second year medical students, Enrollment 100.
- 2014-Present Ethical Issues in Health Care, “Ethical Issues in Managing Drug
Shortages: The Macro, Meso, and Micro Levels,” HESA 583, College of
Social Sciences, Health, and Education Health Services Administration,
Xavier University, Taken by health services administration students,
Enrollment 25.

- 2009 Physical Diagnosis II, Internal Medicine 7160, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100
- 2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by fourth year medical students, Enrollment 100

Small Group Teaching

- 2018-Present Ethics in Research, GNTD 7003-001, University of Cincinnati School of Medicine, Taught 1 time per year, Taken by fellows, MS, and PhD students, Enrollment 110.
- 2007 Physical Diagnosis I, Internal Medicine 7150, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100
- 2003-2012 Medical Ethics, Internal Medicine 7560, University of Utah School of Medicine, Taught 1 time per year, Taken by fourth medical students, Enrollment 100
- 2003 Pediatric Organ System, Pediatrics 7020, University of Utah School of Medicine, Taught 1 time per year, Taken by medical students, Enrollment 100

Graduate Student Committees

- 2018-2022 *Chair*, Scholarship Oversight Committee, William Sveen, Pediatric Critical Care Fellowship, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
- 2018-2020 *Member*, Scholarship Oversight Committee, Anne Heueman, Genetic Counseling, University of Cincinnati, Cincinnati, OH
- 2017-2019 *Chair*, Scholarship Oversight Committee, Bryana Rivers, Genetic Counseling, University of Cincinnati, Cincinnati, OH
- 2013-2015 *Mentor*, Sophia Hufnagel, Combined Pediatrics/Genetics Residency, Cincinnati Children's Hospital Medical Center, Cincinnati, OH
- 2013-2015 *Co-Chair*, Scholarship Oversight Committee, Andrea Murad, Genetic Counseling, University of Cincinnati, Cincinnati, OH
- 2013-2014 *Member*, Scholarship Oversight Committee, Grace Tran, Genetic Counseling, University of Cincinnati, Cincinnati, OH
- 2011-2012 *Chair*, Scholarship Oversight Committee, Kevin E. Nelson, MD, PhD, Pediatric Inpatient Medicine Fellowship, University of Utah, Salt Lake City, UT

Continuing Education Lectures

- 2008 Choosing Healthplans All Together (CHAT) Exercise Facilitator, 18th Annual Intermountain Medical Ethics Conference, "Setting Priorities for Healthcare in Utah: What Choices are We Ready to Make?," Salt Lake City, Utah, October 3.

- 2007 *Speaker*, Infant Medical Surgical Unit, Primary Children’s Medical Center, “Withholding and Withdrawing Artificial Nutrition and Hydration: Can It Be Consistent With Care?,” Salt Lake City, Utah, September 6.
- 2007 *Faculty Scholar-in Residence*, Summer Seminar, “The Role of Religion in Bioethics,” Utah Valley State College, Orem, Utah, May 1.
- 2006 *Workshop Leader*, Faculty Education Retreat, “Publications and Publishing in Medical Education,” University of Utah School of Medicine, Salt Lake City, Utah, September 15.
- 2006 *Breakout Session*, 16th Annual Intermountain Medical Ethics Conference, “Donation after Cardiac Death: Evolution of a Policy,” Salt Lake City, Utah, March 28.

Other Educational Activities

- 2008 *Instructor*, Contemporary Ethical Issues in Medicine and Medical Research, Osher Lifelong Learning Institute, University of Utah, “Religion and Bioethics: Religiously Based Demands for and Refusals of Treatment,” Salt Lake City, Utah, February 7.
- 2007 *Speaker*, Biology Seminar, Utah Valley State College, “Is He Dead?: Criteria of the Determination of Death and Their Implications for Withdrawing Treatment and Recovering Organs for Transplant,” Orem, Utah, September 21.

PEER-REVIEWED JOURNAL ARTICLES

1. Erica K. Salter, D. Micah Hester, Lou Vinarcsik, Armand H. Matheny Antommara, Johan Bester, Jeffrey Blustein, Ellen Wright Clayton, Douglas S. Diekema, Ana S. Iltis, Loretta M. Kopelman, Jay R. Malone, Mark R. Mercurio, Mark C. Navin, Erin Talati Paquette, Thaddeus Mason Pope, Rosamond Rhodes, and Lainie F. Ross, (Forthcoming) “Pediatric Decision Making: Consensus Recommendations,” *Pediatrics*.
2. William N. Sveen, Armand H. Matheny Antommara, Stephen Gilene, and Erika L. Stalets. (2023) “Adverse Events During Apnea Testing for the Determination of Death by Neurologic Criteria: A Single Center, Retrospective Pediatric Cohort.” *Pediatric Critical Care Medicine*. 24: 399-405. PMID: 36815829.
3. Erica K. Salter, Jay R. Malone, Amanda Berg, Annie Friedrich, Alexandra Hucker, Hillary King, and Armand H. Matheny Antommara. (2023) “Triage Policies at U.S. Hospitals with Pediatric Intensive Care Units.” *AJOB Empirical Bioethics*. 14: 84-90. PMID: 36576201.
4. Armand H. Matheny Antommara, Elizabeth Lanphier, Anne Housholder, and Michelle McGowan. (2023). “A mixed methods analysis of requests for religious exemptions to a COVID-19 vaccine requirement.” *AJOB Empirical Bioethics*. 14: 15-22. PMID: 36161802.

5. Anne C Heuerman, Danielle Bessett, Armand H. Matheny Antommara, Leandra K. Toluoso, Nicki Smith, Alison H. Norris and Michelle L. McGowan (2022). "Experiences of reproductive genetic counselors with abortion regulations in Ohio." *Journal of Genetic Counseling*. 31: 641-652. PMID: 34755409.
6. Armand H. Matheny Antommara and Ndidu I. Unaka. (2021) "Counterpoint: Prioritizing Health Care Workers for Scarce Critical Care Resources is Impractical and Unjust." *Journal of Hospital Medicine*. 16: 182-3. PMID 33617445.
7. Gregory A. Grabowski, Armand H. Matheny Antommara, Edwin H. Kolodny, and Pramod K. Mistry. (2021) "Gaucher Disease: Basic and Translational Science Needs for More Complete Therapy and Management." *Molecular Genetics and Metabolism*. 132: 59-75. PMID: 33419694.
8. Armand H. Matheny Antommara, Laura Monhollen, and Joshua K. Schaffzin. (2021) "An Ethical Analysis of Hospital Visitor Restrictions and Masking Requirements During the COVID-19." *Journal of Clinical Ethics*. 32(1): 35-44. PMID 33416516.
9. Armand H. Matheny Antommara (2020) "The Pediatric Hospital Medicine Core Competencies: 4.05 Ethics." *Journal of Hospital Medicine*. 15(S1): 120-121.
10. Armand H. Matheny Antommara, Tyler S. Gibb, Amy L. McGuire, Paul Root Wolpe, Matthew K. Wynia, Megan K. Applewhite, Arthur Caplan, Douglas S. Diekema, D. Micah Hester, Lisa Soleymani Lehmann, Renee McLeod-Sordjan, Tamar Schiff, Holly K. Tabor, Sarah E. Wieten, and Jason T. Eberl for a Task Force of the Association of Bioethics Program Directors (2020) "Ventilator Triage Policies During the COVID-19 Pandemic at U.S. Hospitals Associated With Members of the Association of Bioethics Program Directors." *Annals of Internal Medicine*. 173(3): 188-194. PMID: 32330224.
11. Armand H. Matheny Antommara (2020) "Conflicting Duties and Reciprocal Obligations During a Pandemic." *Journal of Hospital Medicine*. 5:284-286. PMID: 32379030.
12. Mary V. Greiner, Sarah J. Beal, and Armand H. Matheny Antommara (2020) "Perspectives on Informed Consent Practices for Minimal-Risk Research Involving Foster Youth." *Pediatrics*. 45:e20192845. PMID: 32156772.
13. Jennifer deSante-Bertkau, Michelle McGowan, and Armand H. Matheny Antommara (2018) "Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations." *Journal of Clinical Ethics*. 29:291-304. PMID: 30605439.
14. Andrew J. Redmann, Melissa Schopper, Armand H. Matheny Antommara, Judith Ragsdale, Alessandro de Alarcon, Michael J. Jutter, Catherine K. Hart, and Charles M. Myer. (2018) "To Transfuse or Not to Transfuse? Jehovah's Witnesses and PostOperative Hemorrhage in Pediatric Otolaryngology." *International Journal of Pediatric Otorhinolaryngology*. 115:188-192. PMID: 30368384.
15. Armand H. Matheny Antommara, Kyle B. Brothers, John A. Myers, Yana B Feygin, Sharon A. Aufox, Murray H. Brilliant, Pat Conway, Stephanie M. Fullerton, Nanibaa' A. Garrison, Carol R. Horowitz, Gail P. Jarvik, Rongling Li, Evette J. Ludman, Catherine A. McCarty, Jennifer B. McCormick, Nathaniel D. Mercaldo, Melanie F. Myers, Saskia C. Sanderson, Martha J. Shrubsole, Jonathan S. Schildcrout, Janet L.

