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12 Attorneys for Plaintiff
13 CHLOE E. BROCKMAN

14 SUPERIOR COURT OF THE STATE OF CALIFORNIA

15 IN AND FOR THE COUNTY OF SAN JOAQUIN – STOCKTON BRANCH

16 CHLOE E. BROCKMAN aka CHLOE
17 COLE, an individual

18 Plaintiff,

19 v.

20 KAISER FOUNDATION HOSPITALS,
INC., a California Corporation, THE
21 PERMANENTE MEDICAL GROUP, INC.,
a California Corporation, LISA KRISTINE
22 TAYLOR, M.D., an individual, HOP
23 NGUYEN LE, M.D., an individual,
SUSANNE E. WATSON, PHD., an
24 individual, LILIT ASULYAN PSYD, an
individual, and ESTER BALDWIN, LCSW,
25 an individual, and DOES 1 through 50,
inclusive,
26

27 Defendants.
28

Case No.: STK-CV-UMM-2023-0001612

**DECLARATION OF JOHN PERROTTI,
M.D.**

Dept.: 11B
Judge: Hon. Robert T. Waters
Assigned for All Purposes

Action Filed: February 22, 2023
Trial Date: Not Set

1 “Recommendations: Adolescent candidates for (purely) aesthetic breast
2 augmentation should **be at least 18 years of age**. Breast augmentation that is done
3 for aesthetic reasons is best delayed until the patient has sufficient emotional and
4 physical maturity to make an informed decision based on an understanding of the
5 factors involved in this procedure. This includes being realistic about the surgery,
6 expected outcome and possible additional surgeries. In considering emotional
7 maturity for breast augmentation, the patients should request the procedure for
8 themselves, not to satisfy another’s perception of the patient. In addition, they should
9 demonstrate sufficient emotional maturity to understand all aspects of this surgery.
10 This would include having realistic expectations of the procedure itself, the outcome
11 and the potential for future surgeries. Adolescent patients need to understand that,
12 while implants can be surgically removed, the procedure may leave permanent
13 changes on the body, including scarring and tissue changes.”

9 Although augmentation is not the issue in this case, the need for emotional and physical maturity to
10 make a decision to totally remove one’s breasts applies even more dramatically, and teenagers under
11 age 18 years of age should never receive a mastectomy, unless there is a serious reason for requiring
12 such a surgery.

13 11. Until recent years, mastectomies have never been requested by or for minor patients,
14 and even now they are requested only in the context of a minors seeking to remove otherwise healthy
15 breast tissue in order to transition to appear more like the opposite sex. In this context, there has
16 been an unexplained, exponential increase in requests for breast removal surgeries. A 2022 study
17 involving Kaiser patients states: “Compared with adults, research on gender-affirming surgery in
18 adolescents is more limited. The incidence of referrals or requests for gender-affirming mastectomy
19 in adolescents has risen exponentially over the past decade. Although studies have evaluated the
20 increase in gender-affirming surgery in adults, we know of none that report the incidence of gender-
21 affirming mastectomy in adolescents.” Gender-Affirming Mastectomy Trends and Surgical
22 Outcomes in Adolescents, Annie Tang, MD, *et al.*, MD (Ann. Plast. Surg. 2022;88: S325–S331).
23 The provision of mastectomies on minor girls exploded from just several per year in 2013 to nearly
24 50 in 2019. (Ann. Plast. Surg. 2022;88: S325–S331.) Kaiser’s Northern California health system has
25 performed over 200 mastectomies on minor girls between 2013 and 2020. *Id.*

26 12. The efficacy of this so called “treatment” is dubious at best. I am aware of no long-

27
28 (approved 2004, reaffirmed 2015) (https://www.plasticsurgery.org/documents/Health-Policy/Positions/policy-statement_breast-augmentation-in-teenagers.pdf).

