

1 Charles S. LiMandri, SBN 110841
cslimandri@limandri.com
2 Paul M. Jonna, SBN 265389
pjonna@limandri.com
3 Robert E. Weisenburger SBN 305682
rweisenburger@limandri.com
4 LiMANDRI & JONNA LLP
P.O. Box 9120
5 Rancho Santa Fe, California, 92067
Telephone: (858) 759-9930
6 Facsimile: (858) 759-9938

Harmeet K. Dhillon (SBN: 207873)
Harmeet@dhillonlaw.com
John-Paul S. Deol (SBN: 284893)
JPDeol@dhillonlaw.com
Jesse D. Franklin-Murdock (SBN: 339034)
JFranklin-Murdock@dhillonlaw.com
DHILLON LAW GROUP INC.
177 Post Street, Suite 700
San Francisco, California 94108
Telephone: (415) 433-1700
Facsimile: (415) 520-6593

7 Mark E. Trammell*
mtrammell@libertycenter.org
8 CENTER FOR AMERICAN LIBERTY
1311 S. Main Street, Suite 207
9 Mount Airy, MD 21771
Telephone: (703) 687-6212
10 Facsimile: (517) 465-9683
*Admitted *Pro Hac Vice*

11 Attorneys for Plaintiff
12 CHLOE E. BROCKMAN

13 SUPERIOR COURT OF THE STATE OF CALIFORNIA

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

15 CHLOE E. BROCKMAN a/k/a CHLOE
16 COLE, an individual

17 Plaintiff,

18 v.

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

26 Defendants.
27
28

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

**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**

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

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

1 **DECLARATION OF CHARLES S. LiMANDRI**

2 I, Charles S. LiMandri, declare and state as follows:

3 1. I am an attorney at law duly licensed to practice before all courts of the State of
4 California. My law firm, LiMandri & Jonna LLP, is counsel of record for Plaintiff Chloe E.
5 Brockman (“Plaintiff” or “Ms. Brockman” or “Chloe”). This declaration is submitted in support of
6 Plaintiff’s Motion for Leave to Amend Complaint to State Claim for Punitive Damages. I have
7 personal knowledge of the facts stated in this declaration and would testify to them if called upon to
8 do so.

9 2. Attached to the Notice of Lodgment as **Exhibit 1** is a true and correct copy of the
10 document produced by Defendants as Bates No. KFH.Cole.007016 and titled “Gender Affirming
11 Surgery/Hormone Consultation” training materials slide. The document has been produced by the
12 defendants pursuant to the protective order entered in this case and will be filed pursuant to a notice
13 of lodgment concurrently with a motion to seal.

14 3. Attached to the Notice of Lodgment as **Exhibit 2** is a true and correct copy of the
15 document produced by Defendants as Bates No. KFH.Cole.006897 and titled “Top Surgery
16 (reconstruction/reduction)” training materials slide. The document has been produced by the
17 defendants pursuant to the protective order entered in this case and will be filed pursuant to a notice
18 of lodgment concurrently with a motion to seal.

19 4. Attached to the Notice of Lodgment as **Exhibit 4** is a true and correct copy of the
20 document produced by Defendants as Bates No. KFH.Cole.004809 and titled “07/08/2019 - Office
21 Visit in MULTIDIS SERVICES MED” containing photographs of Ms. Brockman’s breasts prior to
22 her surgery. The document has been produced by the defendants pursuant to the protective order
23 entered in this case and will be filed pursuant to a notice of lodgment concurrently with a motion to
24 seal.


25 5. Attached hereto as **Exhibit A** is a true and correct copy of a “Summary of Relevant
26 Citations and References” that I have prepared for this case, and that cites numerous medical,
27 scientific, and other related relevant resources. This document has been prepared based on my firm’s
28 extensive research, and in consultation with plaintiff’s experts, and other knowledgeable sources,

1 over approximately eighteen months. We are presently submitting this document, which contains
2 numerous references to authoritative medical and scientific and related studies and publications, in
3 further support of plaintiff’s motion to amend the complaint to add a claim for punitive damages.

4 6. Attached hereto as **Exhibit B** is a true and correct copy of the following Kaiser
5 medical study: Quinn, P., et al., “Cohort profile: Study of Transition, Outcomes and Gender
6 (STRONG) to assess health status of transgender people,” BMJ Open (2017) (doi:10.1136/ bmjopen-
7 2017-018121).

8 7. Attached hereto as **Exhibit C** are true and correct copies of The WPATH Files
9 “Executive Summary” and “WPATH Files Excerpts” published by Environmental Progress.

10 I declare until penalty of perjury under the laws of the State of California that the foregoing
11 is true and correct. Executed on April 18, 2024, at Rancho Santa Fe, California.

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13 
14 _____
Charles S. LiMandri

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EXHIBIT A

I. Kaiser's violations of the professional standards of care:

1. Kaiser states on its website that it follows the WPATH standards. Notwithstanding the foregoing, Kaiser's "Platinum Rule" is that it will immediately affirm all kids in their gender choices regardless of their age or where they are in their state of transition: <https://www.libsoftiktok.com/p/exclusive-whistleblower-exposes-hospital>; Kaiser also markets gender transition to children without parental knowledge or consent: https://www.libsoftiktok.com/p/kaiser-healthcare-pushes-gender-affirming?utm_source=%2Fsearch%2Fkaiser&utm_medium=reader2;
2. A Kaiser member acting undercover as a transgender patient wrote the following: "The medical workers I met repeatedly reminded me that they were not there to act as 'gatekeepers'. I was able to instantly change my medical records to reflect my new gender identity and pronouns. Despite never being diagnosed with gender dysphoria, I was able to obtain a prescription for testosterone and approval for a 'gender-affirming' double mastectomy from my doctor. It took only three more months (90 days) to be approved for surgery to remove my uterus and have a fake penis constructed from the skin of my thigh or forearm. Therapy was never recommended....My story, which I outline in much more detail below, should convince any half-rational person that gender medicine is not operating like any other field of medicine. Based on a radical concept of 'gender identity,' this medical anomaly preys upon the body-image insecurities common among pubescent minors to bill health insurance companies for permanent cosmetic procedures that often leave their patients with permanently altered bodies, damaged endocrine systems, sexual dysfunction, and infertility.": <https://www.realityslaststand.com/p/i-pretended-to-be-nonbinary-to-expose>;
3. The American Psychological Association Services, Inc. urged the California Department of Managed Health Care (DMHC) to take action to resolve Kaiser's problems in ensuring appropriate access to mental health care for Kaiser patients. (Jared Skillings, Ph.D. Chief of Professional Practice American Psychological Association Services, Inc.): <https://www.nbcsandiego.com/news/local/breakdown-kaiser-permanente-criticized-for-mental-health-care/2723477/>;
4. Hundreds of Kaiser mental health care professionals have gone on strike because of their inability to provide proper counseling and therapy to Kaiser patients and Kaiser has been repeatedly fined by the State of California for its many violations in this regard, including fraudulent reporting of alleged improvements in its system. (See Exhibits to Complaint: <https://libertycenter.org/wp-content/uploads/2023/02/Complaint1.pdf>);
5. The National Union of Healthcare Workers ("NUHW") sent the DMHC a letter accusing Kaiser's internal practices with respect to mental health of being "illegal rationing of care [...] systematic, widespread, and pervasive" and that Kaiser's practice as further being in a "discriminatory fashion that targets enrollees with [mental health issues]"; and that it is "illegal for Kaiser to design its care-delivery system to deliver, as a default outcome, a

system of substandard and noncompliant care that only can be remedied if and when enrollees or their therapists complain to Kaiser's managers.": https://www.dropbox.com/scl/fi/aidtn3031m9k89mbdxjb4/21-0617-NUHW-Ltr-Re-Kaiser-BH-Services_Highlighted.pdf?rlkey=vflees547n0jml12r9et6zirc&dl=0;

6. The NUHW has 1,992 stories of patients sharing their experiences about the extremely poor levels of care they received at Kaiser. For example, one story claims there "was only one child psychiatrist for an island of nearly 120,000 people and less than a dozen therapists." <https://nuhw.org/kaiser-dont-deny/patient-stories/>;
7. Kaiser has a pattern and practice of underfunding and understaffing its mental health department. On October 11, 2023, Kaiser and the DMHC entered into a \$200 million settlement agreement regarding Kaiser's deficient mental health-related care. Kaiser received the largest fine ever levied on a healthcare plan: \$50 million dollars, as well as investing \$150 million dollars over the next five years into Kaiser's mental health departments: <https://wps0.dmhc.ca.gov/enfactions/docs/4367/1697136977902.pdf>;
8. Kaiser's Research Division produced a report that describes in detail the kinds of physical and mental health problems experienced by adolescents and the kind of care that they need: https://about.kaiserpermanente.org/content/dam/kp/mykp/documents/research-briefs/research-brief_adolescent-health.pdf: "Mental health conditions are also a concern for adolescents. The symptoms of mental health conditions, including depression and anxiety, often begin during the teen years... Approximately 1 in 8 adolescents and young adults in the United States live with depression, and suicide is one of the most common causes of death in this age group. Anxiety disorders affect approximately one-third of teens, and attention-deficit/hyperactivity disorder and eating disorders are common in adolescence. Mental health disorders and other health issues may result from adverse childhood experiences (such as traumatic events, economic hardship, or parental separation or divorce), which affect 45% of American youths."
9. Kaiser Permanente's: "Providing Care to LGBTQ Patients" (September 30, 2016) states that .6 % of U.S. population identify as transgender; however, 2% of Kaiser's Northern California staff self-identify as transgender. (PDF pages 10-11): <https://www.dropbox.com/scl/fi/f1sqw328i0vhfdd9rcz2/160929-Providing-LGBTQ-Care-for-Asthma-Network-9.30.16-v2.pptx?rlkey=4gm4zbxvie20zyihf4hiznaop0&dl=0>;
10. There is no true consensus on "gender affirming care" (GFC) for minors as multiple national and international professional associations (representing thousands of reputable medical doctors and mental health care providers), have issued statements against the so-called GFC standards for minors, including the following:
 - i. Society of Evidence Based Gender Medicine: <https://segm.org/>;
 - ii. Association of American Physicians and Surgeons: <https://aapsonline.org/>;
 - iii. American College of Pediatricians: <https://acpeds.org/>;
 - iv. Alliance for Therapeutic Choice: <https://www.therapeuticchoice.org> (mental health providers);
 - v. Do No Harm Medicine: <https://donoharmmedicine.org/>;

- vi. Catholic Medical Association: <https://www.cathmed.org/resources/the-ideology-of-gender-harms-children/>;
 - vii. Christian Medical and Dental Association (CMDA): <https://spaces.hightail.com/space/k2QImA8pDq>; [Microsoft Word - Transgender Identification 2021.doc \(utah.gov\)](#) ;
 - viii. International Federation for Therapeutic and Counseling Choice: <https://archive.iftcc.org/iftcc-principles-for-approaches-to-transgender-treatments/> (mental health providers);
 - ix. Genspect. (2023). Gender Framework: A Vision for Change. The Killarney Group: <https://genspect.org/wp-content/uploads/2023/11/The-Gender-Framework-Draft-One.pdf>;
 - x. World Health Organization (WHO): https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/tgd_faq_16012024.pdf?sfvrsn=79eaf57f_1;
11. The U.S. Centers for Medicare and Medicaid Services (CMS) criteria for treatment for gender dysphoria states at this link: <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=53793&ver=25&bc=CAAAAAAAAAAAAA>:
“The criteria for cross sex hormone therapy are as follows:
- 1. *Persistent, well-documented gender dysphoria;*
 - 2. *Capacity to make a fully informed decision and to consent for 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.*
 - 3. *The individual has a documented Diagnostic and Statistical Manual of Mental Disorders --Fifth Edition, DSM-5™ diagnosis of GD;*
12. The 2012 “Report of the APA Task Force on Treatment of Gender Identity Disorder”, states: “As in other disorders, the recommendation for a particular therapy often hinges on the therapist’s preferences and training. This is especially true for GID, however, in light of **the lack of consensus** regarding either the goals for therapy or the malleability of gender identity, as well as the controversies surrounding the ethics of aiming to influence identity development.”: <https://www.psychiatry.org/getattachment/c43b9df8-13ab-4b50-bda2-1cc079b61ace/Resource-Documents-2012-Report-APA-Task-Force-Treatment-Gender-Identity-Disorder.pdf>;
13. **As of March 22, 2024, twenty-four (24) U.S. states have banned GAC for minors and more appellate courts are upholding those bans:**
<https://www.dailysignal.com/2023/08/28/more-courts-uphold-bans-gender-affirming-care-minors-divisions-abound-is-supreme-court-next-stop/>; and
<https://www.abajournal.com/news/article/6th-circuit-upholds-bans-on-transition-treatment-for-transgender-minors>: (Chief Judge Jeffrey Sutton wrote: “This is a relatively new diagnosis with ever-shifting approaches to care over the last decade or two...Under these

circumstances, it is difficult for anyone to be sure about predicting the long-term consequences of abandoning age limits of any sort for these treatments.”); <https://www.sweetwaternow.com/gender-affirming-procedures-for-minors-outlawed-in-wyoming/>; On April 15, 2024 the U.S. Supreme Court allowed Idaho’s ban on gender affirming care for minors to go into effect during the pendency of a challenge by the ACLU. Under the law, healthcare professionals can face up to ten years in prison for providing treatments such as puberty blockers, cross-sex hormones, and mastectomies that are “inconsistent with the child’s biological sex.”: <https://www.reuters.com/legal/us-supreme-court-lets-idaho-enforce-ban-transgender-care-minors-2024-04-15/>;