- Williams, Maureen E. Smith, Ellen Wright Clayton, Ingrid A. Holm. (2018) “Parents’ Attitudes toward Consent and Data Sharing in Biobanks: A Multi-Site Experimental Survey.” *AJOB Empirical Research*. 21:1-15. PMID: 30240342.
16. Armand H. Matheny Antommara and Cynthia A. Prows. (2018) “Content Analysis of Requests for Religious Exemptions from a Mandatory Influenza Vaccination Program for Healthcare Personnel” *Journal of Medical Ethics*. 44: 389-391. PMID: 29463693.
 17. Armand H. Matheny Antommara (2017) “May Medical Centers Give Nonresident Patients Priority in Scheduling Outpatient Follow-Up Appointments?” *Journal of Clinical Ethics*. 28: 217-221. PMID: 28930708.
 18. Andrea M. Murad, Melanie F. Myers, Susan D. Thompson, Rachel Fisher, and Armand H. Matheny Antommara (2017) “A Qualitative Study of Adolescents’ Understanding of Biobanks and Their Attitudes Toward Participation, Re-contact, and Data Sharing.” *American Journal of Medical Genetics: Part A*. 173: 930-937. PMID: 28328120.
 19. Saskia Sanderson, Kyle Borthers, Nathaniel Mercaldo, Ellen Wright Clayton, Armand Antommara, Sharon Aufox, Murray Brilliant, Diego Campos, David Carrell, John Connolly, Pat Conway, Stephanie Fullerton, Nanibaa Garrison, Carol Horowitz, Gail Jarvik, David Kaufman, Terrie Kitchner, Rongling Li, Evette Ludman, Catherine McCarty, Jennifer McCormick, Valerie McManus, Melanie Myers, Aaron Scrol, Janet Williams, Martha Shrubsole, Jonathan Schildcrout, Maureen Smith, and Ingrid Holm (2017) “Public Attitudes Towards Consent and Data Sharing in Biobank Research: A Large Multisite Experimental Survey in the US.” *The American Journal of Human Genetics*. 100: 414-427. PMID: 28190457.
 20. Maureen E. Smith, Saskia C Sanderson, Kyle B Brothers, Melanie F Myers, Jennifer McCormick, Sharon A Aufox, Martha J Shrubsole, Nanibaa' A Garrison, Nathaniel D Mercaldo, Jonathan S Schildcrout, Ellen Wright Clayton, Armand H. Matheny Antommara, Melissa Basford, Murray Brilliant, John J Connolly, Stephanie M Fullerton, Carol R Horowitz, Gail P Jarvik, Dave Kaufman, Terrie Kitchner, Rongling Li, Evette J Ludman, Catherine McCarty, Valerie McManus, Sarah C Stallings, Janet L Williams, and Ingrid A Holm (2016) “Conducting a Large, Multi-Site Survey about Patients' Views on Broad Consent: Challenges and Solutions.” *BMC Medical Research Methodology*. 16: 162. PMID: 27881091.
 21. Angela Lorts, Thomas D. Ryan, Armand H. Matheny Antommara, Michael Lake, and John Bucuvalas (2016) “Obtaining Consensus Regarding International Transplantation Continues to be Difficult for Pediatric Centers in the United States.” *Pediatric Transplant*. 20: 774-777. PMID: 27477950.
 22. Sophia B. Hufnagel, Lisa J. Martin, Amy Cassidy, Robert J. Hopkin, and Armand H. Matheny Antommara (2016) “Adolescents’ Preferences Regarding Disclosure of Incidental Findings in Genomic Sequencing That Are Not Medically Actionable in Childhood.” *American Journal of Medical Genetics Part A*. 170: 2083-2088. PMID: 27149544.

23. Nanibaa' A. Garrison, Nila A. Sathe, Armand H. Matheny Antommara, Ingrid A. Holm, Saskia Sanderson, Maureen E. Smith, Melissa McPheeters, and Ellen Wright Clayton (2016) "A Systematic Literature Review of Individuals' Perspectives on Broad Consent and Data Sharing in the United States." *Genetics in Medicine*. 18: 663-71. PMID: 26583683.
24. Kyle B. Brothers, Ingrid A. Holm Janet E. Childerhose, Armand H. Matheny Antommara, Barbara A. Bernhardt, Ellen Wright Clayton, Bruce D. Gelb, Steven Joffe, John A. Lynch, Jennifer B. McCormick, Laurence B. McCullough, D. William Parsons, Agnes S. Sundaresan, Wendy A. Wolf, Joon-Ho Yu, and Benjamin S. Wilfond (2016) "When Genomic Research Participants Grow Up: Contact and Consent at the Age of Majority." *The Journal of Pediatrics* 168: 226-31. PMID: 26477867.
25. Erin E. Bennett, Jill Sweney, Cecile Aguayo, Criag Myrick, Armand H. Matheny Antommara, and Susan L. Bratton (2015) "Pediatric Organ Donation Potential at a Children's Hospital." *Pediatric Critical Care Medicine*. 16: 814-820. PMID: 26237656.
26. Anita J. Tarzian, Lucia D. Wocial, and the ASBH Clinical Ethics Consultation Affairs Committee (2015) "A Code of Ethics for Health Care Ethics Consultants: Journey to the Present and Implications for the Field." *American Journal of Bioethics*. 15: 38-51. PMID: 25970392.
27. Armand H. Matheny Antommara, Christopher A. Collura, Ryan M. Antiel, and John D. Lantos (2015) "Two Infants, Same Prognosis, Different Parental Preferences." *Pediatrics*, 135: 918-923. PMID: 25847802.
28. Stefanie Benoit, Armand H. Matheny Antommara, Norbert Weidner, and Angela Lorts (2015) "Difficult Decision: What should we do when a VAD supported child experiences a severe stroke?" *Pediatric Transplantation* 19: 139-43. PMID: 25557132.
29. Kyle B. Brothers, John A. Lynch, Sharon A. Aufox, John J. Connolly, Bruce D. Gelb, Ingrid A. Holm, Saskia C. Sanderson, Jennifer B. McCormick, Janet L. Williams, Wendy A. Wolf, Armand H. Matheny Antommara, and Ellen W. Clayton (2014) "Practical Guidance on Informed Consent for Pediatric Participants in a Biorepository." *Mayo Clinic Proceedings*, 89: 1471-80. PMID: 25264176.
30. Sophia M. Bous Hufnagel and Armand H. Matheny Antommara (2014) "Laboratory Policies on Reporting Secondary Findings in Clinical Whole Exome Sequencing: Initial Uptake of the ACMG's Recommendations." *American Journal of Medical Genetics Part A*, 164: 1328-31. PMID: 24458369.
31. Wylie Burke, Armand H. Matheny Antommara, Robin Bennett, Jeffrey Botkin, Ellen Wright Clayton, Gail E. Henderson, Ingrid A. Holm, Gail P. Jarvik, Muin J. Khoury, Bartha Maria Knoppers, Nancy A. Press, Lainie Friedman Ross, Mark A. Rothstein, Howard Saal, Wendy R. Uhlmann, Benjamin Wilfond, Susan M. Wold, and Ron Zimmern (2013) "Recommendations for Returning Genomic Incidental Findings? We Need to Talk!" *Genetics in Medicine*, 15: 854-859. PMID: 23907645.