1 term, control group studies demonstrating the efficacy of treating the psychological diagnosis of
2 “gender identity disorder” or “gender dysphoria” with surgical rather than psychiatric/psychological
3 interventions, particularly in minors. Indeed, the evidence in this area, particularly as to minors,
4 strongly supports the opposite conclusion that use of psychotherapy to treat and alleviate symptoms
5 from this psychological diagnosis is the best course of treatment.

6 13. Most of the studies evaluating the effect of sex-reassignment treatment on mental
7 health outcomes are low to very low-quality at best. These low-quality studies typically involve a
8 short follow-up period of 1-2 years, suffer from serious selection bias, response bias, reporting bias,
9 and other types of bias, and have no randomized control group which is the gold standard in medical
10 research. On the other hand, the best studies that exist in this area are two 30-40-year population-
11 based studies out of Sweden and Denmark respectively.² Although similar to the other studies in
12 this area they involve no randomized control groups, each of these studies analyzed data from the
13 entire populations of each respective country and span a period of 30-40 years respectively. Thus,
14 the length of these studies and the quantity of analyzed data immensely exceeds that of any other
15 studies of mental health outcomes for those undergoing sex-reassignment treatment. These two
16 studies conclusively establish that individuals who undergo sex-reassignment “treatment” continue
17 to be at a significantly increased risk of suffering from serious mental health morbidity, suicidality,
18 and completed suicide attempts as compared with the general population even after the so-called
19 “treatment” is performed. They indicate a completed suicide attempt rate that is

20 14. Multiple systematic reviews of the relevant literature have concluded that the current
21 research is insufficient to demonstrate the effectiveness of this so called “treatment.” One of the
22 foremost objective medical literature reviews in the U.S. is performed by the Hayes Corporation
23
24

25
26 ² Dhejne, C., et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment*
Surgery: Cohort Study in Sweden, PLOS ONE (Feb. 2011)
27 (<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885>);
28 [Erlangsen, A., et al., Transgender Identity and Suicide Attempts and Mortality in Denmark](https://jamanetwork.com/journals/jama/article-abstract/2806531), JAMA
(June 2023) (<https://jamanetwork.com/journals/jama/article-abstract/2806531>).

1 (“Hayes”).³ Hayes reviewed cross-sex hormone administration for adolescent gender dysphoria in
2 2014 and gave it the lowest “D2” rating: the research findings were “too sparse” and “too limited”
3 to even *suggest* conclusions.⁴ In 2018, Hayes again examined the extant evidence for gender
4 reassignment surgery for minors and re-concluded that it merited its lowest “D2” rating:
5 “insufficient published evidence to assess the safety and/or impact on health outcomes or patient
6 management.”⁵ Finland, Sweden, England, and more recently Florida’s Boards of Medicine, have
7 all conducted systematic reviews of the relevant literature and concluded that the risk/benefit ratio
8 of GAC for youth ranges from unknown to unfavorable.⁶ These countries effectively reversed
9 course from allowing GAC on a widescale to narrowly restricting its availability to minors.

10 15. Although they do not establish standards of care, nor do they purport to establish
11 standards of care, it is important to note the following professional organization and insurance
12 guidelines regarding transition treatment as to minors:

- 13 • The 2009 Endocrine Society Guidelines No. 2.6, state that surgery should not occur
14 “until the individual is **at least 18 yr. old**”:
15 <https://assets.ctfassets.net/6npzwubtvm2/7BpnNKDsqKchRr1ORPYF3p/3e6256ce8dc7336a32085c18128ab5b1/endocrine-guidelines.pdf>;
- 16 • The 2017 Endocrine Society Guidelines No. 2.5, requires that a “compelling reason”
17 existed to initiate cross- sex hormone treatment minor’s **prior to 16 years of age**:
18 <https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence>.
- 19 • The U.S. Centers for Medicare and Medicaid Services (CMS) criteria for treatment
20 for gender dysphoria states:
21 **“The criteria for cross sex hormone therapy are as follows:**
22 1. *Persistent, well-documented gender dysphoria;*
2. *Capacity to make a fully informed decision and to consent for*

23 ³ Hayes regularly reviews the research underlying medical treatments and is nationally
24 authoritative, serving companies that cover 83% of insured Americans. See, Hayes, Inc., *The*
25 *Hayes Difference*: <https://www.hayesinc.com/about-hayes/>.