14. Activist attorneys from large firms, including the Cooley firm representing Kaiser in this case, have also represented militant transgender plaintiffs in seeking to overturn the state bans on GAC for minors. “On March 19, U.S. District Judge Liles C. Burke of the Northern District of Alabama, an appointee of former President Donald Trump, unsealed **an October 2023 report**, which found that 11 out of 39 lawyers for the plaintiffs tried to circumvent random case assignment procedures. The report was conducted by a panel of three Alabama federal judges after Burke expressed concern about judge shopping.”: <https://www.abajournal.com/news/article/lawyers-representing-transgender-plaintiffs-face-possible-sanctions-for-alleged-judge-shopping>; One of those 11 lead attorneys found guilty of “misconduct” by the three judge panel was Kathleen Hartnett, who is also one of the lead attorneys for Kaiser in the Brockman case: <https://www.cooley.com/people/kathleen-hartnett>. <https://www.abajournal.com/news/article/lawyers-representing-transgender-plaintiffs-face-possible-sanctions-for-alleged-judge-shopping>;
15. Recent polling reflects the fact that 78% of U.S. voters, including 67% of Democrats, oppose giving puberty blockers and surgery to minors to change their gender: [67% of Democrats OPPOSE child sex changes: poll | The Post Millennial | thepostmillennial.com](https://www.thepostmillennial.com/67-of-democrats-oppose-child-sex-changes-poll);
16. Due to its extensive medical literature reviews, the National (NHS) in England is no longer prescribing puberty blockers and GAC to minors: <https://www.england.nhs.uk/publication/clinical-policy-puberty-suppressing-hormones/>; “For most young people, a medical pathway will not be the best way to manage their gender-related distress. For those young people for whom a medical pathway is clinically indicated, it is not enough to provide this without also addressing wider mental health and/or psychosocially challenging problems.”: <https://cass.independent-review.uk/home/publications/final-report/>; And the latest German systematic review of the medical literature supports the same Conclusion: <https://pubmed.ncbi.nlm.nih.gov/38410090/>;
17. “A lengthy investigation initiated by centre-right Les Républicains senator Jacqueline Eustache-Brinio has just been made public. **It is alarmed by what has been described as “one of the greatest ethical scandals in the history of medicine”—namely sex reassignment in minors, made possible by the administration of puberty blockers and surgery.** The report, which is detailed and well-argued, points to a number of abuses by health professionals, indoctrinated by a “trans-affirmative” ideology and subject to the influence of experienced trans activist associations. The report’s authors

accuse these associations of unreasonably encouraging gender transition in minors via an intense propaganda campaign on social media.”:

[https://europeanconservative.com/articles/news/french-senators-call-for-ban-on-gender-transition-for-minors/;](https://europeanconservative.com/articles/news/french-senators-call-for-ban-on-gender-transition-for-minors/)

18. “Many European countries do not allow the use of cross-sex hormones until age 16, and only then after completing a number of psychotherapy sessions. In addition, the vast majority of European countries ban surgery until age 16”:
<https://www.forbes.com/sites/joshuacohen/2023/06/06/increasing-number-of-european-nations-adopt-a-more-cautious-approach-to-gender-affirming-care-among-minors/?sh=38b0d9d7efbd;>
19. It is predicted that there will be at least 1,000 medical malpractice lawsuits filed against the Tavistock Clinic by detransitioners in the U.K.: [Tavistock gender clinic facing legal action over ‘failure of care’ claims | The Independent](#); In addition to the lawsuits of Chloe Brockman and Kayla Lovdahl against Kaiser, there have multiple other medical malpractice cases filed in the U.S. on behalf of girls that began GAC as minors:
<https://www.dailywire.com/news/no-one-has-a-right-to-sterilize-a-child-two-detransitioners-sue-doctors-over-medical-interventions;>and
[https://nypost.com/2023/09/14/woman-who-transitioned-at-16-sues-doctors-over-double-mastectomy/;](https://nypost.com/2023/09/14/woman-who-transitioned-at-16-sues-doctors-over-double-mastectomy/) <https://www.foxnews.com/media/detransitioner-files-1m-lawsuit-against-doctors-botched-mastectomy-left-her-permanently-disfigured;>
<https://www.foxnews.com/us/uw-gave-gender-transition-surgeries-without-proper-consent-lawsuit;> [https://www.washingtontimes.com/news/2023/dec/5/surge-of-detransition-lawsuits-pose-threat-to-boom/;](https://www.washingtontimes.com/news/2023/dec/5/surge-of-detransition-lawsuits-pose-threat-to-boom/)
20. WPATH had previously set a minimum age for mastectomies at age 16; however, it admits that it removed any minimum age limitations not for any medical reason but solely so that doctors would not get sued for violating that standard:
[https://www.dailysignal.com/2022/09/16/top-transgender-medical-group-removes-age-recomendations-for-minors/;](https://www.dailysignal.com/2022/09/16/top-transgender-medical-group-removes-age-recomendations-for-minors/) <https://www.dailywire.com/news/wpath-explains-why-they-removed-minimum-age-guidelines-for-children-to-access-transgender-medical-treatments-so-doctors-wont-get-sued;>
21. In 2021 the prestigious British Medical Journal (BMJ) published a systematic review of the clinical practice guidelines (CPG), used by the defendants for gender affirming care (GAC), and found them lacking; the BMJ concluded the following in its report: “Gender minority/trans health in current international CPGs seems limited to a focus on HIV or transition-related interventions. WPATH SOCv7 is due for updating and this study should be used positively to accelerate improvement. Future guideline developers might better address the holistic healthcare needs of gender minority/trans people by enhancing the evidence-base, upgrading the quality of CPGs and increasing the breadth of health topics wherein this population is considered.”:
<https://www.dropbox.com/scl/fi/6paw4imx5lflw0fv9kl1s/BMJ-Systematic-Review-of-GAC.pdf?rlkey=7jk3gq58wza5ba6qzh28kmz5u&dl=0;>

22. “The WPATH Files”, an expose of WPATH released by a whistleblower(s) on March 4, 2024, concludes on page 70: “As this report has shown, **WPATH is not a medical organization. It is not engaged in a scientific quest to discover the best possible way to help vulnerable individuals who are suffering from gender-related distress. Instead, it is a fringe group of activist clinicians and researchers masquerading as a medical group, advocating for a reckless hormonal and surgical experiment to be performed on some of the most vulnerable members of society.** It would be criminal for a surgeon to sever the spinal cord of a person who identified as a quadriplegic or to blind a sighted patient who identified as blind. It is just as unethical to destroy healthy reproductive systems and amputate the healthy breasts and genitals of mentally unwell people...”: [Final+UPDATED+WPATH+Report.pdf \(squarespace.com\)](#); and https://www.realityslaststand.com/p/the-end-of-wpath-introducing-the?utm_source=post-email-title&publication_id=225618&post_id=138642741&utm_campaign=email-post-title&isFreemail=true&r=c4sfo&utm_medium=email; The WPATH Files states on page 9: “SOC8 also contains a chapter on nonbinary medical interventions, which include recommendations on nullification procedures to create a smooth, sexless appearance for people who identify as neither male nor female and penis-preserving vaginoplasties for those patients who desire both sets of genitals.”;
23. Many of the WPATH SOC authors are activists with extreme and even self-contradictory ideologies. For example, Laura Jacobs--an author of WPATH SOC8--is a self-described activist (<https://www.lauraajacobs.com/>) and claims to “feel female and male...both and neither one”. This activist wants to know: “Do we have to stick to penis & vagina norms? Can we have genitalia that looks like flowers or abstract sculpture? Can we have multiple? Can they be interchangeable?” (<https://twitter.com/genspect/status/1770637625143050571>);
24. The year after the 2017 Endocrine Society Guidelines were published, Endo Pharmaceuticals (which profits from the sale of the puberty blocker Supprelin LA), paid Joshua D. Safer (who was an author of both the Endocrine Society Guidelines and the most recent WPATH Standards of Care), to be a consultant. Dr. Safer has acknowledged that “most of the rest of the medical world is more conservative than we [endocrinologists] are” (4:33-4:38), and that the Endocrine Society did not even have “some little data”—“we had none”—to justify the “compelling reasons” language for cross-sex hormones prior to age 16, a change that gave doctors “cover” to do so (5:38-6:18): [State of the Art: Transgender Hormone Care - YouTube](#);
25. Despite Kaiser’s false representations to the contrary, there has never been sufficient scientific support to justify providing transgender health care to children and adolescents. This is evident by the new guidelines for transgender health care, released by the World Health Organization (WHO) on January 15, 2024, which state as follows: “**Why will the guideline only cover adults and not also children or adolescents? • The scope will cover adults only and not address the needs of children and adolescents, because on review, the evidence base for children and adolescents is limited and variable regarding the longer-term outcomes of gender affirming care for children and adolescents**”: https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/tgd_faq_16012024.pdf?sfvrsn=79eaf57f_1;

26. The Dutch are now engaged in a debate over whether the “Dutch Protocol” is appropriate care for all “transgender” youth: https://www.realityslaststand.com/p/the-2023-dutch-debate-over-youth?publication_id=225618&utm_campaign=email-post-title&r=c4sfo;
27. The American Academy of Pediatricians (AAP) has recently called for a “systematic review” of the medical literature concerning GAC for minors. McMaster University epidemiologist Dr. Gordon Guyatt, credited as a developer of the field of evidence-based medicine, stated: “Based on previous systematic reviews, the A.A.P.’s report will most likely find low-quality evidence for pediatric gender care. ‘The policies of the Europeans are much more aligned with the evidence than are the Americans,’ he said.”: [AAP calls for “systematic review of evidence,” yet reaffirms 2018 gender-affirming care policy \(cmda.org\)](https://www.cmda.org/aap-calls-for-systematic-review-of-evidence-yet-reaffirms-2018-gender-affirming-care-policy); AAP’s prior policy statement was based on serious misstatements of the actual research: https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IESOGI/Other/Rebekah_Murphy_20191214_JamesCantor-fact-checking_AAP-Policy.pdf;
28. One of the foremost objective medical literature reviews in the U.S. is performed by the Hayes Corporation (“Hayes”). Hayes regularly reviews the research underlying medical treatments and is nationally authoritative, serving companies that cover 83% of insured Americans. See, Hayes, Inc., *The Hayes Difference*: <https://www.hayesinc.com/about-hayes/>. Hayes reviewed cross-sex hormone administration for adolescent gender dysphoria in 2014 and gave it the lowest “D2” rating: the research findings were “too sparse” and “too limited” to even *suggest* conclusions: <https://spaces.hightail.com/space/HiGfOiTNeR>; Hayes more recently examined the extant evidence for gender reassignment surgery for minors and again concluded that it merited its lowest “D2” rating: “insufficient published evidence to assess the safety and/or impact on health outcomes or patient management.”: <https://spaces.hightail.com/space/CiCkJj4sMA>;
29. A survey the American College Health Association showed that, in 2008, one in 2,000 female undergraduates identified as transgender. By 2021, that figure had jumped to one in 20. Erica Anderson, PhD, a transgender psychologist from UCSF, who treats transgender youth, and who is a past President of the U.S. Chapter of WPATH, has stated: “It is my considered opinion that due to some of the — let’s see, how to say it? what word to choose? — due to some of the, I’ll call it just ‘sloppy,’ sloppy healthcare work, that we’re going to have more young adults who will regret having gone through this process. And that is going to earn me a lot of criticism from some colleagues, but given what I see — and I’m sorry, but it’s my actual experience as a psychologist treating gender variant youth — I’m worried that decisions will be made that will later be regretted by those making them.”: <https://www.thefp.com/p/top-trans-doctors-blow-the-whistle>;
30. Both Dr. Erica Anderson and Dr. Laura Edwards-Leeper call for more assessments for adolescents before medical interventions. Dr. Edwards-Leeper has served as the Chair for the Child Adolescent Committee for WPATH and was selected as a WPATH Standard of Care (SOC) 8 committee member for the revision of both the child and adolescent chapters. Dr. Edwards-Leeper has stated that providers should be **“properly and comprehensively assessing the individual young person and figuring out an individualized treatment plan for them, which may or may not involve medical interventions, but they should always be done before any medical intervention per**

the standards of care, but especially before hormones...” This is “not conversion therapy, you’re not trying to change their gender, you’re just trying to help them sort out where this all came from and what it is that’s actually going to help them feel better...”: [WPATH clinicians stand by statements that more assessment needed — Genspect](#);