32. Armand H. Matheny Antommara (2013) “An Ethical Analysis of Mandatory Influenza Vaccination of Health Care Personnel: Implementing Fairly and Balancing Benefits and Burdens,” *American Journal of Bioethics*, 13: 30-37. PMID: 23952830.
33. Joseph A. Carrese and the Members of the American Society for Bioethics and Humanities Clinical Ethics Consultation Affairs Standing Committee (2012) “HCEC Pearls and Pitfalls: Suggested Do’s and Don’t’s for Healthcare Ethics Consultants,” *Journal of Clinical Ethics*, 23: 234-240. PMID: 23256404.
34. Christopher G Maloney, Armand H Matheny Antommara, James F Bale Jr., Jian Ying, Tom Greene and Rajendu Srivastiva (2012) “Factors Associated with Intern Noncompliance with the 2003 Accreditation Council for Graduate Medical Education’s 30-hour Duty Period Requirement,” *BMC Medical Education* 12: 33. PMID: 22621439.
35. Armand H. Matheny Antommara, Jill Sweney, and W. Bradley Poss (2010) “Critical Appraisal of: Triage Pediatric Critical Care Resources During a Pandemic: Ethical and Medical Considerations,” *Pediatric Critical Care Medicine*, 11:396-400. PMID: 20453611.
36. Armand H. Matheny Antommara, Karen Trotochaud, Kathy Kinlaw, Paul N. Hopkins, and Joel Frader (2009) “Policies on Donation After Cardiac Death at Children’s Hospitals: A Mixed-Methods Analysis of Variation,” *Journal of the American Medical Association*, 301: 1902-8. PMID: 19436017.
37. Kristine M. Pleacher, Elizabeth S. Roach, Willem Van der Werf, Armand H. Matheny Antommara, and Susan L. Bratton (2009) “Impact of a Pediatric Donation after Cardiac Death Program,” *Pediatric Critical Care Medicine*, 10: 166-70. PMID: 19188881.
38. Flory L. Nkoy, Sarah Petersen, Armand H Matheny Antommara, and Christopher G. Maloney (2008) “Validation of an Electronic System for Recording Medical Student Patient Encounters,” *AMIA [American Medical Informatics Association] Annual Symposium Proceedings*, 6: 510-14. PMID: 18999155. Nominated for the Distinguished Paper Award
39. Armand H. Matheny Antommara, Sean D. Firth, and Christopher G. Maloney (2007) “The Evaluation of an Innovative Pediatric Clerkship Structure Using Multiple Outcome Variables including Career Choice” *Journal of Hospital Medicine*, 2: 401-408. PMID: 18081170.
40. Armand H. Matheny Antommara (2006) “‘Who Should Survive?: One of the Choices on Our Conscience:’ Mental Retardation and the History of Contemporary Bioethics.” *Kennedy Institute of Ethics Journal*, 16: 205-224. PMID: 17091558.
41. Armand H. Matheny Antommara (2004) “Do as I Say Not as I Do: Why Bioethicists Should Seek Informed Consent for Some Case Studies.” *Hastings Center Report*, 34 (3): 28-34. PMID: 15281724.
42. Armand H. Matheny Antommara (2004) “A Gower Maneuver: The American Society for Bioethics and Humanities’ Resolution of the ‘Taking Stands’ Debate.” *American Journal of Bioethics*, 4 (Winter): W24-27. PMID: 15035934.

NON PEER-REVIEWED JOURNAL ARTICLES

1. Katherine Wade and Armand H. Matheny Antommara (2016) “Inducing HIV Remission in Neonates: Children’s Rights and Research Ethics.” *Journal of Medicine and Biology*, 58(3): 348-54. PMID 27157354.
2. Armand H. Matheny Antommara (2014) “Response to Open Peer Commentaries on ‘An Ethical Analysis of Mandatory Influenza.’” *American Journal of Bioethics*, 14(7): W1-4. PMID: 24978422.
3. Armand H. Matheny Antommara and Brent D. Kaziny (2012) “Ethical Issues in Pediatric Emergency Medicine’s Preparation for and Response to Disasters.” *Virtual Mentor*, 14: 801-4. PMID: 23351860.
4. Armand H. Matheny Antommara, Tia Powell, Jennifer E. Miller, and Michael D. Christian (2011) “Ethical Issues in Pediatric Emergency Mass Critical Care,” *Pediatric Critical Care Medicine*, 12(6 Suppl): S163-8. PMID: 22067926.
5. Armand H. Matheny Antommara and Emily A. Thorell (2011) “Non-Pharmaceutical Interventions to Limit Transmission of a Pandemic Virus: The Need for Complementary Programs to Address Children’s Diverse Needs.” *Journal of Clinical Ethics*, 22: 25-32. PMID: 21595352.
6. Armand H. Matheny Antommara (2010) “Conscientious Objection in Clinical Practice: Notice, Informed Consent, Referral, and Emergency Treatment.” *Ave Maria Law Review*, 9: 81-99.
7. Armand H. Matheny Antommara (2008) “Defending Positions or Identifying Interests: The Uses of Ethical Argumentation in the Debate over Conscience in Clinical Practice,” *Theoretical Medicine and Bioethics*, 29: 201-12. PMID: 18821078.
8. Armand H. Matheny Antommara (2008) “How can I give her IV antibiotics at home when I have three other children to care for?: Using Dispute System Design to Address Patient-Provider Conflicts in Health Care.” *Hamline Journal of Public Law & Policy*, 29: 273-86.
9. Armand H. Matheny Antommara (2007) “Alternative Dispute Resolution and Pediatric Clinical Ethics Consultation: Why the Limits of Ethical Expertise and the Indeterminacy of the Best Interests Standard Favor Mediation.” *Ohio State Journal on Dispute Resolution*, 23: 17-59.
10. Armand H. Matheny Antommara (2006) “Jehovah’s Witnesses, Roman Catholicism, and Calvinism: Religion and State Intervention in Parental, Medical Decision-Making,” *Journal of Law and Family Studies*, 8: 293-316.
11. Armand H. Matheny Antommara and James F. Bale, Jr. (2002) “Ethical Issues in Clinical Practice: Cases and Analyses,” *Seminars in Pediatric Neurology* 9: 67-76. PMID: 11931129.

REVIEW ARTICLES

Armand H. Matheny Antommara (2010) “Conceptual and Ethical Issues in the Declaration of Death: Current Consensus and Controversies.” *Pediatrics in Review* 31: 427-430. PMID: 20889737.

BOOKS

1. Armand H. Matheny Antommara, ed. (2022) *Ethics Rounds: A Casebook in Pediatric Bioethics Part II*. Itasca, IL: American Academy of Pediatrics.
2. Armand H. Matheny Antommara (1998) *A Retrospective, Political and Ethical Analysis of State Intervention into Parental Healthcare Decisions for Infants with Disabilities*. Wynnewood, Pennsylvania: Evangelicals for Social Action.

BOOK CHAPTERS

1. Armand H. Matheny Antommara (2018) “Against Medical Advice Discharges: Pediatric Considerations.” In *Against-Medical-Advice Discharges from the Hospital: Optimizing Prevention and Management to Promote High-Quality, Patient-Centered Care*. David Alford. New York, Springer: 143-157.
2. Armand H. Matheny Antommara (2016) “Conscientious Objection in Reproductive Medicine.” In *The Oxford Handbook of Reproductive Ethics*. Leslie Francis. Oxford, Oxford University Press: 209-225.
3. Armand H. Matheny Antommara (2011) “Patient Participation in Medical Education.” In *Clinical Ethics in Pediatrics: A Case-based Approach*. Douglas Diekema, Mark Mercurio, and Mary Beth Adam. Cambridge, Cambridge University Press: 221-225.
4. Armand H. Matheny Antommara (2011) “State Intervention in Parental Decision Making: *Gone Baby Gone*.” In *The Picture of Health: Medical Ethics and the Movies*. Henri Colt, Silvia Quadrelli, and Lester Friedman. Oxford, Oxford University Press: 308-12.
5. Armand H. Matheny Antommara (2009) “Managing Conflicts of Interest: A Perspective from a Pediatrician.” In *Professionalism in Medicine: The Case-Based Guide for Medical Students*. John Spandorfer, Charles Pohl, Thomas Nasca and Susan Lee Rattner. Cambridge, Cambridge University Press: 376-7.
6. Armand H. Matheny Antommara (2007) “Do-Not-Resuscitate Orders.” In *Comprehensive Pediatric Hospital Medicine*. L. B. Zaoutis and V. W. Chiang. Philadelphia, Mosby Elsevier: 1200-4.

OTHER

Policy Statements and Technical Reports

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2. American Academy of Pediatrics Committee on Bioethics. Armand H. Matheny Antommara Lead Author. (2013) “Ethical Controversies in Organ Donation After Circulatory Death.” *Pediatrics*. 131: 1021-1026. PMID: 23629612.