26 ⁴ <https://spaces.hightail.com/space/HiGfOiTNeR>.

27 ⁵ <https://spaces.hightail.com/space/CiCkJj4sMA>.

28 ⁶ Levine, S.B., Abbruzzese, E. Current Concerns About Gender-Affirming Therapy in
Adolescents. *Curr Sex Health Rep* 15, 113–123 (2023). <https://doi.org/10.1007/s11930-023-00358-x>

treatment;

3. **Member must be at least 18 years of age;**

4. *If significant medical or mental health concerns are present, they must be reasonably well controlled.*”; and

“Surgical treatment for gender dysphoria may be considered medically necessary when ALL of the following criteria are met:

1. **The individual is at least 18 years of age.**

2. *A gender reassignment treatment plan is created specific to an individual beneficiary.*

The individual has a documented Diagnostic and Statistical Manual of Mental Disorders --Fifth Edition, DSM-5™ diagnosis of GD;

<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=53793&ver=25&bc=CAAAAAAAAAAAAA>

- Kaiser’s own health plan criteria for the Pacific Northwest Region of Washington and Oregon require that a patient be at least 18 years of age to receive a mastectomy and in exceptional circumstances allows a patient to receive a mastectomy as young as 16, but no younger.⁷

16. Desistence rates are also a critical issue for minors who desire to receive sex reassignment surgery. As to minors, eleven unchallenged studies of desistence rates in youth show that around 80%-90% of minors desist from an opposite sex gender identity upon reaching adulthood.⁸ The American Psychiatric Association DSM-5 identifies these same desistence rates based on the same studies.⁹ Thus, every indication from these studies is that the vast majority of youth who undergo permanent sex-reassignment “treatment” will come to regret their decision and

⁷ <https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/health-plan-documents/coverage-information/clinical-review-gender-affirming-procedures-nw.pdf>

⁸ Buttons, C., *Finland’s Leading Gender Dysphoria Expert Says 4 Out Of 5 Children Grow Out Of Gender Confusion*, THE DAILY WIRE (Feb 2023); Korte, A., et al., *Gender Identity Disorders in Childhood and Adolescence*, DTSCH ARZTEBL INT. (Nov. 2008) (DOI: [10.3238/arztebl.2008.0834](https://doi.org/10.3238/arztebl.2008.0834)); Cantor, J., *Do Trans-Kids Stay Trans- When They Grow Up?* SEXOLOGY TODAY (http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html (accessed Feb. 7, 2023)) (summarizing the eleven studies of desistence including three large scale follow-up studies and eight smaller scall studies).

⁹ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition Text Revision DSM-5-TR™*, AMERICAN PSYCHIATRIC ASSOCIATOIN PUBLISHING, page 517 (<https://ebooks.appi.org/epubreader/diagnostic-statistical-manual-mental-disorders-fifth-edition-text-revision-dsm5tr>).

1 have devastating physical changes to their body because they will eventually desist from their
2 transgender identity.

3 17. With respect to general suicide risk in mental healthcare, psychotherapy has been
4 successfully employed to reduce such risk. As an example, in a systematic review of the
5 effectiveness of psychotherapy on suicidal outcomes, it was found that in twenty-three assessed
6 studies, there was a “decrease of suicidal ideation rates in 95.7% of them.”¹⁰ With respect to suicide
7 attempts, seventeen studies were examined and 88.2% showed positive (good) results. (*Id.*). Given
8 that a high percentage of adolescents have comorbid psychiatric conditions in association with
9 gender dysphoria, a reasonable approach to treating these young people (and avoiding the harms of
10 hormones and surgeries) would be to employ such psychotherapeutic approaches.