31. Over the past almost two years, there have been six systematic reviews of the evidence surrounding “gender-affirming” medical treatments for children and adolescents (i.e., puberty blockers and cross-sex hormones) conducted by research teams across the globe, and every single one of them has reached the conclusion that “the evidence for mental-health benefits of hormonal interventions for minors to be of low or very low certainty,” whereas, “[b]y contrast, the risks are significant and include sterility, lifelong dependence on medication and the anguish of regret.” Every systematic review has also contradicted the claims that non-medical intervention for gender diverse youth leads to increased suicides. “There is no reliable evidence to suggest that hormonal transition is an effective suicide-prevention measure.”: <https://www.wsj.com/articles/trans-gender-affirming-care-transition-hormone-surgery-evidence-c1961e27>;
32. Puberty blockers followed by cross-sex hormones leads to infertility and sterility. Stephen B. Levine, E. Abbruzzese & Julia W. Mason (2022), *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, Journal of Sex & Marital Therapy, 48:7, 706-727: <https://doi.org/10.1080/0092623X.2022.2046221>; The effect of “prolonged treatment with exogenous testosterone on ovarian function is uncertain”, <https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence>;
33. A study from the Mayo Clinic, dated March 27, 2024, found “mild-to-severe sex gland atrophy in [puberty blocker] treated [boys]” and raised “a potential concern regarding the complete ‘reversibility’ and reproductive fitness of SSC.”: <https://www.dropbox.com/scl/fi/ka6pxa01wj7bbkx1x2gz/Puberty-Blocker-and-Aging-Impact-on-Testicular-Cell-States.pdf?rlkey=fpnuxqxs87mdhyabzebuj7jd&dl=0>;
34. The American College of Pediatricians (ACPed) has released a position statement titled *Mental Health in Adolescents with Incongruence of Gender Identity and Biological Sex*. **The authors reviewed over 60 studies and concluded that social transition, puberty blockers, and cross-sex hormones have no demonstrable, long-term benefit on psychosocial well-being of adolescents with gender dysphoria.** The paper details studies that have led many countries to reject transgender interventions in adolescents in favor of psychological treatment: <https://acpeds.org/press/pediatricians-release-position-statement-reviewing-over-60-studies-on-mental-health-in-adolescents-with-gender-dysphoria>;
35. Respected psychiatrists and psychologists who helped pioneer transgender care for adults for decades, in various countries, have warned against the dangers of providing such treatment to minors, including the following: Paul McHugh, MD, Stephen Levine, MD, and Robin Dea, MD, from the United States; as well as Kenneth Zucker, PhD, from Canada; and, also recently, Rittakerttu Kaltiala, MD, from Finland: <https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor>;

36. Whistleblowers are coming forward to document the fact that the failure to treat the comorbidities of gender dysphoria kids at transgender clinics is causing them serious harm: <https://www.thefp.com/p/i-thought-i-was-saving-trans-kids>; and [Dr. Eithan Haim - Targeted by Biden DoJ/HHS for Whistleblowing Re: Pediatric Transgender Program - YouTube](#).

* **See also Footnote 2:** The California Supreme Court has held that in medical malpractice cases the “standard of practice in the community” can itself be shown to be “negligent”. Moreover, those medical professionals that hold themselves out as specialists should be held to an even higher standard of practice.

II. Kaiser’s Lack of Proper Informed Consent:

1. A disproportionately high percentage of adolescents with autism (including Kayla Lovdahl) have identified as transgender as compared to the general population: <https://www.transgendertrend.com/autism-gender-identity-introduction/#sdfootnote1sym>; and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10313553/>; “Researchers found that 24 percent of the gender-diverse and transgender respondents were autistic compared with 5 percent of the study’s cisgender participants”: <https://www.autismspeaks.org/science-news/study-finds-higher-rates-gender-diversity-among-autistic-individuals>; “[A]utistic traits of ‘fixating’ on issues could convince children they are the wrong sex.” (this article discusses views expressed by Ken Zucker, Ph.D., one of the authors of WPATH SOC 7) : <https://nationalpost.com/health/are-autistic-children-more-likely-to-believe-theyre-transgender-controversial-toronto-expert-backs-link>;
2. “In a nationwide online sample of US adolescents, TGAs [transgender adolescents] had elevated rates of psychological, physical, and sexual abuse compared with heterosexual CGAs [cisgender adolescents]. Risk for psychological abuse was highest among TGAs assigned female at birth.”: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8344346/>;
3. The American Society of Plastic Surgeons (ASPS) states in its “Briefing Paper: Plastic Surgery for Teenagers” as follows: “Informed Consent: At the highest level of care, every surgery has risks as well as benefits. ASPS recognizes the physician-patient relationship is one of shared decision-making. This decision-making process is called informed consent. The ASPS “*Statement of Principle on Informed Consent*” details the information that should be discussed and understood by the patient as well as the patient’s parents or guardian, including: details of the surgery, benefits, possible consequences and side effects of the operation, potential risks and adverse outcomes as well as their probability and severity; alternatives to the procedure being considered and their benefits, risks and consequences; and the anticipated outcome. For more information on informed consent, patients are encouraged to talk with their surgeons.”: <https://www.plasticsurgery.org/news/briefing-papers/briefing-paper-plastic-surgery-for-teenagers>;

4. The 2015 American Psychological Association “*Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*”, page 842, states: “Additionally, adolescents can become intensely focused on their immediate desires, resulting in outward displays of frustration and resentment when faced with any delay in receiving the medical treatment from which they feel they would benefit and to which they feel entitled (Angello, 2013; Edwards-Leeper & Spack, 2012). This intense focus on immediate needs may create challenges in assuring that adolescents are cognitively and emotionally able to make life-altering decisions to change their name or gender marker, begin hormone therapy (which may affect fertility), or pursue surgery.”:
<https://www.apa.org/practice/guidelines/transgender.pdf>;
5. “Brain maturation during adolescence (ages 10–24 years) could be governed by several factors...sex hormones including estrogen, progesterone, and testosterone can influence the development and maturation of the adolescent brain...Furthermore, the adolescent brain evolves its capability to organize, regulate impulses, and weigh risks and rewards; however, these changes can 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.”: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3621648/>; and <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2892678/>; <https://www.nature.com/articles/tp201454>; and <https://twitter.com/865Mando/status/1743049598384455738> (trans mass shooters);
6. The top transgender influencers on social media have tens of millions of followers: <https://izea.com/resources/trans-influencers/#:~:text=Dylan%20Mulvaney,with%20a%20Queerties'%20Groundbreaker%20Award>; “Today’s teens are spending less time with friends and most of their free time alone on screens. They’re struggling with depression, anxiety, and body image issues.”: <https://verilymag.com/2024/02/gen-zs-search-for-fulfillment-less-sex-and-more-porn-and-a-deep-desire-for-friendship-2024>; “Breaking the data down by gender we found 58% of females say they don’t have a positive body image compared to 43% of males.”:<https://youthsense.com.au/parents/gen-zs-body-image-problem/>;

7. “Animal studies, single case reports and studies of the impact of puberty blockers in children with precocious puberty indicate that these treatments may be associated with reductions in IQ.”: [The Impact of Suppressing Puberty on Neuropsychological Function \(authorea.com\)](https://www.authorea.com/publications/12960869); <https://www.dailymail.co.uk/news/article-12960869/Puberty-blockers-given-children-say-born-wrong-body-want-change-gender-lower-IQs.html>; and “*Top Doctors In Transgender Field Admit Puberty Blockers Aren’t So ‘Reversible’*”: **“Both puberty blockers and cross-sex hormones come with serious health risks. Puberty blockers can affect bone growth and density and cause sexual dysfunction, voice damage, and infertility, among other issues. Cross-sex hormones can cause infertility, deadly blood clots, heart attacks, increased cancer risks of the breasts and ovaries, liver dysfunction, worsening psychological illness, and other serious conditions.”**: <https://www.dailywire.com/news/top-doctors-in-transgender-field-admit-puberty-blockers-arent-so-reversible-report> (with inset videos from WPATH physicians);
8. “We conclude that treatment pathways that delay decisions about medical transition until the child has had the chance to grow and mature into an autonomous adulthood would be most consistent with the open future principle.”: <https://link.springer.com/article/10.1007/s10508-024-02850-4>;
9. “Three issues tend to obscure the salience of informed consent: conspicuous mental health problems, uncertainty about the minor’s personal capacity to understand the irreversible nature of the interventions, and parental disagreement. Physical and psychiatric comorbidities can contribute to the formation of a new identity, develop as its consequence, or bear no connection to it. Assessing mental health and the minor’s functionality is one of the reasons why rapid affirmative care may be dangerous for patients and their families. For example, when situations involve autism, learning disorders, sexual abuse, attachment problems, trauma, separation anxiety, previous depressed or anxious states, neglect, low IQ, past psychotic illness, eating disorders or parental mental illness, clinicians must choose between ignoring these potentially causative conditions and comorbidities and providing appropriate treatment before affirmative care (D’Angelo et al., 2020). For youth less than the age of majority, informed consent via parents provides a legal route for treatment but it does not make the decision to socially transition, provide hormones, or surgically remove breasts or testes less fraught with uncertainty. The best that health professionals can do is to ensure that the consent process informs the patient and parents of the current state of science, which is sorely lacking in quality research. It is the professionals’ responsibility to ensure that the benefits patients and parents seek, and the risks they are assuming, are clearly appreciated as they prepare to make this often-excruciating decision.” Stephen B. Levine, E. Abbruzzese & Julia W. Mason (2022), *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*, *Journal of Sex & Marital Therapy*, 48:7, 706-727: <https://doi.org/10.1080/0092623X.2022.2046221>;
10. Kaiser Permanente’s: “Providing Care to LGBTQ Patients” (September 30, 2016) states: “Mental health evaluation for readiness to start hormones (optional in informed consent model)” (PDF page 38): <https://www.dropbox.com/scl/fi/f1sqw328i0vhfdd9rxcz2/Providing-LGBTQ-Care-for-Asthma-Network-9.30.16-v2.pptx?rlkey=4gm4zbie20zyihf4hiznaop0&dl=0>;

11. Kaiser did not fully inform Brockman and her parents that puberty blockers were not approved for treating gender dysphoria by the FDA; rather, they have been approved for chemically castrating convicted sex offenders, and they have serious potential harmful affects on adolescents: <https://flboardofmedicine.gov/forms/Puberty-Suppression-Treatment-for-Patients-with-Gender-Dysphoria-Patient-Information-and-Parental-Consent-and-Assent-for-Minors.pdf>; <https://kffhealthnews.org/news/women-fear-drug-they-used-to-halt-puberty-led-to-health-problems/>; In a new study, the majority of children put on puberty blockers and hormone drugs experienced erratic and fluctuating mental health, including over a third whose mental health “reliably deteriorated.”: <https://www.medrxiv.org/content/10.1101/2023.05.30.23290763v3.full>; Hormone therapy may increase cardiovascular risk during gender transition | ScienceDaily: <https://www.sciencedaily.com/releases/2019/02/190218093959.htm>;
12. Kaiser did not inform Brockman that Puberty blockers are more than a “pause button”: Roughly 98% of children who take them go on to take cross-sex hormones. A 2021 study from the UK found that only 1 out of 44 children placed on puberty blockers did not continue to take cross-sex hormones: <https://statsforgender.org/puberty-blockers/>; “Big pharma, big hospital systems, surgical centers and doctors seek to gain profits. Lupron [a puberty blocker prescribed to children] monthly is \$775 alone. That’s a \$27,000 ‘pause button’ at 5 years [of age]...Multiply this together with the huge rise in cases documented or observed in Western nations and a major windfall is to be had.”: <https://www.rt.com/usa/469766-transgender-pharma-drugs-surgery/>;
13. Kaiser did not inform Brockman that if she went through puberty blockers, testosterone, and “top surgery”, and not the much more complex “bottom surgery”, she would be left with a masculinized chest, but female reproductive organs, and would therefore have neither a completely male or female body; moreover, bottom surgery has an extremely high complication rate, requiring further life-long medicalization: “Trans surgery nightmares revealed: 81% endure pain in the five years after gender-change procedures, more than half say having sex is painful - and a third are left incontinent, survey shows.”: <https://www.dailymail.co.uk/news/article-12312219/Trans-surgery-nightmares-revealed-81-endure-pain-five-years-gender-change-procedures-half-say-having-sex-painful-left-incontinent-survey-shows.html>; https://www.dailymail.co.uk/news/article-13092239/Top-Canadian-surgeon-unwittingly-reveals-TRUTH-sex-change-ops-unearthed-video-lifts-lid-ill-trained-doctors-dying-appendages-dreaded-complications.html?ito=native_share_article-bottom;
14. A new long-term Dutch study finds the desire to be the opposite sex in adolescence is common, temporary, and “decreases with age.”: <https://www.dropbox.com/scl/fi/l2d450booljctmc5vkbjt/New-long-term-study-finds-desire-to-be-the-opposite-sex-in-adolescence-is-common-temporary-and-declines-with-age.pdf?rlkey=vlz16z0s3xu3su3xd2cy74yo1&dl=0>; and <https://www.dropbox.com/scl/fi/tigt0rxdjym16kmw07v7w/Rawee.2024.Development-of-Gender-Non-Contentedness-During-Adolescence-and-Early-Adulthood.pdf?rlkey=k5wa6351e811d5tnhvg032i82&dl=0>; Experts on both sides of the pubertal suppression debate agree that 80 percent to 95 percent of children with GD