3. American Academy of Pediatrics Committee on Bioethics and Committee on Genetics and the American College of Medical Genetics and Genomics Social, Ethical, and Legal Issues Committee (2013) "Policy Statement: Ethical and Policy Issues in Genetic Testing and Screening of Children." *Pediatrics*. 131: 620-622. PMID: 23428972.
4. Lainie Friedman Ross, Howard M. Saal, Karen L. David, Rebecca R. Anderson and the American Academy of Pediatrics Committee on Bioethics and Committee on Genetics and the American College of Medical Genetics and Genomics Social, Ethical, and Legal Issues Committee (2013) "Technical Report: Ethical and Policy Issues in Genetic Testing and Screening of Children." *Genetics in Medicine*. 15: 234-245. PMID: 23429433.
5. American Academy of Pediatrics Committee for Pediatric Research and Committee on Bioethics (2012) "Human Embryonic Stem Cell (hESC) and Human Embryo Research." *Pediatrics* 130: 972-977. PMID: 23109685.
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7. American Academy of Pediatrics Committee on Pediatric Emergency Medicine and Committee on Bioethics (2011) "Consent for Emergency Medical Services for Children and Adolescents." *Pediatrics* 128: 427-433. PMID: 21788221.
8. Council on School Health and Committee on Bioethics. Robert Murray and Armand H. Matheny Antommara Lead Authors. (2010) "Honoring –Do-Not-Attempt Resuscitation Requests in Schools." *Pediatrics* 125; 1073-1077. PMID: 20421255.
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11. Committee on Bioethics. Armand H. Matheny Antommara Lead Author. (2009) "Physician Refusal to Provide Information or Treatment Based on Claims of Conscience." *Pediatrics*. 124; 1689-93. PMID: 19948636.
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14. Lainie Friedman Ross, J. Richard Thistlethwaite, Jr., and the Committee on Bioethics (2008) "Minors as Living Solid-Organ Donors." *Pediatrics* 122: 454-61. PMID: 18676567.
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17. American Academy of Pediatrics. Committee on Bioethics (2007) "Professionalism in Pediatrics: Statement of Principles." *Pediatrics* 120:895-7. PMID: 17908776.

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7. Jennifer E. deSante-Bertkau, Timothy K. Knilans, Govind Persad, Patricia J. Zettler, Holly Fernandez Lynch, and Armand H. Matheny Antommara. (2021) "Off-Label Prescription of COVID-19 Vaccines in Children: Clinical, Ethical, and Legal Issues." *Pediatrics*. 149: e2021054578. PMID: 34615694.
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12. Liza-Marie Johnson, Erica C. Kaye, Kimberly Sawyer, Alex M. Brenner, Stefan J. Friedrichsdorf, Abby R. Rosenberg, Armand H. Matheny Antommara. (2021) "Opioid Management in the Dying Child With Addiction." *Pediatrics* 147: e2020046219. PMID 33446508.

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1. Armand H. Matheny Antommara (2014) Authored 4 questions. NEJM Knowledge+ Family Medicine Board Review. NEJM Group.
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Editorials

1. Armand H. Matheny Antommara, Chris Feudtner, Mary Beth Benner, and Felicia Cohn on Behalf of the Healthcare Ethics Consultant-Certified Certification Commission (2020) "The Healthcare Ethics Consultant-Certified Program: Fair, Feasible, and Defensible, But Neither Definite Nor Finished," *American Journal of Bioethics* 20:1-5. PMID: 32105202.
2. Armand H. Matheny Antommara and Pamela W. Popp (2020) "The Potential Roles of Surrogacy Ladders, Standby Guardians, and Medicolegal Partnerships, in Surrogate Decision Making for Parents of Minor Children," *Journal of Pediatrics* 220:11-13. PMID 31952849.

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3. Mary V. Greiner and Armand H. Matheny Antommara. (2022) "Enrolling Foster Youth in Clinical Trials: Avoiding the Harm of Exclusion." *American Journal of Bioethics*. 22(4):85-86. PMID: 35420526.
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13. Armand H. Matheny Antommara and Richard F. Ittenabch (2016) "Quality Attestation's Portfolio Evaluation Is Feasible, But Is It Reliable and Valid?" *American Journal of Bioethics* 16: 35-38. PMID: 26913658.
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16. Armand H. Matheny Antommara (2015) "Intensified Conflict Instead of Closure: Clinical Ethics Consultants' Recommendations' Potential to Exacerbate Ethical Conflicts." *American Journal of Bioethics* 15: 52-4. PMID: 25562231.
17. Lainie Friedman Ross and Armand H. Matheny Antommara (2014) "The need to promote all pediatric stem cell donors' understanding and interests." *Pediatrics* 133: e1356-e1357. PMID: 24777208.
18. Armand H. Matheny Antommara (2014) "Pubertal Suppression and Professional Obligations: May a Pediatric Endocrinologist Refuse to Treat an Adolescent with Gender Dysphoria." *American Journal of Bioethics* 13: 43-46. PMID: 24422933.
19. Armand H. Matheny Antommara (2012) "Empowering, Teaching, and Occasionally Advocating: Clinical Ethics Consultants' Duties to All of the Participants in the Process." *American Journal of Bioethics* 12 11-3. PMID: 22852533.

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22. William Meadow, Chris Feudtner, Armand H. Matheny Antommara, Dane Sommer, John Lantos (2010) “A Premature Baby with Necrotizing Enterocolitis Whose Parents Are Jehovah’s Witnesses.” *Pediatrics*. 216: 151-155. PMID: 20566607.
23. C. C. Weitzman, S. Schlegel, Nancy Murphy, Armand H. Matheny Antommara, J. P. Brosco, Martin T. Stein (2009) “When Clinicians and a Parent Disagree on the Extent of Medical Care.” *Journal of Developmental and Behavioral Pediatrics*. 30: 242-3. PMID: 19525718. Reprinted as (2010) *Journal of Developmental and Behavioral Pediatrics*. 31: S92-5. PMID: 20414087
24. Armand H. Matheny Antommara and Susan Bratton (2008) “Nurses’ Attitudes toward Donation after Cardiac Death: Implications for Nurses’ Roles and Moral Distress.” *Pediatric Critical Care Medicine*, 9: 339-40. PMID: 18446100.
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26. Armand H. Matheny Antommara (2006) “The Proper Scope of Analysis of Conscientious Objection in Healthcare: Individual Rights or Professional Obligations” *Teaching Ethics*, 7: 127-31.
27. Armand H. Matheny Antommara and Rajendu Srivastava (2006) “If Cardiologists Take Care of Patients with Heart Disease, What do Hospitalists Treat?: Hospitalists and the Doctor-Patient Relationship.” *American Journal of Bioethics*, 6: 47-9. PMID: 16423793.
28. Armand H. Matheny Antommara (2003) “I Paid Out-of-Pocket for My Son’s Circumcision at Happy Valley Tattoo and Piercing: Alternative Framings of the Debate over Routine Neonatal Male Circumcision,” *American Journal of Bioethics* 3: 51-3. PMID: 12859817.

Letters

1. Benjamin S. Wilfond, David Magnus, Armand H Matheny Antommara, Paul Appelbaum, Judy Aschner, Keith J. Barrington, Tom Beauchamp, Renee D. Boss, Wylie Burke, Arthur L. Caplan, Alexander M. Capron, Mildred Cho, Ellen Wright Clayton, F. Sessions Cole, Brian A. Darlow, Douglas Diekema, Ruth R. Faden, Chris Feudtner, Joseph J. Fins, Norman C. Fost, Joel Frader, D. Micah Hester, Annie Janvier, Steven Joffe, Jeffrey Kahn, Nancy E. Kass, Eric Kodish, John D. Lantos, Laurence McCullough, Ross McKinney, Jr., William Meadow, P. Pearl O’Rourke, Kathleen E. Powderly, DeWayne M. Pursley, Lainie Friedman Ross, Sadath Sayeed, Richard R. Sharp, Jeremy Sugarman, William O. Tarnow-Mordi, Holly Taylor, Tom Tomlison, Robert D. Truog, Yoram T. Unguru, Kathryn L. Weise, David Woodrum,

- Stuart Youngner (2013) “The OHRP and SUPPORT,” *New England Journal of Medicine*, 368: e36. PMID: 23738513.
2. Lainie Friedman Ross and Armand H. Matheny Antommara (2011) “In Further Defense of the American Academy of Pediatrics Committee on Bioethics ‘Children as Hematopoietic Stem Cell Donors’ Statement.” *Pediatric Blood & Cancer*. 57: 1088-9.
 3. Armand H. Matheny Antommara (2011) “Growth Attenuation: Health Outcomes and Social Services.” *Hastings Center Report*, 41(5): 4. PMID: 21980886.
 4. Susan Bratton and Armand H. Matheny Antommara (2010) “Dead Donor Rule and Organ Procurement: The Authors Reply.” *Pediatric Critical Care Medicine*, 11: 314-5.
 5. Armand H. Matheny Antommara and Joel Frader (2009) “Policies of Children’s Hospitals on Donation After Cardiac Death—Reply.” *Journal of the American Medical Association*, 302: 845.