11 18. In summary, for the reasons summarized above and other reasons, a double
12 mastectomy should never be performed on a minor without a serious and immediate need to perform
13 such a surgery. A “gender dysphoria” or “gender identity disorder” diagnosis does not constitute
14 such a serious and immediate need. Minors have a high rate of desistence and there is no reliable
15 evidence demonstrating that such treatment is efficacious. There is also no reason why a permanent,
16 irreversible, and likely devastating physical change should be preferred over non-permanent and
17 standard psychotherapy methods. Any requests by a minor to receive a double mastectomy for the
18 purpose of sex-reassignment should be delayed until at least 18 years of age and re-evaluated at that
19 time. Performing such a surgery on a 15-year-old biologic female like Chloe constitutes a deliberate
20 decision to ignore the available medical evidentiary research on this issue, and represents a knowing
21 and deliberate breach of the relevant standards of care.

22 19. Additionally, this willful and deliberate breach of the standard of care is aggravated
23 by a concurrent failure to provide informed consent regarding any of the risk issues discussed above.
24 Based on my assessment of the discussions that took place between Chloe and Dr. Hop Nguyen Le,
25

26 ¹⁰ Méndez-Bustos P, Calati R, Rubio-Ramírez F, Olié E, Courtet P, Lopez-Castroman J.
27 Effectiveness of Psychotherapy on Suicidal Risk: A Systematic Review of Observational Studies.
28 Front Psychol. 2019 Feb 19;10:277. doi: 10.3389/fpsyg.2019.00277. PMID: 30837920; PMCID:
PMC6389707

1 Chloe’s cosmetic surgeon, Dr. Le provided Chloe only with the type of information about a double
2 mastectomy that a (typically adult) cancer patient receives, and not facts specific to her situation as
3 a minor with gender dysphoria and healthy breasts. The available evidence in the medical records
4 and in declarations filed concurrently herewith indicates that Dr. Le failed to discussed any of the
5 following with Chloe and/or her parents: 1) high desistence rates for minors and the high risk of
6 regret based upon the same, 2) the option of receiving psychotherapy instead, 3) the high risk of
7 continued increased psychiatric morbidity and suicidality even after completing sex reassignment,
8 4) the lack of long term, randomized control studies in this area and the low-quality of the medical
9 research upon which this proposed treatment is based, 5) the long term implications of testosterone
10 on the female reproductive organs and the eventual need for a complete hysterectomy, 6) the
11 implications on intimacy and relationships of having a masculinized chest but female reproductive
12 organs, and 7) the next step of “bottom surgery,” the related high complication rates and resulting
13 lifelong medicalization. These, among potentially others, represent critical issues of informed
14 consent pertaining to performing a double mastectomy in Chloe’s situation. The failure to convey
15 this critical information further buttresses the existence of a deliberate intent to cause Chloe harm
16 by concealing from her and her parents’ any information that might dissuade them from continuing
17 down this destructive path. As a result, on Defendant Le’s recommendation, Chloe has now
18 deliberately incurred a permanent physical injury that she now severely regrets.

19 20. In addition to all of the foregoing, a proper psychological evaluation is also a critical
20 pre-requisite to any consideration for surgery on a minor. In 2012, the American Psychiatric
21 Association (“APA”) Task Force on the Treatment of Gender Identity Disorder advised that teens
22 be “screened carefully” for trauma as well as for other psychiatric disorders that may produce gender
23 confusion.¹¹ The APA Handbook on Sexuality and Psychology states: “Premature labeling of
24 gender identity should be avoided. . .This approach runs the risk of neglecting individual problems
25 the child might be experiencing and may involve an early gender role transition that might be

27 ¹¹ Byne W, Bradley SJ, Coleman E, Eyler AE, Green R, Menvielle EJ, et al. Report of the
28 American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. Archives
of Sexual Behavior. 2012; 41: 759-796. mid:22736225).