accepted their biological sex by late adolescence. (Cohen-Kettenis PT, Delemarre-van de Waal HA, Gooren LJ. “*The treatment of adolescent transsexuals: changing insights*”. *J Sexual Med* 2008; 5: 1892–1897 <https://www.dropbox.com/home/KEY%20POINTS%20LIST%20CITATIONS%20-%2001-23-24?select=L-1.+APA+advises+that+teens+need+to+be+%27screened+carefully%27+for+trauma.pdf&preview=L-103.1+Acceptance+of+biological+sex.pdf>); The American Psychiatric Association’s DSM-5 (<https://www.psychiatry.org/psychiatrists/practice/dsm>) gender dysphoria desistence rates of 70 to 97 percent in “natal males” and 50 to 88 percent in “natal females.” The American Psychological Association’s *Psychology states* that the vast majority of gender dysphoric boys and girls accept their birth/chromosomal sex by adolescence or adulthood: *APA Handbook on Sexuality and Psychology* (<https://www.thepublicdiscourse.com/2018/01/20547/>); Kaiser did not inform Brockman that if she just let puberty take its course, it was highly likely that she would grow to become more comfortable with the changes in, and appearance of, her body. “Evidence from the 10 available prospective follow-up studies from childhood to adolescence (reviewed in the study by Ristori and Steensma28) indicates that for ~80% of children who meet the criteria for GDC, the GD recedes with puberty”: [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5841333/#:~:text=Childhood%20GD%20a nd%20puberty%20development&text=27%20Evidence%20from%20the%2010,the%20G D%20recedes%20with%20puberty](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5841333/#:~:text=Childhood%20GD%20a nd%20puberty%20development&text=27%20Evidence%20from%20the%2010,the%20G D%20recedes%20with%20puberty;);

15. The Kaiser defendants coerced consent from Chloe Brockman’s parents by falsely representing that she was a high suicide risk if she did not transition. This is despite the fact that there is no credible scientific evidence to support this coercive threat. Moreover, Chloe had no suicidal ideation before she began “gender affirming care”. A 2024 study in the authoritative *British Medical Journal* concluded that the scientific evidence indicates that deaths by suicide of teens with gender dysphoria was more likely due to their history of associated psychopathology rather than their gender dysphoria diagnosis. <https://mentalhealth.bmj.com/content/27/1/e300940>; <https://nypost.com/2024/02/24/opinion/a-finnish-study-is-changing-how-we-approach-trans-kids/>; and <https://seqm.org/Suicide-Gender-Dysphoric-Adolescent-Young-Adult-Finland-2024>: “**That neither the current study nor several other studies to date have been able to demonstrate that gender transition reduces suicide or serious suicide attempts adds to the concern that the suicide narrative has been inappropriately used to promote medical gender transitions of youth.**”; “Study finds that the attempted-suicide rate among transgender women who received a vaginoplasty in California was twice as high during the period after the surgery compared with the period before the surgery”: <https://www.auajournals.org/doi/10.1097/JU.0000000000001971.20>;
16. **Lupron Depot-Ped: Adverse Reactions** (Section 6.2): “**Psychiatric Disorders:** emotional lability, such as crying, irritability, impatience, anger, and aggression. **Depression, including rare reports of suicidal ideation and attempt.** Many, but not all, of these patients had a history of psychiatric illness or other comorbidities with an increased risk of depression.”: <https://www.dropbox.com/scl/fi/72lnhgtlbd13b65s104m3/LupronPed-Adverse-Reactions.pdf?rlkey=sbmym79adaj8xon108x534xdq&dl=0>;

17. The most thorough follow-up of sex-reassigned people—extending over 30 years and conducted in Sweden, where the culture is strongly supportive of the transgendered, documents their lifelong mental unrest. Ten to 15 years after surgical reassignment, the suicide rate of those who had undergone sex-reassignment surgery rose to almost 20 times that of comparable peers:
<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885>; and
<https://www.heritage.org/gender/commentary/sex-reassignment-doesnt-work-here-the-evidence>;
18. While still reported as “rare” by the gender medicine establishment (Coleman et al., 2022; McNamara et al., 2022), the rate of medical detransition is already 10%-30% just a few years following transition (Boyd et al., 2022; Hall et al., 2021; Roberts et al., 2022). These numbers are likely to rise in the future as regret historically has taken up to a decade to materialize (Dhejne et al., 2014): <https://segm.org/transition-regret-and-detransition>;
<https://www.transgendertrend.com/detransition/>;
<https://twitter.com/NotScottNewgent/status/1634682798903635970>;and
<https://www.nytimes.com/2024/02/02/opinion/transgender-children-gender-dysphoria.html>;
19. Kaiser did not give any of the following warnings to Brockman as part of the informed consent process: “Starved of estrogen, the female reproductive organs begin to break down, becoming dry, hardened, fused, inflamed, and prone to infection. This increasing atrophy in the uterus and vagina can be extremely painful, making something as simple as walking a difficult feat. After several years on testosterone, the atrophy typically worsens to the point that hysterectomies are recommended. In short: testosterone slowly kills the female reproductive organs until they have to be surgically removed.” (Abigail Favale, p. 188, “*The Genesis of Gender*,” citing Baldassarre, et.al., “*Effects of High Dose Testosterone Administration on Vaginal Epithelium and Estrogen Receptors of Young Women*”, International Journal of Impotence Research 25 (2013): 172-177. (https://www.dropbox.com/scl/fi/fwk4n4ailfhftfwoc1ce/Baldassarre_et_al-2013-International_Journal_of_Impotence_Research.pdf?rlkey=d6vsshcwvxt060mpnwjxxy7ll&dl=0);
20. Kaiser did not inform Brockman that using a chest binder could cause health problems and break down her breast tissue, leaving her breasts permanently disfigured. “In extreme cases, breast tissue can become permanently damaged...Strong, prolonged pressure around the chest and back can also cause changes to normal spine alignment, which may result in chronic pain.”: <https://www.sharp.com/health-news/chest-binding-tips-and-risks>;
21. While the goal of a referral for transgender care is to improve mental health, the long-term mental health outcomes for transgender individuals is poor. The Gender-affirming treatment and mental health diagnoses in Danish transgender persons, a nationwide register-based cohort study, “found that the odds ratio for mental health disorders was more than five times higher in transgender persons compared to controls at baseline. The risk for mental and behavioral disorders in transgender persons increased rapidly during the first year after the index date followed by a decreasing trend, but the odds ratio remained elevated throughout follow-up, especially in transgender person’s assigned male

at birth.”: <https://www.nationalreview.com/corner/danish-studies-mental-cardiac-health-worse-in-transgendered-persons/>;

22. In addition to mental health, the physical health of transgender individuals is poor when compared to similarly situated control groups. The Cardiovascular risk in Danish transgender persons, a matched historical cohort study found “higher risk of any CVD [cardiovascular disease] in transgenders compared to controls of same and other birth sex with the highest risk for any CVD in transgenders AFAB [assigned female at birth] compared to control men. Furthermore, the incidence rate of arterial, venous and metabolic outcomes was higher in transgenders compared to controls. GAHT [gender affirming hormone treatment] was a statistically significant mediator of risk of any CVD in transgenders AFAB, whereas GAHT was not a statistically significant mediator in AMAB [assigned male at birth]: <https://www.nationalreview.com/corner/danish-studies-mental-cardiac-health-worse-in-transgendered-persons/>;

23. The Detransitioner Bill of Rights states:

“SECTION 3. RIGHT TO INFORMED CONSENT:

- (a) No healthcare professional or physician may provide pharmaceutical or surgical treatment to minors to address an inconsistency between the minor’s sex and the minor’s perceived gender or perceived sex unless the healthcare professional or physician has obtained informed consent from the minor and the minor’s parent(s) or legal guardian(s).
- (b) For purposes of this section, informed consent for any treatment requires both verbal and written notice in at least 14-point, proportionally spaced typeface of the following facts, verbatim, during every single medical visit for treatment, for a period of no less than 12 months:
 - (1) No reliable studies have shown that these treatments reduce the risk of suicide in children or adolescents with gender dysphoria.
 - (2) The Federal Food & Drug Administration has not approved the use of puberty blockers or cross- sex hormones for the purpose of treating gender dysphoria or gender incongruence. In other words, using these medications to treat gender dysphoria or gender incongruence is considered “off-label” use because they are not being used for their approved purpose.
 - (3) European governments, including the United Kingdom, Sweden, and Finland, have studied these treatments and have concluded there is no reliable evidence showing that the potential benefits of puberty blockers and cross-sex hormones for this purpose outweigh the risks. Those governments instead recommend psychotherapy as the first line of treatment for children and adolescents with gender dysphoria.
 - (4) The use of puberty blockers and cross-sex hormones for this purpose increases the risk of your child or adolescent being sterilized, meaning that he or she will never be able to have children.
 - (5) The use of puberty blockers and cross-sex hormones for this purpose carry numerous other risks of physical harm, including severely decreased bone density, heart disease, stroke, and cancer.

(6) The effect of these treatments on the brain development of your child or adolescent is entirely unknown.”:

<https://dw-wp-production.imgix.net/2023/10/Detransitioner-Bill-of-Rights.pdf>;

24. The effects of puberty blockers are not reversible:
<https://www.thepublicdiscourse.com/2020/01/59422/>;

25. Minors on puberty blockers experience a drop in their IQ:
<https://pubmed.ncbi.nlm.nih.gov/11683207/>; and
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5694455/>;

***See Footnote 3:** The U.S. Supreme Court has recognized that minors lack the maturity to make major life-altering decisions; also: If a medical practitioner knows or should know of a patient’s unique concerns or lack of familiarity with medical procedures, this knowledge may expand the scope of required disclosures and require additional instructional language. (See, [Truman v. Thomas \(1980\) 27 Cal.3d 285, 291](#)); and

***Footnote 4:** “Waiver” is not a legal defense to the lack of informed consent as it is “void as against public policy.”

III. Kaiser’s Explosive Growth in Gender Affirming Care:

1. In a large December 2017 study of 6456 transgender patients from 2006 to 2014, Kaiser admits as follows: “Critical knowledge gaps include the effect of HT [hormone therapy] and surgery on gender dysphoria (the feeling of distress when natal sex does not match gender identity) and other mental health issues, hematological side effects of HT and risk of cardiovascular disease, metabolic or endocrine disorders and cancer following hormonal or surgical gender affirmation.”: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5770907/>; Moreover, Kaiser had this information when it started Chloe Brockman on Testosterone in February 2018;
2. Youth referrals for gender reassignment having risen several thousand percent in the last decade, and nearly doubled between 2020/2021 and 2021/2022 (NHS, 2022b; Respaud & Terhune, 2022); and Rates of gender dysphoria have soared in every state except one since 2018- -with children now making up one in five diagnoses:
<https://www.dailymail.co.uk/health/article-12992859/gender-dysphoria-changed-state-rising.html>;
3. A 2022 study involving Kaiser patients states: “*Compared with adults, research on gender-affirming surgery in adolescents is more limited. The incidence of referrals or requests for gender-affirming mastectomy in adolescents has risen exponentially over the past decade. Although studies have evaluated the increase in gender-affirming surgery in adults, we know of none that report the incidence of gender-affirming mastectomy in adolescents.*” (*Gender-Affirming Mastectomy Trends and Surgical Outcomes in Adolescents*, Annie

Tang, MD, A.J. Carlo Hojilla, PhD, Jordan E. Jackson, MD, Kara A. Rothenberg, MD, Rebecca C. Gologorsky, MD, Douglas A. Stram, MS, Colin M. Mooney, MD, Stephanie L. Hernandez, MA, LMFT, and Karen M. Yokoo, MD (Ann Plast Surg 2022;88: S325–S331).): <https://spaces.hightail.com/space/jbQqhkWR7X>;