Case Reports

Armand H. Matheny Antommara (2002) "Case 4.9: Inappropriate Access to a Celebrity's Medical Records." In *Ethics and Information Technology: A Case-Based Approach to a Health Care System in Transition*, James G. Anderson and Kenneth W. Goodman, 79-80. New York: Springer-Verlag.

Book Reviews

1. Armand H. Matheny Antommara (In Press) Review of *Mormonism, Medicine, and Bioethics*, by Courtney S. Campbell. *Mormon Studies Review*.
2. Armand H. Matheny Antommara (2023) ”An Ambitious Goal: A Grounded, Informed, and Compelling Theological Bioethics.” Review of *Disability’s Challenge to Theology: Genes, Eugenics, and the Metaphysics of Modern Medicine* by Devan Stahl. *Hastings Center Report* 53(2): 44-45.
3. Armand H. Matheny Antommara (2021) Review of *When Harry Became Sally: Responding to the Transgender Moment*, by Ryan T. Anderson. *Journal of Medical Humanities* 42: 195-9. PMID 31808021.
4. Armand H. Matheny Antommara (2012) Review of *The Ethics of Organ Transplantation*, by Steven J. Jensen, ed., *Journal of the American Medical Association* 308: 1482-3.
5. Armand H Matheny Antommara (2012) Review of *The Soul of Medicine: Spiritual Perspectives and Clinical Practice*, by John R. Peteet and Michael N. D'Ambra, ed., *Journal of the American Medical Association* 308: 87.
6. Armand H. Matheny Antommara (2009) Review of *Conflicts of Conscience in Health Care: An Institutional Compromise*, by Holly Fernandez Lynch. *American Journal of Bioethics* 9: 63-4.
7. Armand H. Matheny Antommara (2008) Review of *A Practical Guide to Clinical Ethics Consulting: Expertise, Ethos, and Power*, by Christopher Meyers. *American Journal of Bioethics* 8: 72-3.

8. Armand H. Matheny Antommara (2004) Review of *Children, Ethics, and Modern Medicine*, by Richard B. Miller. *American Journal of Bioethics* 4: 127-8.
9. Armand H. Matheny Antommara (2002) Review of *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*, by Thomasine Kushner and David Thomasma, ed. *American Journal of Bioethics* 2: 70-1. PMID: 22494193.
10. Armand H. Matheny Antommara (1999) Review of *Human Cloning: Religious Responses*, by Ronald Cole-Turner, ed. *Prism* 6 (March/April): 21.
11. Armand H. Matheny Antommara (1999) Review of *Christian Theology and Medical Ethics: Four Contemporary Approaches*, by James B. Tubbs, Jr. *Journal of Religion* 79 (April): 333-5.
12. Armand H. Matheny Antommara (1997) Review of *Body, Soul, and Bioethics*, by Gilbert C. Meilaender. *Prism* 4 (May/June): 28.

Newspaper Articles

1. W. Bradley Poss and Armand H. Matheny Antommara (2010) “Mass casualty planning must incorporate needs of children.” *AAP News* 31 (July): 38.
2. Robert Murray and Armand H. Matheny Antommara (2010) “Pediatricians should work with school nurses to develop action plans for children with DNAR orders.” *AAP News* 31 (May): 30..
3. Armand H. Matheny Antommara (2009) “Addressing physicians’ conscientious objections in health care.” *AAP News* 30 (December): 32.

UNPUBLISHED POSTER PRESENTATIONS

1. Armand H. Matheny Antommara. (2018) “Ethical Issues in the Care of International Patients: A Case Study.” International Conference on Clinical Ethics and Consultation, Oxford, United Kingdom.
1. Jill S Sweney, Brad Poss, Colin Grissom, Brent Wallace, and Armand H Matheny Antommara, (2010) “Development of a Statewide Pediatric Pandemic Triage Plan in Utah.” Pediatric Academic Societies Annual Meeting, Vancouver, Canada. E-PAS20103713.147.
2. Christopher G. Maloney, Armand H. Matheny Antommara, James F. Bale, Thomas Greene, Jian Ying, Gena Fletcher, and Rajendu Srivastava (2010) “Why Do Pediatric Interns Violate the 30 Hour Work Rule?” Pediatric Academic Societies Annual Meeting, Vancouver, Canada. E-PAS20101500.596
3. Armand H. Matheny Antommara and Edward B. Clark (2007) “Resolving Conflict through Bioethics Mediation.” 3rd International Conference on Ethics Consultation and Clinical Ethics, Toronto, Canada.
4. Elizabeth Tyson, Tracy Hill, Armand Antommara, Gena Fletcher, and Flory Nkoy (2007) “Physician Practice Patterns Regarding Nasogastric Feeding Supplementation and Intravenous Fluids in Bronchiolitis Patients.” Pediatrics Academic Societies Annual Meeting, Toronto, Canada. E-PAS2007:61300.

ORAL PRESENTATIONS

Keynote/Plenary Lectures

International

1. 2021, *Panelist*, Partnership for Quality Medical Donations, Charitable Access Programming for Rare Diseases, “Ethical Issues,” Webinar, April 6.
2. 2017, *Invited Speaker*, Spina Bifida Fetoscopic Repair Study Group and Consortium, “Ethics of Innovation and Research in Fetal Surgery,” Cincinnati, Ohio, October 26.
3. 2014, *Invited Speaker*, CIC 2013 CCI: Canadian Immunization Conference, “Condition-of-Service Influenza Prevention in Health Care Settings,” Ottawa, Canada, December 2.
4. 2014, *Invited Speaker*, National Conference of the Chinese Pediatric Society, “A Brief Introduction to Pediatric Research and Clinical Ethics,” Chongqing, China, September 12.

National

1. 2020, *Panelist*, Children’s Mercy Bioethics Center, “Ethical Issues in the COVID Pandemic at Children’s Hospitals,” Webinar, March 2.
2. 2019, *Invited Speaker*, North American Fetal Therapy Network (NAFTnet), “Ethics of Innovation,” Chicago, Illinois, October 12.
3. 2019, *Panelist*, National Society of Genetic Counselors Prenatal Special Interest Group, “Fetal Intervention Ethics,” Webinar, September 12.
4. 2017, *Invited Participant*, American College of Epidemiology Annual Meeting, Preconference Workshop, “Extreme Personal Exposure Biomarker Levels: Guidance for Study Investigators,” New Orleans, Louisiana, September 24.
5. 2016, *Invited Speaker*, American Academy of Pediatrics National Conference & Exhibition, Joint Program: Section on Hospital Medicine and Section on Bioethics, “Resource Allocation: Do We Spend Money to Save One Patient with Ebola or Over a 1,000?” San Francisco, California, October 23.
6. 2016, *Invited Speaker*, 26th Annual Specialist Education in Extracorporeal Membrane Oxygenation (SEECHMO) Conference, “Ethical Issues in ECMO: The Bridge to Nowhere,” Cincinnati, Ohio, June 5.
7. 2015, *Invited Speaker*, Extracorporeal Life Support Organization (ELSO) 26th Annual Conference, “ECMO-Supported Donation after Circulatory Death: An Ethical Analysis,” Atlanta, Georgia, September 20.
8. 2014, *Invited Speaker*, Pediatric Evidence-Based Practice 2014 Conference: Evidence Implementation for Changing Models of Pediatric Health Care, “Ethical Issues in Evidence-Based Practice,” Cincinnati, Ohio, September 19.
9. 2014, *Invited Speaker*, 6th Annual David Kline Symposium on Public Philosophy: Exploring the Synergy Between Pediatric Bioethics and Child Rights, “Does Predictive Genetic Testing for Adult Onset Conditions that Are Not Medically Actionable in Childhood Violate Children’s Rights?” Jacksonville, Florida, March 6.