1 challenging to reverse if cross-gender feelings do not persist.”¹²

2 21. The 2015 American Psychological Association “Guidelines for Psychological
3 Practice With Transgender and Gender Nonconforming People” states: “Additionally, adolescents
4 can become intensely focused on their immediate desires, resulting in outward displays of frustration
5 and resentment when faced with any delay in receiving the medical treatment from which they feel
6 they would benefit and to which they feel entitled.”¹³ “This intense focus on immediate needs may
7 create challenges in assuring that adolescents are cognitively and emotionally able to make life-
8 altering decisions to change their name or gender marker, begin hormone therapy (which may affect
9 fertility), or pursue surgery.”¹⁴

10 22. Additionally, well established research on the plasticity of minors’ cognitive
11 functions, notes as follows:

12 Brain maturation during adolescence (ages 10–24 years) could be governed
13 by several factors...sex hormones including estrogen, progesterone, and
14 testosterone can influence the development and maturation of the adolescent
15 brain...Furthermore, the adolescent brain evolves its capability to organize,
16 regulate impulses, and weigh risks and rewards; however, these changes can
17 make adolescents highly vulnerable to risk-taking behavior...Plasticity
permits adolescents to learn and adapt in order to acquire independence;
however, plasticity also increases an individual’s vulnerability toward
making improper decisions because the brain’s region-specific neurocircuitry
remains under construction, thus making it difficult to think critically and
rationally before making complex decisions.

18 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3621648/>.

19 23. WPATH Society Standard 6.3 for adolescents requires “a comprehensive
20 biopsychosocial assessment” before receiving GAC. WPATH Society Standard 6.12.d for
21 adolescents counseled that a patient’s “mental health concerns that may interfere with diagnostic
22 clarity, capacity to consent, and gender-affirming medical treatments have been addressed.”
23 WPATH, SOC 7, No. 3 required Defendants to “[a]ssess and treat any co-existing mental health
24 concerns (or refer to another mental health professional for treatment)” and instructed that “such

25 _____
26 ¹² W. Bockting, Ch. 24: Transgender Identity Development, in 1 American Psychological
27 Association Handbook on Sexuality and Psychology 744, 750 (D. Tolman & L. Diamond eds.,
2014).

28 ¹³ (Angello, 2013; Edwards-Leeper & Spack, 2012)

¹⁴ <https://www.apa.org/practice/guidelines/transgender.pdf>.

1 concerns should be addressed as part of the overall treatment plan.” WPATH SOC 7 required that
2 Defendants conduct an “extensive exploration of psychological, family, and social issues.”

3 24. Just because surgeons may not be trained in psychological evaluation does not
4 absolve them of the responsibility of conducting some basic common-sense inquiry into the reasons
5 and motivations for a patient, particularly a minor patient, seeking to remove healthy breast tissue.
6 The surgeon should also review the psychological evaluation report and confirm that it has properly
7 and thoroughly performed by a properly trained mental health professional.

8 25. Based on the medical records and Ms. Brockman’s declaration testimony, Dr. Le
9 failed to perform any inquiry into the underlying motivations for Chloe’s surgery request, her related
10 mental health history, her mental health history in the months leading up to the surgery, which had
11 declined including Chloe’s first experiences of suicidal ideation. Dr. Le failed to ensure that
12 adequate mental health evaluation was performed. Dr. Le also failed to discover that Chloe’s
13 concern for being further sexually assaulted was one of her motivations for seeking the surgery.
14 This fact should have been discovered by some basic inquiry, should have immediately prompted a
15 stop to any further surgery, and should have resulted in further extensive psychological evaluation
16 and therapy. Instead, Dr. Le rubber stamped the file and performed the surgery. The failure to
17 perform any basic inquiry regarding Chloe’s request for surgery further supports that this was a
18 deliberate scheme to push Chloe through the transgender conveyor belt without any regard for the
19 severe physical harm that it would cause to Chloe.