4. In the U.S., surgeries to remove breasts for adolescent girls increased nearly 500 percent between 2016 and 2019: Kristen Monaco, “Gender-affirming Chest Surgeries Increase by Nearly 5X in Teens,” MedPage Today, October 17, 2022: <https://spaces.hightail.com/space/BF1zkC72QV>;
5. There were at least 417 pediatric transgender patients at the Northern California Kaiser Clinic, for the period 2015-2018. (<https://pubmed.ncbi.nlm.nih.gov/31619510/>);
6. At the Kaiser Permanente health care system in Northern California, the incidence of mastectomies on minor girls rose from a handful of operations in 2013 to nearly 50 in 2019. (Ann Plast Surg 2022;88: S325–S331): <https://spaces.hightail.com/space/jbQqhkWR7X>;
7. Between 2013 and 2020 Kaiser performed over 200 mastectomies on minor girls. (Ann Plast Surg 2022;88: S325–S331); <https://spaces.hightail.com/space/jbQqhkWR7X>;
8. Full-time Kaiser Permanente doctors are paid a salary and are also eligible for “incentives”. “Non-Permanente physicians associated with [Kaiser] Medical Groups are paid a predetermined amount for each service that they provide, commonly called fee-for-service payments or by capitation. Other providers of medical and hospital services may be paid in a number of ways. The most common forms of payment include fee-for-service payments, percent discount from charges, per diem or daily rates, and case rates.”: [https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/health-plan-documents/coverage-information/how-kaiser-permanente-providers-are-paid-ca-en.pdf#:~:text=These%20incentives%20are%20based%20on%20several%20things%2C%20including%3A,Plan%20to%20provide%20stop-loss%20protection%20to%20its%20physicians](https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/health-plan-documents/coverage-information/how-kaiser-permanente-providers-are-paid-ca-en.pdf#:~:text=These%20incentives%20are%20based%20on%20several%20things%2C%20including%3A,Plan%20to%20provide%20stop-loss%20protection%20to%20its%20physicians;);
9. “One hospital, Kaiser Permanente Oakland, carried out 70 top surgeries in 2019 on teenagers age 13 to 18, up from five in 2013, according to researchers who led a recent study.” Dr Karen Yokoo, a retired plastic surgeon at the hospital stated: “*I can’t honestly think of another field where the volume has exploded like that.*”: <https://www.nytimes.com/2022/09/26/health/top-surgery-transgender-teenagers.html>;
10. A “horrified” Kaiser hospital worker leaked a DEI training program “pushing 3-year olds identifying as transgender.” The DEI training from Kaiser Permanente is reported as having stated: “Many transgender people have ALWAYS known their true gender.”: <https://www.foxnews.com/media/horrified-hospital-employee-leaks-dei-training-promoting-3-year-olds-identifying-as-trans>; and [SCOOP: New mandatory hospital staff training promotes transitioning 4-year-olds \(libsoftiktok.com\)](https://libsoftiktok.com). Yet, doctors have warned that children are not always trustworthy when it comes to their own identities and behavior; in that regard, see this study documenting

how some children engage in dangerous activities while dressed in superhero costumes: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2083410/>;

11. Kaiser policies are designed to avoid "gate keeping", and to generally assume that kids know their gender identity, and that those chosen identities should be accepted and supported by adults; yet, some school age kids are even allowed by teachers and school officials to identify in class as cats: <https://elvisduran.iheart.com/content/2022-08-23-teen-who-identifies-as-a-cat-allowed-by-school-to-act-feline-not-speak/>; and <https://nypost.com/2023/06/19/student-called-despicable-by-teacher-after-questioning-peer-who-identifies-as-a-cat/>; some young children identify in school as other animals as well, called collectively as "furries": <https://www.dailymail.co.uk/news/article-12213579/How-schools-allowing-kids-identify-cats-horses-dinosaurs.html>; it should be obvious to any reasonable person that this calls into serious question the judgment of these immature children, as well as the ideologically driven adults who support them in their delusions;
12. Although purposely wrapped-up in a deceptive "scientific veneer", the transgender movement is actually a top-down radical political ideology: "This is the great project of the transgender movement: to abolish the distinctions of man and woman, to transcend the limitations established by God and nature, and to connect the personal struggle of trans individuals to the political struggle to transform society in a radical way": <https://christopherrufo.com/p/inside-the-transgender-empire>;
13. Kaiser's long track record of pushing radical gender ideology has helped it earn a 100% perfect score on the Corporate Equity Index (CEI) of the Human Rights Campaign Foundation for 16 consecutive years: [A Best Place to Work for LGBTQ+ Equality | Kaiser Permanente](#);
14. Kaiser's highest CEI rating provides it with opportunities for huge financial profits with multi-trillion dollar investment corporations like BlackRock and Vanguard: [Inside the woke scoring system guiding American companies \(nypost.com\)](#); Consequently, BlackRock invests millions in Kaiser, see SEC report, page 18: <https://www.sec.gov/Archives/edgar/data/799113/000119312519026643/d647337dncsrs.htm>; and Kaiser invests millions in Vanguard: <https://www.myplaniq.com/LTISystem/jsp/portfolio/ViewPortfolioDetail.action?ID=41298>; "The cultural shifts we see today regarding gender identity are largely influenced by huge capital inflows from governments, philanthropists, corporations, and investment management and accounting firms like Blackrock and Ernst & Young": "How a Handful of Billionaires Created the Transgender 'Movement'": <https://europeanconservative.com/articles/interviews/how-a-handful-of-billionaires-created-the-transgender-movement-an-interview-with-jennifer-bilek/>;
15. Kaiser is California's largest health care provider and has more than 700 health care facilities that treat about 8.8 million patients in the state. On September 8, 2023, authorities said that Kaiser Permanente has agreed to pay \$49 million as part of a settlement with California. Prosecutors say the health care giant illegally disposed of thousands of private medical records, hazardous materials and medical waste, including blood and body parts, in dumpsters headed to local landfills. In 2021, the federal government sued Kaiser

Permanente, alleging the health care giant committed Medicare fraud and pressured doctors to list incorrect diagnoses on medical records in order to receive higher reimbursements: <https://www.10news.com/news/kaiser-to-pay-49-million-to-california-for-illegally-dumping-private-medical-records-medical-waste>;

16. Kaiser is the fourth largest health care system in the U.S. by net patient revenue: [Top 10 largest health systems in the U.S. \(definitivehc.com\)](#). Most recently, Kaiser reported net income of \$24.9 billion for just the third quarter of 2023: <https://about.kaiserpermanente.org/news/kaiser-foundation-health-plan-and-hospitals-q3-2023-financials>; and after Chloe Cole had her breasts removed in 2020, Kaiser reported net income of \$8.1 billion in 2021 alone: <https://www.statista.com/statistics/401048/kaiser-permanente-net-income/#:~:text=Kaiser%20Permanente's%20net%20income%202007%2D2022&text=In%202022%2C%20the%20company%20had,consortium%20headquartered%20in%20Oakland%2C%20California>; Additionally, Kaiser's website states that Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals, and their respective subsidiaries, reported revenues of nearly \$25 Billion (see <https://about.kaiserpermanente.org/news/kaiser-foundation-health-plan-and-hospitals-q3-2023-financials>);
17. Paul McHugh, M.D., former Chief of Psychiatry at Johns Hopkins, has stated the following about gender affirming care for minors: *"This is child abuse. It's like performing liposuction on an anorexic child...It is a disorder of the mind. Not a disorder of the body. Dealing with it in this way is not dealing with the problem that truly exists."*: <https://www.foxnews.com/us/controversial-therapy-for-pre-teen-transgender-patient-raises-questions>. Dr. McHugh has further stated: *"I will tell you what is going to happen to change the tide; it's going to be major lawsuits by families or individuals who have been through this, gone down this pathway and come back out the other side—and they are going to take down not only the physicians, but the drug companies and the hospital, healthcare systems, and the insurance companies that allowed this to happen, and that's when this will all end."*: <https://www.youtube.com/watch?v=rUeqEoARKOA>, See 48:05-48:41.

***Footnote 1:** Chloe Brockman and Kayla Lovdahl treated at the same Kaiser facility in Northern California during approximately the same time period. One difference is that Chloe began taking Testosterone, approved by Kristine Taylor, MD (endocrinology) in February 2018, at the **age of 13**. At that time, there were new September 2017 Endocrine Society Guidelines. Those guidelines allowed cross-sex hormones to be prescribed to a minor under 16 if there was a *"compelling reason"*. Kayla clearly fell under the former September 2009 Endocrine Society Guidelines, as she was approved by the same Kristine Taylor, MD to start taking Testosterone in June 2017, also at the **age of 13**. Those 2009 Guidelines, No. 2.4, state: **"We suggest that pubertal development of the desired opposite sex be initiated at about the age of 16 yr**, using a gradually increasing dose schedule of cross-sex steroids. (2 ⊕○○○)" (bolding added): <https://academic.oup.com/jcem/article/94/9/3132/2596324>. Thus, there was not yet even the contrived *"compelling reason"* exception to the lower age limit of 16 in those guidelines at that time. Susanne Watson, PhD (psychology) referred Chloe for the double mastectomy at **age 15** in July 2019; and the same Dr. Watson referred Kayla for a double mastectomy at **age 13** in March

2017, both in violation of the 2009 Endocrine Society Guidelines. (See Part I, Nos 12-14 above). The Kaiser defendants also ignored the fact that both Chloe Brockman and Kayla Lovdahl have struggled with “body dysmorphia” issues, as Chloe had a cleft pallet and Kayla was overweight; and both of them had early pubertal development which attracted unwanted attention. (See Endnote).

***Footnote 2:** Even if the Kaiser defendants were following the so-called “standard of practice in the community” (which they were not), that would still not be sufficient to avoid liability when that community practice regarding GAC was itself negligent. As the California Supreme Court recognized in *Leonard v. Watsonville Community Hospital* (1956) 47 Cal.2d 509, 519-520: “negligence cannot be excused on the ground that others in the same locality practice the same kind of negligence.” (citing and quoting multiple other cases). Moreover, the California Supreme Court has held that those that hold themselves out as specialists in their field should be held to an even higher standard of care: “In the first place, the special obligation of the professional is exemplified by his duty not merely to perform his work with ordinary care but to use the skill, prudence, and diligence commonly exercised by practitioners of his profession. If he further specializes within the profession, he must meet the standards of knowledge and skill of such specialists. The standards for admissibility of expert testimony in medical malpractice cases in California are very broad: 36A Cal. Jur. 3d *Healing Arts and Institutions* § 494 (e.g., no geographical requirement). Furthermore, expert medical opinions are not required to be generally accepted within the relevant scientific community. *People v. Eubanks* (2011) 53 Cal.4th 110, 140.

***Footnote 3:** “Though it does not require the wisdom of a Supreme Court Justice to see, the Supreme Court recognizes that youth tend to make impetuous and ill-considered life decisions. ‘First, as any parent knows and as the scientific and sociological studies tend to confirm, a lack of maturity and an underdeveloped sense of responsibility are found in youth more often than in adults and are more understandable among the young. These qualities often result in impetuous and ill-considered actions and decisions.’ *Roper v. Simmons*, 543 U.S. 551, 569 (2005) (citations omitted). In the same vein, and perhaps especially true in the school setting, ‘juveniles are more vulnerable or susceptible to negative influences and outside pressures, including peer pressure.’ *Id.* And ‘the character of a juvenile is not as well formed as that of an adult. The personality traits of juveniles are more transitory, less fixed.’ *Id.* at 570 (citation omitted). Indeed, notes the Court, ‘the relevance of youth as a mitigating factor derives from the fact that the signature qualities of youth are transient; as individuals mature, the impetuosity and recklessness that may dominate in younger years can subside.’ *Id.*”: *Mirabelli v. State of California*, page 14 (italics added): <https://www.dropbox.com/scl/fi/ff1c5kvfsij6zqd1mbh9z/Mirabelli-v-Olson-Order-re-Prelim-Inj-MTDs-FINAL.pdf?rlkey=t4b30zkn7q3ht8ymty9ku1vw9&dl=0> and <https://www.thomasmoresociety.org/news/california-federal-court-issues-order-blocking-school-from-forcing-teachers-to-lie-to-parents#gsc.tab=0>; (the *Mirabelli* case is the ninth consecutive win in recent years against the State of California by Brockman’s counsel).

***Footnote 4:** Kaiser’s third affirmative defense of “waiver” in their Answer to Brockman’s First Amended Complaint, is void as against public policy, because one cannot be required to waive in advance of medical treatment any negligence by a hospital, doctor, or surgeon. *Tunkl v. Regents of University of Cal.* (1963) 60 Cal.2d 92; and *Belshaw v. Feinstein* (1968) 258 Cal.App.2d 711, 725–27.