10. 2010, *Invited Speaker*, Quest for Research Excellence: The Intersection of Standards, Culture and Ethics in Childhood Obesity, “Research Integrity and Religious Issues in Childhood Obesity Research,” Denver, Colorado, April 21.
11. 2010, *Invited Speaker*, Symposium on the Future of Rights of Conscience in Health Care: Legal and Ethical Perspectives, J. Reuben Clark Law School at Brigham Young University and the Ave Maria School of Law, “Conscientious Objection in Clinical Practice: Disclosure, Consent, Referral, and Emergency Treatment,” Provo, Utah, February 26.
12. 2009, *Invited Speaker*, Pediatric Organ Donation Summit, “Research Findings Regarding Variations in Pediatric Hospital Donation after Cardiac Death Policies,” Chicago, Illinois, August 18.
13. 2008, *Meet-the-Experts*, American Academy of Pediatrics National Conference & Exhibition, “Physician Refusal to Provide Treatment: What are the ethical issues?” Boston, Massachusetts, October 11.
14. 2008, *Invited Conference Faulty*, Conscience and Clinical Practice: Medical Ethics in the Face of Moral Controversy, The MacLean Center for Clinical Medical Ethics at the University of Chicago, “Defending Positions or Identifying Interests: The Uses of Ethical Argumentation in the Debate over Conscience in Clinical Practice,” Chicago, IL, March 18.
15. 2007, *Symposium Speaker*, Alternative Dispute Resolution Strategies in End-of-Life Decisions, The Ohio State University Mortiz College of Law, “The Representation of Children in Disputes at the End-of-Life,” Columbus, Ohio, January 18.
16. 2005, *Keynote Speaker*, Decisions and Families, *Journal of Law and Family Studies* and The University of Utah S.J. Quinney College of Law, “Jehovah’s Witnesses, Roman Catholicism, and Calvinism: Religion and State Intervention in Parental, Medical Decision-Making,” Salt Lake City, Utah, September 23.

Regional/Local

1. 2023, *Speaker*, Yale Ethics Program, Yale School of Medicine, “Gender-Affirming Care,” New Haven, Connecticut, March 8.
2. 2021, *Panelist*, Pediatric Residency Noon Conference, University of Tennessee Health Science Center, “Bioethics Rounds—Ethical Issues in the Care of Transgender Adolescents,” Memphis, Tennessee, September 21.
3. 2020, *Keynote Speaker*, 53rd Annual Clinical Advances in Pediatrics, “Referral to a Fetal Care Center: How You Can Help Patients’ Mothers Address the Ethical Issues,” Kansas City, Kansas, September 16.
4. 2019, *Speaker*, Patient and Family Support Services, Primary Children’s Hospital, “Ethical Issues in the Care of Trans Adolescents,” Salt Lake City, Utah, December 5.
5. 2019, *Speaker*, Evening Ethics, Program in Medical Ethics and Humanities, University of Utah School of Medicine, “Patients, Parents, and Professionals: Ethical Issues in the Treatment of Trans Adolescents,” Salt Lake City, Utah, December 4.

6. 2019, *Speaker*, Pediatric Hospital Medicine Board Review Course, “Ethics, Legal Issues, and Human Rights including Ethics in Research,” Cincinnati, Ohio, September 8.
7. 2019, *Speaker*, Advances in Fetology, “Evolving Attitudes Toward the Treatment of Children with Trisomies,” Cincinnati, Ohio, September 6.
8. 2019, *Speaker*, Half-Day Ethics Training: Ethics Consultation & Ethics Committees, “Navigating the Rapids of Clinical Ethics Consultation: Intake, Recommendations, and Documentation,” Salt Lake City, Utah, June 1.
9. 2019, *Speaker*, Scientific and Ethical Underpinnings of Gene Transfer/Therapy in Vulnerable Populations: Considerations Supporting Novel Treatments, BioNJ, “What Next? An Ethical analysis of Prioritizing Conditions and Populations for Developing Novel Therapies,” Cranbury, New Jersey, March 7.
10. 2018, *Panelist*, Periviability, 17th Annual Regional Perinatal Summit, Cincinnati, Ohio, October 12.
11. 2018, *Speaker*, Regional Advance Practice Registered Nurse (APRN) Conference, “Adults are Not Large Children: Ethical Issues in Caring for Adults in Children’s Hospitals,” Cincinnati, Ohio, April 26.
12. 2018, *Speaker*, Southern Ohio/Northern Kentucky Sigma Theta Tau International Annual Conference, “Between Hope and Hype: Ethical Issues in Precision Medicine,” Sharonville, Ohio, March 2.
13. 2017, *Speaker*, Advances in Fetology 2017, “Ethics of Innovation and Research: Special Considerations in Fetal Therapy Centers,” Cincinnati, Ohio, October 27.
14. 2016, *Speaker*, End-of-Life Pediatric Palliative Care Regional Conference, “Ethical/Legal Issues in Pediatric Palliative Care,” Cincinnati, Ohio, September 15.
15. 2016, *Speaker*, 26th Annual Bioethics Network of Ohio (BENO) Conference, “When Does Parental Refusal of Medical Treatment for Religious Reasons Constitute Neglect?” Dublin, Ohio, May 29.
16. 2014, *Speaker*, Cincinnati Comprehensive Sickle Cell Center Symposium: Research Ethics of Hydroxyurea Therapy for Sickle Cell Disease During Pregnancy and Lactation, “Ethical Issues in Research with Pregnant and Lactating Women,” Cincinnati, Ohio, October 30.
17. 2014, *Speaker*, Advances in Fetology 2014, “The ‘Miracle Baby’ and Other Cases for Discussion,” Cincinnati, Ohio, September 26.
18. 2014, *Speaker*, Advances in Fetology 2014, “‘Can you tell me ...?’: Achieving Informed Consent Given the Prevalence of Low Health Literacy,” Cincinnati, Ohio, September 26.
19. 2014, *Panelist*, Center for Clinical & Translational Science & Training, Secrets of the Dead: The Ethics of Sharing their Data, Cincinnati, Ohio, August 28.
20. 2014, *Speaker*, Office for Human Research Protections Research Community Forum: Clinical Research ... and All That Regulatory Jazz, “Research Results and Incidental Findings: Do Investigators Have a Duty to Return Results to Participants,” Cincinnati, Ohio, May 21.

21. 2013, *Opening Presentation*, Empirical Bioethics: Emerging Trends for the 21st Century, University of Cincinnati Center for Clinical & Translational Science & Training, “Empirical vs. Normative Ethics: A Comparison of Methods,” Cincinnati, Ohio, February 21.
22. 2012, *Videoconference*, New York State Task Force on Life and the Law, “Pediatric Critical Care Triage,” New York, New York, March 1.
23. 2011, *Presenter*, Fall Faculty Development Workshop, College of Social Work, University of Utah, “Teaching Ethics to Students in the Professions,” Salt Lake City, Utah, November 14.
24. 2011, *Speaker*, 15th Annual Conference, Utah Chapter of the National Association of Pediatric Nurse Practitioners, “Ethical Issues in Pediatric Practice,” Salt Lake City, Utah, September 22.
25. 2011, *Speaker*, Code Silver! Active Shooter in the Hospital, Utah Hospitals & Health Systems Association, Salt Lake City, Utah, March 21.
26. 2009, *Speaker*, Medical Staff Leadership Conference, Intermountain Healthcare, “The Ethics of Leadership,” Park City, Utah, October 30.
27. 2008, *Speaker*, The Art and Medicine of Caring: Supporting Hope for Children and Families, Primary Children’s Medical Center, “Medically Provided Hydration and Nutrition: Ethical Considerations,” Salt Lake City, Utah, February 25.
28. 2005, *Speaker*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners) Chapter Pharmacology and Pediatric Conference, “Immunization Update,” Salt Lake City, Utah, August 18.
29. 2005, *Keynote Speaker*, 17th Annual Conference, Utah Society for Social Work Leadership in Health Care, “Brain Death: Accommodation and Consultation,” Salt Lake City, March 18.
30. 2004, *Continuing Education Presentation*, Utah NAPNAP (National Association of Pediatric Nurse Practitioners), “Febrile Seizures,” Salt Lake City, Utah, April 22.
31. 2004, *Speaker*, Advocacy Workshop for Primary Care Providers, “Ethics of Advocacy,” Park City, Utah, April 3.
32. 2002, *Speaker*, 16th Annual Biologic Basis of Pediatric Practice Symposium, “Stem Cells: Religious Perspectives,” Deer Valley, Utah, September 14.

Meeting Presentations

International

1. 2023, *Speaker*, International Conference on Clinical Ethics and Consultation, “Addressing Ethical and Conceptual Issues in Gender-Affirming Medical Care Outside of the Hospital,” Rome, Italy, June 8.
2. 2018, *Speaker*, International Conference on Clinical Ethics and Consultation, “A Systematic Review of Typologies Used to Characterize Clinical Ethics Consultations,” Oxford, United Kingdom, June 21.