20 26. This complete failure on the part of the entire team of treating providers with regard
21 to Chloe’s utterly failed sex-reassignment “treatment” further demonstrates a systemic failure
22 caused by deliberate institutional decisions on the part of the hospital and medical group to
23 deliberately push sex-reassignment “treatment” on minors regardless of the poor-quality evidence
24 and severe risk of causing serious permanent injury to minor patients participating in this so-called
25 “treatment.”

26 27. In summary, based on my professional judgment and experience as well as
27 information summarized above and other information that I have reviewed as well as Chloe’s files
28

1 in this matter, Dr. Hop Nguyen Le deliberately and knowingly deviated from the standard of care
2 by performing a double mastectomy on Chloe at age 15, deliberately and knowingly concealed
3 critical information that should have been a fundamental part of any informed consent discussion in
4 Chloe's case, and deliberately and knowingly avoided any inquiry into Chloe's motivations for
5 seeking surgery that might have uncovered a reason not to perform the surgery.

6 I declare until penalty of perjury under the laws of the State of California that the foregoing
7 is true and correct. Executed on 2/9, 2024, at New York, NY.

8
9 
10 John Perrotti, M.D.

EXHIBIT 1

JOHN A. PERROTTI MD

30 Central Park South 1CD

New York, NY 10019

Tel. 212-258-2200

ACADEMIC APPOINTMENTS:

Assistant Clinical Professor of Surgery
New York Medical College, Valhalla, New York, May 1996

Adjunct Staff, Department of Plastic Surgery
The Cleveland Clinic, Cleveland, Ohio, Oct 2012

Program Director, Aesthetic Plastic Surgery Fellowship
Manhattan Eye, Ear and Throat Hospital, New York, 2000-2002

BOARD CERTIFICATION:

American Board of Plastic Surgery (2000/2010/2020)

LICENSE: New York
Florida

HOSPITAL APPOINTMENTS:

Lenox Hill Hospital, New York (Manhattan Eye, Ear and Throat Hospital, New York)
(Private aesthetic surgery practice; work with plastic surgery residents and aesthetic fellows)

Metropolitan Hospital Center, New York
(Attend general plastic surgery clinic, take emergency call and perform general plastic surgery to correct deformities, repair injuries, treat disease and improve function; direct and coordinate activities of residents and physician assistants; work with general surgery residents and medical students)

(St. Vincent's Hospital and Medical Center, New York)

RESIDENCY TRAINING:

Cosmetic Surgery Fellow

Drs. Baker, Stuzin, Baker, Miami, FL, 1998

Plastic Surgery Resident (PGY VI-VII)

The Cleveland Clinic Foundation, Cleveland, OH, 1996-1998

General Surgery Chief Resident (PGY V)

St. Vincent's Hospital and Medical Center/New York Medical College, NY, NY, 1995-96

General Surgery Resident (PGY II-IV)

St. Vincent's Hospital and Medical Center/New York Medical College, NY, NY, 1992-95

General Surgery Intern (PGY I)

St. Vincent's Hospital and Medical Center/New York Medical College, NY, NY, 1991-92

JOHN A. PERROTTI MD

EDUCATION:

M.D., June 1991
New York Medical College, Valhalla, New York

PUBLICATIONS:

Perrotti, J.A., Lampeter, W., Botox: The Ultraconcentrated Technique, QMP's Plastic Surgery Pulse News, Vol. 2, No. 4, Feb 2011.

Perrotti, J.A., Baker, T.J., Chemical Peels and Dermabrasion: Aesthetic Plastic Surgery. London: Saunders/Elsevier, 2009.

Perrotti, J.A., Cutaneous Resurfacing: Chemical Peeling, Dermabrasion and Laser Resurfacing: Grabb & Smith's Plastic Surgery. Philadelphia: Lippincott, Williams & Wilkins, 2007.

Perrotti, JA. Reply: Shorter hours for Residents, Plast Recon Surg, Vol. 114, No. 5:1363, Nov 2004.