EXHIBIT B

BMJ Open Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people

Virginia P Quinn,¹ Rebecca Nash,² Enid Hunkeler,³ Richard Contreras,¹ Lee Cromwell,⁴ Tracy A Becerra-Culqui,¹ Darios Getahun,¹ Shawn Giammattei,⁵ Timothy L Lash,² Andrea Millman,⁶ Brandi Robinson,⁴ Douglas Roblin,⁷ Michael J Silverberg,⁶ Jennifer Slovis,⁸ Vin Tangpricha,^{9,10} Dennis Tolsma,⁴ Cadence Valentine,¹ Kevin Ward,² Savannah Winter,⁴ Michael Goodman²

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ABSTRACT

Purpose The Study of Transition, Outcomes and Gender (STRONG) was initiated to assess the health status of transgender people in general and following gender-affirming treatments at Kaiser Permanente health plans in Georgia, Northern California and Southern California. The objectives of this communication are to describe methods of cohort ascertainment and data collection and to characterise the study population.

Participants A stepwise methodology involving computerised searches of electronic medical records and free-text validation of eligibility and gender identity was used to identify a cohort of 6456 members with first evidence of transgender status (index date) between 2006 and 2014. The cohort included 3475 (54%) transfeminine (TF), 2892 (45%) transmasculine (TM) and 89 (1%) members whose natal sex and gender identity remained undetermined from the records. The cohort was matched to 127 608 enrollees with no transgender evidence (63 825 women and 63 783 men) on year of birth, race/ethnicity, study site and membership year of the index date. Cohort follow-up extends through the end of 2016.

Findings to date About 58% of TF and 52% of TM cohort members received hormonal therapy at Kaiser Permanente. Chest surgery was more common among TM participants (12% vs 0.3%). The proportions of transgender participants who underwent genital reconstruction surgeries were similar (4%–5%) in the two transgender groups. Results indicate that there are sufficient numbers of events in the TF and TM cohorts to further examine mental health status, cardiovascular events, diabetes, HIV and most common cancers.

Future plans STRONG is well positioned to fill existing knowledge gaps through comparisons of transgender and reference populations and through analyses of health status before and after gender affirmation treatment. Analyses will include incidence of cardiovascular disease, mental health, HIV and diabetes, as well as changes in laboratory-based endpoints (eg, polycythemia and bone density), overall and in relation to gender affirmation therapy.

Strengths and limitations of this study

- Perhaps the most important strength of this study is systematic cohort identification without a need for participant opt-in.
- Additional strengths include accurate determination of gender identity and comprehensive ascertainment of hormonal and surgical treatment received at Kaiser Permanente.
- Notable weaknesses of the study include relatively short follow-up, dearth of information on gender affirmation treatment received outside of the health plans and lack of data on outcomes not captured in the medical records.

INTRODUCTION

Transgender people are a diverse group of individuals whose biological sex does not match their gender identity.¹ Typically, sex is assigned at birth based on the appearance of the genitalia.² In contrast, an individual's gender identity is defined as being a male/man, female/woman or of a different gender.^{2,3} Many transgender people may not self-identify based on binary definitions;⁴ however, a person whose gender identity differs from a male natal sex assignment is often referred to as male-to-female or trans woman, and a person whose gender identity differs from a female natal sex is often referred to as a female-to-male or trans man.^{5,6} More recently, the terms transfeminine (TF) and transmasculine (TM) have become preferred as they also apply to individuals who do not identify with binary gender categories.⁷

Transgender individuals sometimes seek medical gender affirmation, which may involve administration of cross-sex hormone therapy (HT) to achieve desired masculinisation or



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For numbered affiliations see end of article.

Correspondence to

Dr Michael Goodman;
mgoodm2@emory.edu

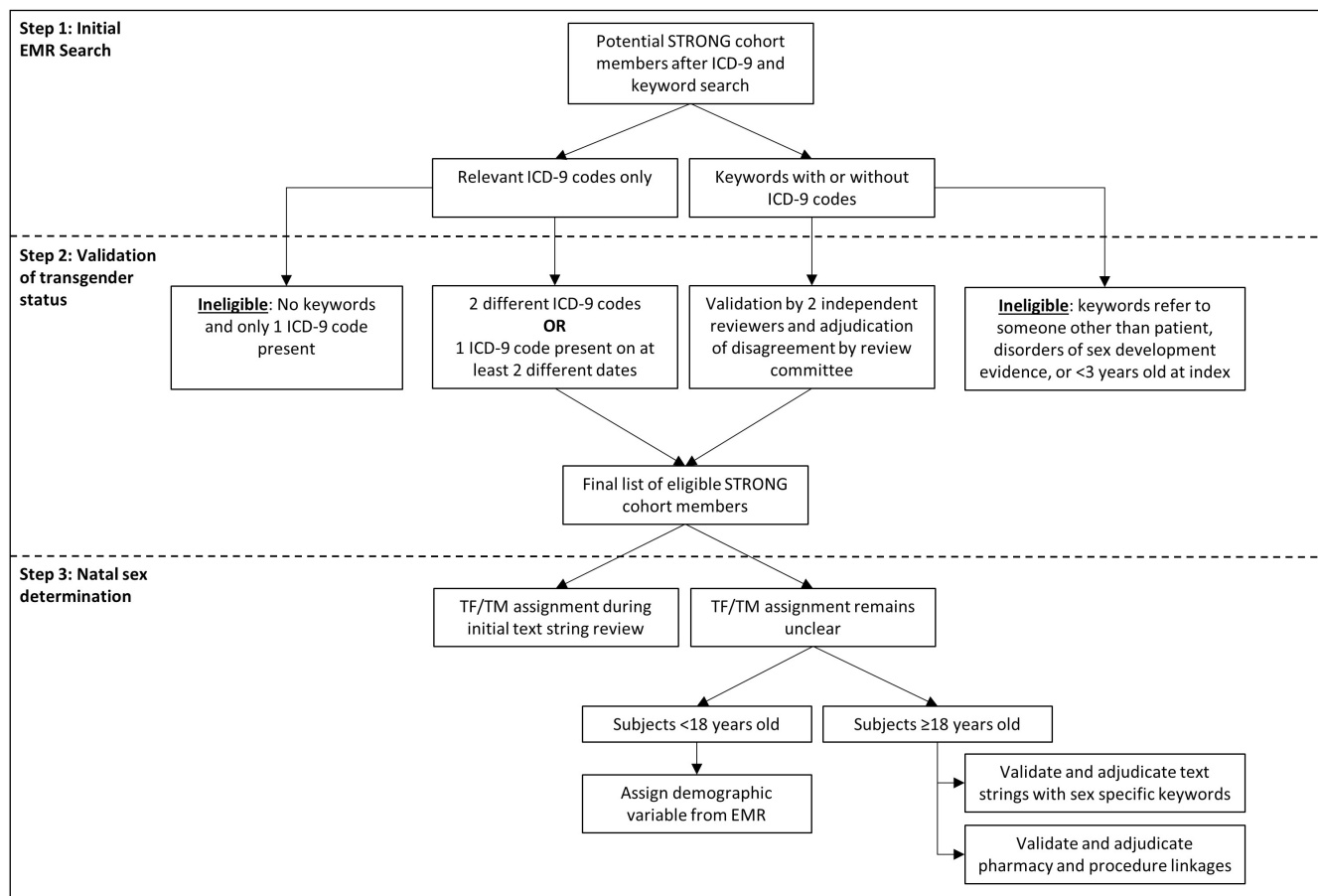


Figure 1 STRONG transgender cohort ascertainment flow diagram. EMR, electronic medical record; ICD-9; International Classification of Diseases, Ninth edition; STRONG, Study of Transition, Outcomes and Gender; TF, transfeminine; TM, transmasculine.

feminisation, and/or surgical change of the genitalia and other sex characteristics.^{8,9} Although several organisations have established guidelines for clinical care of transgender patients,^{9,10} many issues in transgender health and gender affirmation therapy remain unresolved due to lack of direct evidence.¹¹ Consequently, many current practices and standards of care are based on expert opinion, case reports or extrapolation of research findings from other populations. For example, current recommendations regarding risk of venous thromboembolism in TF patients receiving oestrogen are based on the observed effects of hormone replacement therapy in postmenopausal women.^{12,13} Similarly, expected health risks in TM are inferred from comorbidities associated with polycystic ovary syndrome.¹⁴

Critical knowledge gaps include the effect of HT and surgery on gender dysphoria (the feeling of distress when natal sex does not match gender identity¹⁵) and other mental health issues, haematological side effects of HT and risk of cardiovascular disease, metabolic or endocrine disorders and cancer following hormonal or surgical gender affirmation.¹⁶ A direct evaluation of some of these issues requires longitudinal studies with large numbers of TM and TF participants with sufficient follow-up and variable history of surgical interventions and cross-sex HT

use.¹⁷ These considerations motivated the design of the longitudinal cohort for 'Study of Transition, Outcomes and Gender (STRONG)'. This paper provides a summary of the challenges facing transgender health research, describes the main elements of the STRONG study design and data collection and discusses lessons learnt during the implementation of this project. In this 'cohort profile' communication, we offer a detailed documentation of methods used to assemble, validate and characterise the STRONG cohort and offer an overall description of the study population that will provide data for a multitude of subsequent hypothesis-testing studies.

METHODOLOGICAL CHALLENGES FACING TRANSGENDER HEALTH STUDIES

The methodological challenges in observational studies of transgender health fall into five categories: (1) attaining sufficient sample size and statistical power; (2) systematic and comprehensive identification of eligible study participants and comparable reference groups; (3) determination of natal sex and/or gender identity; (4) assessment of current and past gender affirmation treatment and (5) engagement of patient and physician stakeholders at all stages of research.¹⁷

Table 1 ICD-9 codes and keywords used to identify potentially eligible STRONG transgender cohort members among KPGA, KPSC and KPNC members

ICD-9 diagnostic codes	ICD-9 V codes*+internal KP codes	Keywords
302.5—trans-sexualism	V49.89+121141596—other conditions influencing health: transgender	'Transgender'
302.50—trans-sexualism with unspecified sexual history (aka 'trans-sexualism not otherwise specified')	V45.77+121141596—acquired absence of genital organs: history of sex reassignment surgery	'Transsexual'
302.51—trans-sexualism with asexual history	V07.8+12124952—other specified prophylactic measure: male-to-female hormone supplementation	'Transvestite'
302.52—trans-sexualism with homosexual history	V07.8+12124310—other specified prophylactic measure: female-to-male hormone supplementation	'Gender identity'
302.53—trans-sexualism with heterosexual history		'Gender dysphoria'
302.85—gender identity disorder in adolescents or adults		'Gender reassignment'
302.6—gender identity disorder in children		
302.3—transvestic fetishism		

*ICD-9 V codes are used for supplementary classification of factors influencing health status.^{40,41} As V codes may cover several conditions, they have to be used in conjunction with internal KP codes to ensure specificity.

ICD-9, International Classification of Diseases Ninth edition; KP, Kaiser Permanente; KPGA, Kaiser Permanente health plan located in Georgia; KPNC, Kaiser Permanente health plan located in Northern California; KPSC, Kaiser Permanente health plan located in Southern California; STRONG, Study of Transition, Outcomes and Gender.

Transgender people represent a hard-to-reach population, and to date most existing cohorts assessing transgender health were assembled in specialised clinics that provide gender affirmation care.^{18, 19} This approach provides good options for collecting detailed treatment data and biospecimens but may exclude individuals who have not sought or who have already completed treatment, and makes it difficult to select comparable reference groups.²⁰ In addition, establishing a large clinic-based cohort requires coordination across multiple sites, is costly and may still have small numbers resulting in studies of relatively low statistical power.¹⁷

Besides clinic-based studies, previous efforts to identify transgender individuals for health research also involved population surveys²¹ and reviews of electronic records for relevant International Classification of Diseases (ICD) codes.^{22, 23} While surveys offer generalisable population

estimates, they may be affected by recall bias and low response rates and require large-scale efforts to identify sufficient numbers of transgender people. Reliance on ICD codes allows identifying large samples from insurance claims or electronic medical records (EMRs), but may exclude eligible study participants who do not have or do not wish to receive a transgender-specific diagnosis.²⁴

A critical aspect of transgender research is accurate identification of gender identity. In recent years, the US Department of Health and Human Services issued a directive that EMR systems should enable providers to record gender identity and sexual orientation.²⁵ This directive should improve documentation over time; but in the meantime, determination of TF or TM status presents a methodological challenge because the available demographic data can reflect natal sex or gender identity, without specifying which is which. Assessing TM/TF

Table 2 Keywords used for STRONG transgender cohort natal sex assignment

Category	Keyword Type	Keywords
Transfeminine	Natal sex keywords	'Testes', 'testicular', 'penis', 'penile', 'prostate', 'prostatic', 'PSA', 'scrotum', 'neovagina', 'neo vagina', 'neo-vagina', 'sperm', 'erection'
	Hormonal therapy keywords	'Estrogen', 'anti-androgen', 'progesterone', 'aldactone', 'avodart', 'cenestin', 'climara', 'cyprostat', 'cyproterone', 'delestrogen', 'depo-estradiol', 'divigel', 'dutasteride', 'elestrin', 'enjuvia', 'estrace', 'estradiol', 'estroderm', 'estrogel', 'estrosorb', 'flutamide', 'finasteride', 'lupron', 'medroxyprogesterone', 'premarin', 'premphe', 'premp', 'propecia', 'proscar', 'prometrium', 'provera', 'spironolactone'
	Procedure keywords	'Castration', 'orchiectomy', 'penectomy', 'vaginoplasty', 'breast augmentation', 'breast enlargement', 'laryngeal shave', 'feminization', 'electrolysis', 'hair transplant', 'collagen', 'silicone', 'voice therapy'
Transmasculine	Natal sex keywords	'Ovary', 'ovaries', 'ovarian', 'cervix', 'uterus', 'uterine', 'vagina', 'PAP smear', 'menstrual bleeding', 'menses'
	Hormonal therapy keywords	'Android', 'androderm', 'androgel', 'axiron', 'delatestryl', 'depo-testosterone', 'striant', 'testim'
	Procedure keywords	'Vaginectomy', 'phalloplasty', 'metoidioplasty', 'mastectomy', 'hysterectomy', 'oophorectomy'

PAP, Papanicolau; PSA, prostate specific antigen; STRONG, Study of Transition, Outcomes and Gender.