National

1. 2023, Kelsey S. Ryan, Rakhi Gupta Bassuray, Leela Sarathy, Sharon Ostfeld, Armand H. Matheny Antommara, Erin Rholl, Steven R. Leuthner, and Christy L. Cummings. *Workshop Presenter*, Pediatric Academic Societies Annual Meeting, “How Can Newborn Toxicology Testing be Equitable?” Washington, DC, April 30.
2. 2022, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “A Mixed Methods Analysis of Requests for Religious Exemptions to a COVID-19 Vaccine Requirement.” Portland, Oregon, October 27.
3. 2022, *Panelist*, American Society for Bioethics and Humanities Annual Meeting, Pediatric Ethics Affinity Group, “When Ethical Healthcare Is Prohibited By Law, How Do We Respond?” Portland, Oregon, October 27.
4. 2022, *Speaker*, APPD/PAS Fellow Core Curriculum Workshop, Pediatric Academic Societies Annual Meeting, “From Idea to Implementation: Navigating the Ethical Landscape of Pediatric Clinical Research,” Denver, Colorado, April 22.
5. 2021, *Panelist*, Pediatric Endocrine Society Annual Meeting, Difference of Sex Development Special Interest Group, Virtual Conference, April 29.
6. 2020, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Is This Child Dead? Controversies Regarding the Neurological Criteria for Death,” Virtual Conference, October 17.
7. 2020, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Contemporary Ethical Controversy in Fetal Therapy: Innovation, Research, Access, and Justice,” Virtual Conference, October 15.
8. 2020, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “K-12 Schools and Mandatory Public Health Programs During the COVID-19 Pandemic,” Virtual Conference, October 15.
9. 2019, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Ethical Issues in Translating Gene Transfer Studies Involving Children with Neurodegenerative Disorders,” Pittsburgh, Pennsylvania, October 26.
10. 2019, *Moderator*, Pediatric Academic Societies Annual Meeting, Clinical Bioethics, Baltimore, Maryland, April 28.
11. 2018, *Presenter*, American Society for Bioethics and Humanities Annual Meeting, “Looking to the Past, Understanding the Present, and Imaging the Future of Bioethics and Medical Humanities’ Engagement with Transgender Health,” Anaheim, California, October 19.
12. 2018, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Should Vaccination Be a Prerequisite for Sold Organ Transplantation?” Anaheim, California, October 18.
13. 2018, Lindsey Douglas, Armand H. Matheny Antommara, Derek Williams. *Workshop Presenter*, Pediatric Hospital Medicine Annual Meeting, “IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB).” Atlanta, Georgia, July 20.

14. 2018, Alan Schroeder, Armand H. Matheny Antommara, Hannah Bassett, Kevin Chi, Shawn Ralston, Rebecca Blankenburg, *Workshop Speaker*, Pediatric Hospital Medicine Annual Meeting, “When You Don’t Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress,” Atlanta, Georgia, July 20.
15. 2018, Alan Schroeder, Hannah Bassett, Rebecca Blankenburg, Kevin Chi, Shawn Ralston, Armand H. Matheny Antommara, *Workshop Speaker*, Pediatric Academic Societies Annual Meeting, “When You Don’t Agree with the Plan: Balancing Diplomacy, Value, and Moral Distress,” Toronto, Ontario, Canada, May 7.
16. 2017, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Tensions in Informed Consent for Gender Affirming Hormone Therapy and Fertility Preservation in Transgender Adolescents,” Kansas City, Missouri, October 19.
17. Lindsey Douglas, Armand H. Matheny Antommara, and Derek Williams. 2017, *Workshop Leader*, PHM[Pediatric Hospital Medicine]2017, “IRB Approved! Tips and Tricks to Smooth Sailing through the Institutional Review Board (IRB) Process,” Nashville, Tennessee, July 21.
18. 2016, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Ethical Challenges in the Care of International Patients: Organization, Justice, and Cultural Considerations,” Washington, DC, October 9.
19. 2015, *Coauthor*, The American Society of Human Genetics Annual Meeting, “Adolescents’ Opinions on Disclosure of Non-Actionable Secondary Findings in Whole Exome Sequencing,” Baltimore, Maryland, October 9.
20. 2012, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “A Public Health Ethics Analysis of the Mandatory Immunization of Healthcare Personnel: Minimizing Burdens and Increasing Fairness,” Washington, DC, October 21.
21. Armand H. Matheny Antommara, Valerie Gutmann Koch, Susie A. Han, Carrie S. Zoubul. 2012, *Moderator*, American Society for Bioethics and Humanities Annual Meeting, “Representing the Underrepresented in Allocating Scarce Resources in a Public Health Emergency: Ethical and Legal Considerations,” Washington, DC, October 21.
22. 2012, *Platform Presentation*, Pediatric Academic Societies Annual Meeting, “Qualitative Analysis of International Variation in Donation after Circulatory Death Policies and Rates,” Boston, Massachusetts, April 30. Publication 3150.4.
23. 2011, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “The Intersection of Policy, Medicine, and Ethics during a Public Health Disaster: Special Considerations for Children and Families,” Minneapolis, Minnesota, October 13.
24. Armand H. Matheny Antommara and Joel Frader. 2010, *Workshop Leader*, Pediatric Academic Societies Annual Meeting, “Conscientious Objection in Health Care: Respecting Conscience and Providing Access,” Vancouver, British Columbia, Canada. May 1. Session 1710.

25. 2009, *Workshop Leader*, American Society for Bioethics and Humanities Annual Meeting, “Advanced Clinical Ethics Consultation Skills Workshop: Process and Interpersonal Skills,” Washington, DC, October 15.
26. 2009, *Platform Presentation*, Pediatric Academic Societies Annual Meeting, “Qualitative Analysis of Donation after Cardiac Death Policies at Children’s Hospitals,” Baltimore, Maryland, May 2. Publication 2120.6.
27. 2008, *Speaker*, American Society for Bioethics and Humanities Annual Meeting, “Qualitative Analysis of Donation After Cardiac Death (DCD) Policies at Children’s Hospitals,” Cleveland, Ohio, October 26.
28. 2007, *Participant*, Hamline University School of Law Biennial Symposium on Advanced Issues in Dispute Resolution, “An Intentional Conversation About Conflict Resolution in Health Care,” Saint Paul, Minnesota, November 8-10.
29. 2007, *Speaker*, American Society of Bioethics and Humanities Annual Meeting, “Bioethics Consultation and Alternative Dispute Resolution: Opportunities for Collaboration,” Washington, DC, October 21.
30. 2007, *Speaker*, American Society of Bioethics and Humanities Annual Meeting, “DNAR Orders in Schools: Collaborations Beyond the Hospital,” Washington, DC, October 18.
31. Armand H. Matheny Antommara and Jeannie DePaulis. 2007, *Speaker*, National Association of Children’s Hospitals and Related Institutions Annual Meeting, “Using Mediation to Address Conflict and Form Stronger Therapeutic Alliances,” San Antonio, Texas, October 9.
32. 2006, *Speaker*, American Society of Bioethics and Humanities Annual Meeting, “Bioethics Mediation: A Critique,” Denver, Colorado, October 28.
33. 2005, *Panelist*, American Society of Bioethics and Humanities Annual Meeting, “How I See This Case: ‘He Is Not His Brain,’” Washington, DC, October 20.
34. 2005, *Paper Presentation*, Pediatric Ethics: Setting an Agenda for the Future, The Cleveland Clinic, “‘He Is Not His Brain:’ Accommodating Objections to ‘Brain Death,’” Cleveland, Ohio, September 9.
35. 2004, *Speaker*, American Society for Bioethics and Humanities Spring Meeting, “Verification and Balance: Reporting Within the Constraints of Patient Confidentiality,” San Antonio, Texas, March 13.
36. 2002, *Panelist*, American Society for Bioethics and Humanities Annual Meeting, “‘Who Should Survive?:’ Mental Retardation and the History of Bioethics,” Baltimore, Maryland, October 24.

Invited/Visiting Professor Presentations

1. 2013, Visiting Professor, “How to Listen, Speak and Think Ethically: A Multidisciplinary Approach,” Norton Suburban Hospital and Kosair Children’s Hospital, Louisville, Kentucky, May 22.

2. 2010, Visiting Professor, Program in Bioethics and Humanities and Department of Pediatrics, “What to Do When Parents Want Everything Done: ‘Futility’ and Ethics Facilitation,” University of Iowa Carver College of Medicine, Iowa City, Iowa, September 10.