Perrotti, JA. Shorter hours for Residents, Plast Recon Surg, Vol. 112, No. 5:1498, Nov 2003.

Perrotti, JA. Discussion: The Role of Preoperative Antibiotic Prophylaxis in Cosmetic Surgery, Plast Recon Surg, Vol. 109, No. 6:2574-2575, June 2002.

Perrotti, JA, Castor, SA, Perez PC, Zins, JE. Antibiotic Use in Aesthetic Surgery: A National Survey and Literature Review, Plast Recon Surg, Vol. 109, No. 5:1685-1693, April 2002.

Perrotti, JA. Managed care's attempt to capture aesthetic surgery, Plast Recon Surg, Vol. 108, No. 5:1447, October 2001.

Sharma S, Perrotti, JA, Longaker MT. Traumatic Abdominal Wall Pseudolipoma following Suction-Assisted Lipectomy, Plast Recon Surg, Vol. 105, No. 7:2589-2593, June 2000.

Perrotti JA, Papay FA. Use of Blake silicone drains in breast reconstruction surgery, Contemporary Surgery, December 1997.

PRESENTATIONS:

Faculty/OR Coordinator: Advances in Aesthetic Plastic Surgery Symposium, NY, 2000-2008.

Acoustic Stereotactic Orbital Positioning
American Society of Plastic and Reconstructive Surgeons, Boston, October 1998;
Interdisciplinary Congress on Craniofacial and Skull Base Surgery, Cancun, January 1998;
Ohio Valley Society for Plastic and Reconstructive Surgery, Indianapolis, June 1997.

Antibiotic Use in Liposuction: A National Survey and Literature Review
Lipoplasty Society of North America, Boston, October 1998.

Antibiotic Use in Aesthetic Surgery: A National Survey and Literature Review
International Confederation for Plastic Surgery, San Francisco, June 1999;
Ohio Valley Society for Plastic and Reconstructive Surgery, Farmington, June 1998.

JOHN A. PERROTTI MD

Hydroxyapatite Cement for Reconstruction of Craniofacial Defects
British Association of Plastic Surgery/PSEF, London, December, 1998;
Ohio Valley Society for Plastic and Reconstructive Surgery, Farmington, June 1998.

Midfacial Suspension Utilizing the Mitek Bone Anchor
Interdisciplinary Congress on Craniofacial and Skull Base Surgery, Cancun, January 1998;
Ohio Valley Society for Plastic and Reconstructive Surgery, Indianapolis, June 1997.

The Impact of Ultrasonography on General Surgery Residency Training
Grand Rounds, St. Vincent's Hospital and Medical Center, New York, June 1996.

Choledochal Cyst - Diagnosis and Treatment
Grand Rounds, St. Vincent's Hospital and Medical Center, New York, March 1995

VOLUNTEERISM:

Volunteer Member, NYC Medical Reserve Corps, 2009-present

Interplast: Kathmandu, Nepal, November 1997

Elmer Lindsay Memorial Center, Fire Island, NY, 2007-2011

MISCELLANEOUS:

Member, Quality Assurance Committee
Manhattan Eye, Ear and Throat Hospital, New York, 2000-2007

Member, Operating Room Committee
Metropolitan Hospital Center, New York, 2008-present

Coordinator, Monthly Aesthetic Plastic Surgery Lecture Series
Manhattan Eye, Ear and Throat Hospital, New York, 2000-2002

"The Best Beauty Docs", New York Magazine (10/6/03)

2008-24 Castle-Connelly Top Doctors-New York Metro Area

COURT OF THE STATE OF CALIFORNIA SAN JOAQUIN SUPERIOR COURT – STOCKTON BRANCH		FOR COURT USE ONLY
TITLE OF CASE (Abbreviated) Chloe E. Brockman v. Kaiser Foundation Hospitals, Inc., et al.		
ATTORNEY(S) NAME AND ADDRESS Charles S. LiMandri, Esq; Paul M. Jonna, Esq. Robert E. Weisenburger, Esq. LiMANDRI & JONNA LLP P.O. Box 9120 Rancho Santa Fe, California 92067 Tele: (858) 759-9930; Fax: (858) 759-9938		
ATTORNEY(S) FOR: Plaintiff Chloe E. Brockman	Dept. 11B	CASE NO.: STK-CV-UMM-2023-0001612