Box Data available for Study of Transition, Outcomes and Gender transgender cohort

Data categories and specific elements

Demographic and membership characteristics

- ▶ Age, sex and race/ethnicity
- ▶ Health plan site
- ▶ Area-based socioeconomic status factors*
- ▶ Enrolment/disenrolment intervals
- ▶ Insurance plan type

General health indicators

- ▶ Height/weight (body mass index)*
- ▶ Smoking status*
- ▶ Comorbidities

Gender affirmation procedures

- ▶ Current Procedure Terminology and/or International Classification of Diseases code
- ▶ Date of procedure
- ▶ History of gender affirmation procedures (clinical notes)

Pharmacy records (hormone therapy, psychiatric medications)

- ▶ Medication prescribed
- ▶ Filled prescription for medication
- ▶ Dose
- ▶ Form
- ▶ Dates of prescription and fill

Visit-associated diagnoses

- ▶ Cardiovascular disease
- ▶ Diabetes
- ▶ HIV
- ▶ Mental health problems

Cancer diagnoses

- ▶ Stage
- ▶ Site
- ▶ Histology
- ▶ Date of diagnosis

Laboratory results

- ▶ Laboratory test
- ▶ Value
- ▶ Date

Vital status

- ▶ Date of death
- ▶ Cause of death

Note: *Assessed at index date (date of first evidence of transgender status in electronic medical record).

status can be achieved by asking two questions about natal sex and gender identity²⁶; however, reliance on self-report requires contact with individual participants and is subject to non-response, which increases the risk of selection bias.

Insurance coverage for gender affirmation therapy has increased over time^{27–29}; however, it remains sporadic and incomplete, and many transgender people seek care outside of regular healthcare plans.³⁰ This presents a specific challenge for any study that aims to ascertain hormonal exposures and surgical procedures, particularly for transgender people with no or inadequate insurance coverage and for persons who initiated gender-affirming therapy years ago.

In a rapidly developing field, such as transgender health, even experienced researchers may lack specific expertise required to prioritise research questions and select the most relevant patient-centred outcome measures. Thus, it is important to involve members of the transgender community and their physicians to ensure that the proposed research questions, study design and data collection methods are relevant, appropriate and feasible.³¹ Conversely, as the research methods and interpretation of findings are becoming increasingly complex, researchers should communicate with stakeholders directly to convey information relevant to their decision-making.³²

In sum, transgender health research faces significant methodological challenges and logistical barriers. These challenges and barriers contribute to the lack of knowledge about the health risks in this population and preclude development of evidence-based recommendations for transgender healthcare.¹¹

COHORT DESCRIPTION

Study goals, design and setting

STRONG was initiated in September 2013 with the primary long-term goal of assessing the health status of transgender individuals overall, among TF/TM subgroups, and in both subgroups after different types of gender-affirming treatment. It was designed as an EMR-based retrospective/prospective cohort study of transgender members enrolled in three Kaiser Permanente (KP) health plans located in Georgia (KPGA), Northern California (KPNC) and Southern California (KPSC). These health plans are prepaid integrated care systems and currently provide comprehensive health services to approximately 8 million members. Individuals and their families may enrol through an employer, state or federal programmes such as Medicaid and Medicare, or directly. The populations of enrollees are sociodemographically diverse and broadly representative of the communities in the corresponding areas.^{33 34}

The three KP organisations are members of several research consortia including the Healthcare Systems Research Network³⁵ and the Mental Health Research Network.³⁶ They share similarly structured databases organised into ‘Virtual Data Warehouses’ (VDW), with files stored behind security firewalls at each site. The files have identical variable names, formats and specifications that allow using centrally generated and/or distributed programs to create harmonised analytic datasets.³⁷ VDW files are linked by unique individual identifiers, allowing researchers to construct historical and prospective cohorts.³⁸

The study was conducted in partnership with the Emory University, which served as the coordinating centre. All activities described in this manuscript were reviewed and approved by the Institutional Review Boards (IRBs) of the four institutions.

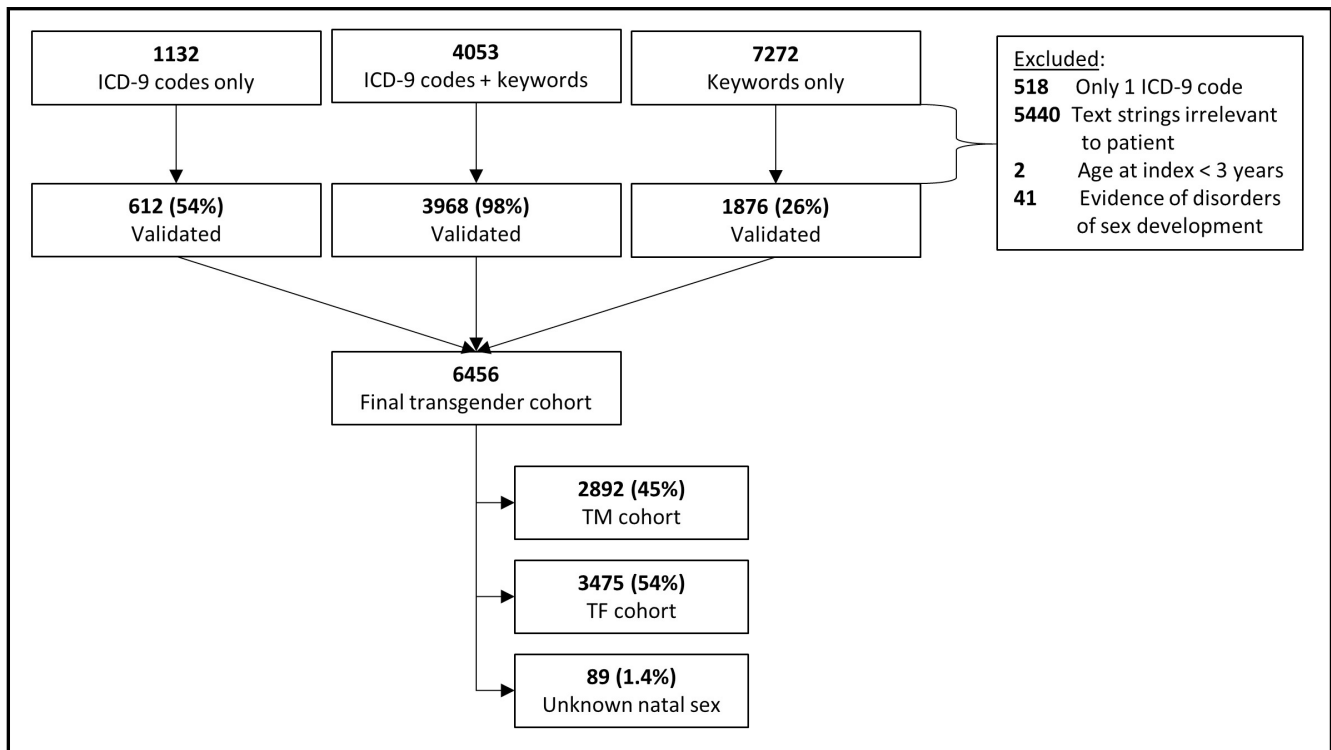


Figure 2 Results of STRONG transgender cohort ascertainment and validation. ICD-9; International Classification of Diseases Ninth edition; STRONG, Study of Transition, Outcomes and Gender; TF, transfeminine; TM, transmasculine.

The stakeholder involvement was achieved by assembling a project advisory group. To recruit the Stakeholder Advisory Group members, investigators at each site were charged with identifying a leading clinician specialising in transgender care. The physicians were then asked to nominate one or two patients to serve as representatives of the transgender community. The resulting Stakeholder Advisory Group included 12 members. The stakeholders made a number of important contributions to the project at various stages of study design, planning and implementation, as described below.

Cohort ascertainment

Figure 1 shows the three-step algorithm used to identify transgender cohort members. It includes initial EMR search to identify cohort candidates (step 1), validation of transgender status (step 2) and determination of TM/TF status (step 3).

Step 1: Initial EMR search

A computer programme written using Statistical Analysis Software (SAS) V.9.4 (SAS Institute Inc., Cary, NC) was used to search the EMRs of KPGA, KPNC and KPSC members of all ages enrolled between 1 January 2006 and 31 December 2014 to identify two types of evidence supporting transgender status: (1) relevant International Classification of Diseases, Ninth edition (ICD-9) codes and (2) presence of relevant specific keywords in free-text clinical notes (table 1). The program was developed and pilot-tested at KPGA and then distributed to the

remaining sites. Cohort ascertainment was undertaken before the health plans switched to ICD-10 codes.

The diagnostic ICD-9 codes suggestive of transgender status were selected based on consultations with the STRONG Stakeholder Advisory Group and methodologies described in earlier studies.^{23 39} Transvestic fetishism (ICD-9 code 302.3) was included based on previous observations that men who initially meet criteria for this diagnostic category may later experience persistent gender dysphoria consistent with transgender status.²²

We also used ICD-9 V codes, which allow for supplementary classification of factors influencing health status.^{40 41} As V codes may cover several conditions, we used them in conjunction with internal KP codes to ensure specificity. For example, a combination of ICD-9 code V49.89 and KP code 121141596 means ‘Other conditions influencing health: transgender’.

The second method of transgender ascertainment involved another custom-written program that identified the relevant keywords in free-text clinical notes recognising that both appropriate and inappropriate terms could be found in the EMR. During pilot testing, an expanded list of keywords provided by the stakeholders was used; that list was gradually shortened after stepwise removal of keywords that did not contribute additional cases. The resulting list provided a complete cohort ascertainment with the shortest program running time.