Grand Round Presentations

1. 2019, David Green Lectureship, “Establishing Goals of Care and Ethically Limiting Treatment,” Primary Children’s Hospital, Salt Lake City, Utah, December 5.
2. 2018, “The Ethics of Medical Intervention for Transgender Youth,” El Rio Health, Tucson, Arizona, September 29.
3. 2018, Pediatrics, “Patient Selection, Justice, and Cultural Difference: Ethical Issues in the Care of International Patients,” Cleveland Clinic, Cleveland, Ohio, April 10.
4. 2018, Bioethics, “Reversibility, Fertility, and Conflict: Ethical Issues in the Care of Transgender and Gender Nonconforming Children and Adolescents,” Cleveland Clinic, Cleveland, Ohio, April 9.
5. 2017, Heart Institute, “‘Have you ever thought about what you would want—if god forbid—you became sicker?’: Talking with adult patients about advance directives,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, October 16.
6. 2017, Pediatrics, “Respectful, Effective Treatment of Jehovah’s Witnesses,” with Judith R. Ragsdale, PhD, MDiv and David Morales, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, March 14.
7. 2017, Pediatrics, “Ethical Dilemmas about Discharging Patients When There Are Disagreements Concerning Safety,” Seattle Children’s Hospital, Seattle, Washington, January 19.
8. 2015, Pediatrics, “‘Nonbeneficial’ Treatment: What must providers offer and what can they withhold?,” Greenville Health System, Greenville, South Carolina, May 10.
9. 2014, Advance Practice Providers, “Common Ethical Issues,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, August 13.
10. 2014, Respiratory Therapy, “Do-Not-Resuscitate (DNR) Orders,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, July 15.
11. 2013, Heart Institute, “No Not Months. Twenty-Two *Years*-Old: Transiting Patients to an Adult Model of Care.” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, October 21.
12. 2013, Division of Neonatology, “This Premature Infant Has a *BRCA1* Mutation!?: Ethical Issues in Clinical Whole Exome Sequencing for Neonatologists.” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, October 11.
13. 2013, Department of Pediatrics, “Adults are Not Large Children: Ethical Issues in Caring for Adults in Children’s Hospitals,” Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, February 26.
14. 2012, “Mandate or Moratorium?: Persisting Ethical Controversies in Donation after Circulatory Death,” Cedars-Sinai Medical Center, Los Angeles, California, May 16.

15. 2011, Division of Pediatric Neurology Friday Lecture Series, “Inducing or Treating ‘Seizures’ with Placebos: Is It Ever Ethical?,” University of Utah, Salt Lake City, Utah, October 7.
16. 2011, Department of Surgery, “DNR Orders in the OR and other Ethical Issues in Pediatric Surgery: Case Discussions,” Primary Children’s Medical Center, Salt Lake City, Utah, October 3.
17. 2009, Department of Pediatrics, “What to Do When Parents Want Everything Done: ‘Futility’ and Bioethical Mediation,” Primary Children’s Medical Center, Salt Lake City, Utah, September 17.
18. 2008, Division of Pulmonology and Critical Care, “Futility: May Clinicians Ever Unilaterally Withhold or Withdraw Medical Treatment?” Utah Valley Regional Medical Center, Provo, Utah, April 17.
19. 2007, Division of Otolaryngology-Head and Neck Surgery, “Advance Directives, Durable Powers of Attorney for Healthcare, and Do Not Attempt Resuscitation Orders: Oh My!,” University of Utah School of Medicine, Salt Lake City, Utah, June 20.

Outreach Presentations

1. 2019, *Panelist*, Cincinnati Edition, WVXU, “The Ethics of Human Gene Editing,” Cincinnati, Ohio, June 13.
2. 2019, *Speaker*, Adult Forum, Indian Hill Church, “Medical Ethics,” Indian Hill, Ohio, March 24.
3. 2016, *Speaker*, Conversations in Bioethics: The Intersection of Biology, Technology, and Faith, Mt. Washington Presbyterian Church, “Genetic Testing,” Cincinnati, Ohio, October 12.
4. 2008, *Speaker*, Science in Society, Co-sponsored by KCPW and the City Library, “Death—Choices,” Salt Lake City, Utah, November 20.
5. 2003, *Panelist*, Utah Symposium in Science and Literature, “The Goodness Switch: What Happens to Ethics if Behavior is All in Our Brains?” Salt Lake City, Utah, October 10.
6. 2002, *Respondent*, H. Tristram Englehardt, Jr. “The Culture Wars in Bioethics,” Salt Lake Community College, Salt Lake City, Utah, March 29.

Podcasts

1. 2021, “Ethics of COVID Vaccines in Kids,” PHM from Pittsburgh, August 12.
2. 2020, COVID Quandaries: Episode 1, “Is Getting Sick Just Part of the Job?” Hard Call, October 6.

EXHIBIT B

TABLE 1: Level of Evidence Supporting Recommendations in Various Medical Specialties

Specialty	Time Frame	Guidelines N	Recommendations N	Grading System	Level of Evidence		
					High N (%)	Medium N (%)	Low N (%)
Cardiology ¹	9/30/2008	16	2,680	ACA/AHA	314 (11.7)	1,089 (40.6)	1,246 (46.5)
Cardiology ²	2/1/2019	51	6,349	NS	722 (11.4)	2,518 (39.7)	3,069 (48.3)
Endocrinology ³	1995-2011	29	1,762	NS	191 (10.8)	766 (43.5)	804 (45.6)
Infectious Diseases ⁴	7/30/2009	44	4,182	IDSA/USPHS	617 (14.8)	1,240 (29.7)	2,325 (55.5)
Obstetrics and Gynecology ⁵	6/1998-12/2004	55	438	USPSTF	128 (29)	143 (33)	167 (38)
Primary Care ⁶	NS	721	3,251	SORT	576 (18)	1,099 (34)	1,576 (49)

ACC-American College of Cardiology, AHA-American Heart Association, ECS-European Society for Cardiology, IDSA-Infectious Diseases Society of America, NS-Not Specified, SORT-Strength of Recommendations Taxonomy, USPHS-United States Public Health Service, USPSTF-United States Preventative Services Task Force

¹ Tricoci P, Allen JM, Kramer JM, Califf RM, Smith SC, Jr. Scientific evidence underlying the ACC/AHA clinical practice guidelines. *JAMA*. 2009;301(8):831-41.

Level A--evidence from multiple randomized trials or meta-analyses

Level B--evidence from a single randomized trial or nonrandomized studies

Level C--expert opinion, case studies, or standards of care

² Fanaroff AC, Califf RM, Windecker S, Smith SC, Jr., Lopes RD. Levels of evidence supporting American College of Cardiology/American Heart Association and European Society of Cardiology guidelines, 2008-2018. *JAMA*. 2019;321(11):1069-1080.

Level A--multiple RCTs or a single, large RCT

Level B--observational studies or a single RCT

Level C--expert opinion only

³ Hazlehurst JM, Armstrong MJ, Sherlock M, et al. A comparative quality assessment of evidence-based clinical guidelines in endocrinology. *Clin Endocrinol (Oxf)*. 2013;78(2):183-90.

High--well-conducted, randomized, controlled trials and meta-analyses

Moderate--nonrandomized studies (i.e. case series, retrospective cohort studies)

Low--expert opinion

⁴ Khan AR, Khan S, Zimmerman V, Baddour LM, Tleyjeh IM. Quality and strength of evidence of the Infectious Diseases Society of America clinical practice guidelines. *Clin Infect Dis*. 2010;51(10):1147-1156.

I-->= 1 properly randomized controlled trial

II-->= 1 well-designed clinical trial, without randomization, cohort or case-controlled analytic studied (preferably from > 1 center), multiple time series, or dramatic results from uncontrolled experiments

III--opinion of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

⁵ Chauhan SP, Berghella V, Sanderson M, Magann EF, Morrison JC. American College of Obstetricians and Gynecologists practice bulletins: an overview. *Am J Obstet Gynecol*. 2006;194(6):1564-1572; discussion 1072-5.

Level A--good and consistent scientific evidence,

Level B--limited or inconsistent scientific evidence,

Level C--consensus and expert opinion.

⁶ Ebell MH, Sokol R, Lee A, Simons C, Early J. How good is the evidence to support primary care practice? *Evid Based Med*. Jun 2017;22(3):88-92.

A--consistent and good quality patient-oriented evidence

B--inconsistent or limited quality patient-oriented evidence

C--consensus, usual practice, opinion, disease-oriented evidence, or case series

Good Quality--validated clinical decision rules, meta-analyses of high-quality studies and high-quality individual cohort studies for diagnosis; meta-analyses of randomized controlled trials, high-quality individual randomized controlled trials, and all or none studies for treatment and prevention; and meta-analyses of good quality cohort studies and individual cohort studies with good follow-up for prognosis

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

KANAUTICA ZAYRE-BROWN

Plaintiff,

No. 3:22-cv-00191

NORTH CAROLINA DEPARTMENT OF
ADULT CORRECTION, et al.

Defendants,

EXHIBIT INDEX

Exhibit	Description
Exhibit 1	Rebuttal Report of Dr. Randi C. Ettner, Ph. D.
Exhibit 2	Rebuttal Report of Dr. Armand H. Antommara , M.D., Ph. D.