PROOF OF SERVICE

I, Rebecca M. Oakley, declare that: I am over the age of 18 years and not a party to the action; I am employed in, or am a resident of the County of San Diego, California, and my business address is P.O. Box 9120, Rancho Santa Fe, CA 92067, Telephone number (858) 759-9930; Facsimile number (858) 759-9938. I further declare that I served the following document(s) on the parties in this action:

Motion for Leave to Amend

1. **PLAINTIFF CHLOE E. BROCKMAN’S NOTICE OF MOTION AND MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
2. **PLAINTIFF CHLOE E. BROCKMAN’S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
3. **PLAINTIFF CHLOE E. BROCKMAN’S NOTICE OF LODGMENT OF CONFIDENTIALLY MARKED DOCUMENTS IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
4. **DECLARATION OF CHLOE E. BROCKMAN;**
5. **DECLARATION OF CHARLES S. LIMANDRI IN SUPPORT OF PLAINTIFF CHLOE E. BROCKMAN’S MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;**
6. **DECLARATION OF JOCELYN T. BROCKMAN;**
7. **DECLARATION OF ROBIN A. DEA, M.D.;**
8. **DECLARATION OF NATHAN SZAJNBERG, M.D.;**
9. **DECLARATION OF MICHAEL LAIDLAW, M.D.;**
10. **DECLARATION OF JOHN PERROTTI, M.D.;**
11. **DECLARATION OF STEPHEN B. LEVINE, M.D.;**
12. **DECLARATION OF TIM CROSBY, LMFT;**
13. **DECLARATION OF KAYLA LOVDAHL;**
14. **DECLARATION OF ELISABETH “BETH” BOURNE;**
15. **DECLARATION OF LAUREN WOHL-SANCHEZ; and**
16. **[Proposed] ORDER In SUPPORT OF PLAINTIFF CHLOE E. BROCKMAN’S MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES.**

Motion to Seal

1. **PLAINTIFF CHLOE E. BROCKMAN’S NOTICE OF MOTION AND MOTION TO SEAL DOCUMENTS LODGED IN SUPPORT OF MOTION FOR LEAVE TO AMEND**

COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES;

- 2. PLAINTIFF CHLOE E. BROCKMAN'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO SEAL DOCUMENTS LODGED IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES; and**
- 3. [Proposed] ORDER In SUPPORT OF PLAINTIFF CHLOE E. BROCKMAN'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION TO SEAL DOCUMENTS LODGED IN SUPPORT OF MOTION FOR LEAVE TO AMEND COMPLAINT TO STATE CLAIM FOR PUNITIVE DAMAGES**

by one or more of the following methods of service to:

****SEE ATTACHED SERVICE LIST**

 (BY U.S. MAIL) I caused such document(s) to be sealed in envelopes, and with the correct postage thereon fully prepaid, either deposited in the United States Postal Service or placed for collection and mailing following ordinary business practices.

 X **(BY E-MAIL/ELECTRONIC MAIL)** I caused a copy of the foregoing document(s) to be sent to the persons at the e-mail addresses listed above, this date via internet/electronic mail.

 X **(BY ELECTRONIC FILING/SERVICE)** I caused such document(s) to be Electronically Filed and/or Service through OneLegal.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on April 18, 2024



Rebecca M. Oakley

COURT OF THE STATE OF CALIFORNIA
SAN JOAQUIN SUPERIOR COURT – STOCKTON BRANCH

Chloe E. Brockman v. Kaiser Foundation Hospitals, Inc., et al.
CASE NO.: STK-CV-UMM-2023-0001612

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