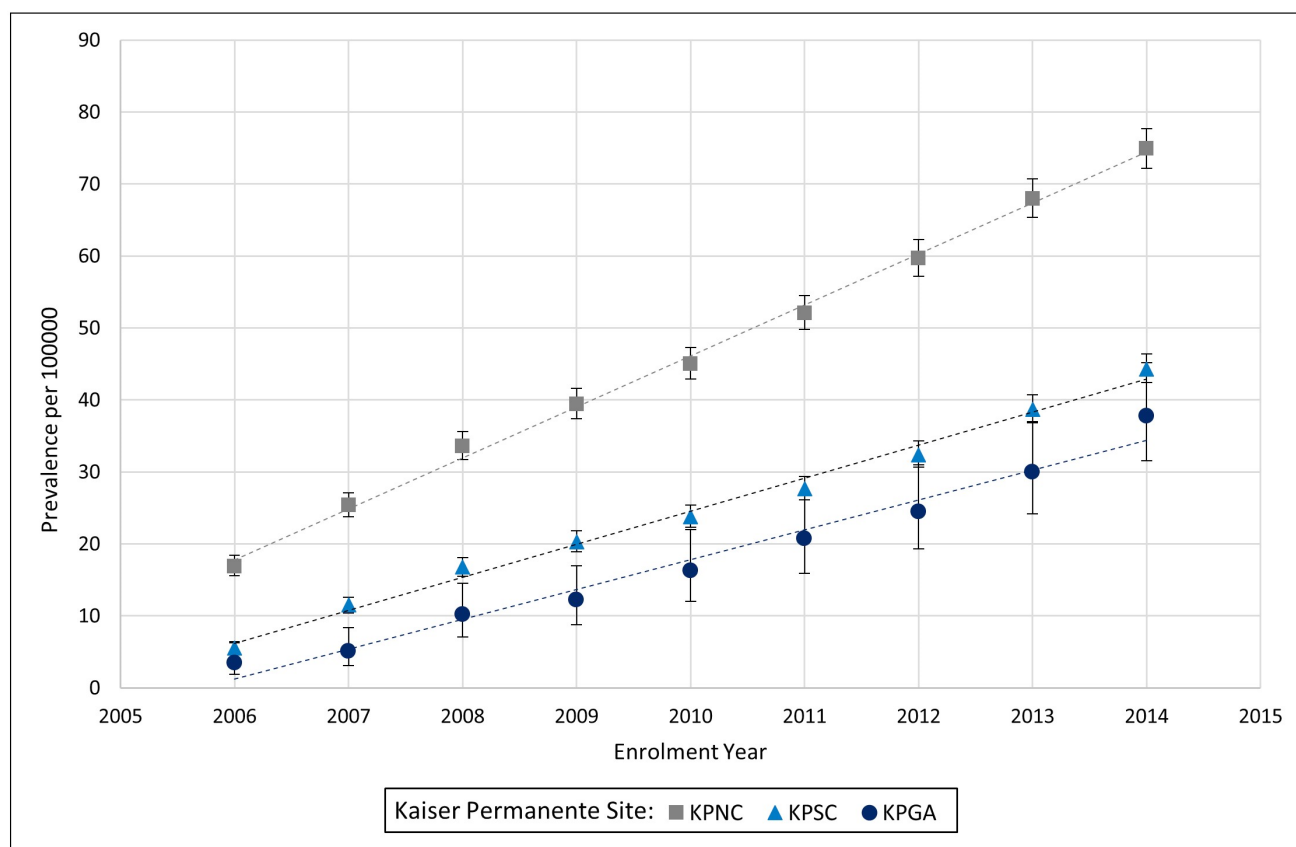


Figure 3 Prevalence of transgender status by site and year of health plan enrolment. Dotted lines represent linear trends. KPGA, Kaiser Permanente health plan located in Georgia; KPNC, Kaiser Permanente health plan located in Northern California; KPSC, Kaiser Permanente health plan located in Southern California.

Step 2: Cohort validation

A separate program extracted short strings of text that included 100 characters before and 50 characters after each keyword of interest. When clinical notes contained relevant keywords (with or without an ICD-9 code), transgender status was confirmed through an examination of the deidentified text strings by two trained reviewers. Disagreements among reviewers were adjudicated by a review committee that included two physician investigators (MG and VT) and the project manager (RN).

Cohort candidates with no keywords but at least two different diagnostic codes or the same code on different dates were considered eligible. The validity of this approach was confirmed using unstructured chart review during pilot testing of the study protocol, as described previously.²⁴

Members who had evidence of disorders of sex development (ie, abnormalities of chromosomal, gonadal or anatomic sex⁴²) and those younger than 3 years of age at the index date were excluded.

Step 3: Determination of TF/TM status

Each eligible study participant was categorised as TF or TM using several methods. We used all keyword text strings and ICD-9 codes extracted for step 1 to identify

additional words such as ‘male-to-female’, ‘female-to-male’ and gender affirmation V codes (V07.8+12124952 and V07.8+12124310). During the validation of transgender status, the reviewers were also instructed to categorise each eligible person as ‘natal male’, ‘natal female’ or ‘unclear’.

For persons whose TF/TM status was unclear after the initial review and for persons with ICD-9 codes only, another free-text program was developed to search for keywords reflecting natal sex anatomy (eg, ‘testes’ or ‘ovaries’), history of specific procedures (eg, orchiectomy or hysterectomy) or evidence of hormonal therapy (eg, oestrogen or testosterone). The keywords used for assigning TM/TF status are included in table 2. Text strings containing TF-specific and TM-specific keywords were reviewed and adjudicated as discussed above.

Gender affirmation treatment status

During the initial STRONG cohort validation (step 2) and natal sex determination (step 3), reviewers were instructed to check a box for ‘Evidence of treatment’ if the text strings provided an indication of receipt or referral for HT, surgery or other relevant procedures (eg, electrolysis). Disagreements were adjudicated as described previously.

Table 3 Characteristics of the STRONG transgender cohort

Participant characteristics	Overall transgender cohort, n (%)	TF cohort, n (%)*	TM cohort, n (%)*
Health plan site			
KPNC	3842 (60)	1949 (56)	1831 (63)
KPSC	2440 (38)	1431 (41)	982 (34)
KPGA	174 (2.7)	95 (2.7)	79 (2.7)
Race/ethnicity			
Non-Hispanic white	3532 (55)	1828 (53)	1669 (58)
Non-Hispanic black	510 (7.9)	248 (7.1)	256 (8.9)
Asian	515 (8.0)	305 (8.8)	203 (7.0)
Hispanic	1232 (19)	710 (20)	503 (17)
Other/unknown	667 (10)	384 (11)	261 (9.0)
Age†			
3–17 years	1347 (21)	588 (17)	745 (26)
18–25 years	1431 (22)	655 (19)	753 (26)
26–35 years	1329 (21)	600 (17)	707 (24)
36–45 years	939 (15)	577 (17)	347 (12)
46–55 years	779 (12)	552 (16)	219 (7.6)
>55 years	631 (9.8)	503 (14)	121 (4.2)
Smoking status†			
Current	1011 (16)	506 (15)	489 (17)
Former	873 (14)	461 (13)	401 (14)
Never	4029 (62)	2196 (63)	1795 (62)
Unknown	543 (8.4)	312 (9.0)	207 (7.2)
BMI†			
Underweight	150 (2.3)	96 (2.8)	52 (1.8)
Normal weight	2404 (37)	1356 (39)	1025 (35)
Overweight	1648 (26)	915 (26)	710 (25)
Obese	1690 (26)	777 (22)	886 (31)
Unknown	564 (8.7)	331 (9.5)	219 (7.6)
Medicaid status†			
Yes	265 (4.1)	138 (4.0)	123 (4.3)
No	6029 (93)	3251 (94)	2702 (93)
Unknown	162 (2.5)	86 (2.5)	67 (2.3)
Census-level education status			
<30% of residents have high school or less	2634 (41)	1405 (40)	1194 (41)
30%–50% of residents have high school or less	2233 (35)	1218 (35)	979 (34)
>50% have high school or less	1467 (23)	795 (23)	655 (23)
Unknown	122 (1.9)	57 (1.6)	64 (2.2)
Total, n (%)	6456 (100)	3475 (54)	2892 (45)

*Excludes 89 persons with unknown natal sex.

†Assessed at index date (date of first evidence of transgender status in electronic medical records).

KPGA, Kaiser Permanente health plan located in Georgia; KPNC, Kaiser Permanente health plan located in Northern California; KPSC, Kaiser Permanente health plan located in Southern California; STRONG, Study of Transition, Outcomes and Gender; TF, transfeminine; TM, transmasculine.

In addition to text string reviews, gender affirmation treatment status was determined by linkage with cross-sex hormone prescriptions using national drug codes, as well as ICD-9, ICD-10 and Current Procedure Terminology (CPT) codes reflecting surgeries and other interventions (online supplementary tables 1–6). TF drugs (eg,

oestradiol, spironolactone) in a natal male and TM drugs (eg, testosterone) in a natal female were considered as evidence of HT.

As a result of these steps, cohort members were categorised based on evidence of HT and surgical or other gender affirmation procedures. Gender affirmation

Table 4 Gender affirmation status of the STRONG transgender cohort members

Gender affirmation evidence and type	Overall transgender cohort, n (%)	TF cohort, n (%)*	TM cohort, n (%)*
Evidence of treatment			
Any†	4040 (63)	2244 (65)	1792 (62)
None	2416 (37)	1231 (35)	1100 (38)
Cross-sex hormone therapy			
Specific evidence at KP	3544 (55)	2030 (58)	1514 (52)
Evidence in the text only	187 (2.9)	112 (3.2)	72 (2.5)
No evidence	2725 (42)	1333 (38)	1306 (45)
Gender affirmation surgery			
Top surgery at KP only	369 (5.7)	12 (0.3)	357 (12)
Orchiectomy at KP with or without top	52 (0.8)	52 (1.5)	0 (0)
Hysterectomy and/or oophorectomy at KP with or without top	311 (4.8)	0 (0)	311 (11)
Genital reconstruction at KP with or without other surgery	299 (4.6)	181 (5.2)	118 (4.1)
Evidence in the text only	432 (6.7)	253 (7.3)	179 (6.2)
No evidence	4993 (77)	2977 (86)	1927 (67)
Procedures to alter secondary sex characteristics			
Specific evidence at KP	678 (11)	385 (11)	293 (10)
Evidence in the text only	58 (0.9)	52 (1.5)	6 (0.2)
No evidence	5720 (89)	3038 (87)	2593 (90)
Total	6456 (100)	3475 (100)	2892 (100)

*Excludes 89 persons with unknown natal sex.

†Includes non-specific history and referral for treatment.

KP, Kaiser Permanente; STRONG, Study of Transition, Outcomes and Gender; TF, transfeminine; TM, transmasculine.

procedures were categorised as: bottom (eg, vaginoplasty for TF or vaginectomy for TM); top (eg, breast augmentation for TF or mastectomy for TM); interventions to change secondary sex characteristics (eg, electrolysis) or not specified (ie, evidence of surgery in the text only).

Selection of the reference cohort

Up to 10 male and 10 female KP enrollees without evidence of transgender status were matched to each member of the final validated transgender cohort on year of birth (within 5-year groups for adults and 2-year groups for children and adolescents), race/ethnicity, KP site and membership year at the index date. Index date was defined as the date of the first recorded evidence of transgender status in the EMR. For some transgender cohort members, the number of reference males or females was less than 10 due to duplicate matches; however, no transgender participant had less than seven referents of either sex. A cluster ID for each matched group was assigned to allow stratified analyses (eg, by HT type or gender-affirming surgery).

Data integration and follow-up

Patient identification numbers for both the transgender and reference cohorts were linked to multiple data sources to obtain ICD-9 and ICD-10 diagnostic codes for the conditions of primary interest (eg, mental health

conditions, cardiovascular diseases and diabetes); disease registries to ascertain incident cancers and HIV diagnoses; psychiatric and behavioural healthcare utilisation; pharmacy records to track mental health treatment and HT receipt over time; and dates and results of laboratory tests including bone scans, blood chemistry analyses, hormone levels and blood cell counts (box). Mortality was ascertained from linkages to death registries. All members of the cohort were assigned a study ID by the programmer at each KP site and no personally identifiable information was included in the aggregated analytic file. To date, cohort follow-up extends through the end of 2016.

FINDINGS TO DATE

Initial review of the EMRs identified 12457 potential transgender individuals. Of these, 7272 (58%) were identified through keywords only, 1132 (9%) through ICD-9 codes only and the remaining 4053 (33%) had both ICD-9 codes and keywords (figure 2). Among these candidates, 6456 were confirmed as transgender: 10% from ICD-9 codes alone, 29% from keywords alone and 61% from both codes and keywords. Based on validation results, the positive predictive values for keywords, diagnostic codes and both were 26%, 54% and 98%, respectively. The leading reason for non-eligibility was the use of a keyword

Table 5 Frequency of health outcomes in the STRONG TF cohort relative to matched comparison groups

Health outcomes	TF cohort, n (%) [*]	Reference males, n (%) [*]	Reference females, n (%) [*]
Cardiovascular disease			
Venous thromboembolism	86 (2.5)	670 (1.9)	677 (2.0)
Stroke	88 (2.5)	943 (2.7)	674 (2.0)
Myocardial infarction	61 (1.8)	664 (1.9)	319 (0.9)
Peripheral artery disease	106 (3.1)	879 (2.6)	645 (1.9)
Unstable angina	64 (1.8)	656 (1.9)	336 (1.0)
Mental health[†]			
Anxiety	1337 (38)	4323 (13)	7485 (22)
Depression	1705 (49)	4721 (14)	8726 (25)
Self-inflicted injury [‡]	75 (2.2)	100 (0.3)	204 (0.6)
Suicidal ideation	175 (5.0)	157 (0.5)	194 (0.6)
Substance abuse disorder	524 (15)	2860 (8.3)	1680 (4.9)
Cancer primary site			
Colorectum	10 (0.3)	107 (0.3)	91 (0.3)
Lung and bronchus	9 (0.3)	58 (0.2)	59 (0.2)
Lymphatic and haematopoietic	22 (0.6)	168 (0.5)	106 (0.3)
Melanoma	10 (0.3)	227 (0.7)	180 (0.5)
Prostate	25 (0.7)	451 (1.3)	0 (0.0)
Other chronic conditions[†]			
HIV [§]	186 (5.4)	190 (0.6)	15 (0.0)
Diabetes	313 (9.0)	3358 (9.8)	2619 (7.6)
Vital status			
Alive	3372 (97)	33562 (98)	33839 (98)
Dead	103 (3.0)	818 (2.4)	551 (1.6)
Total	3475 (100)	34380 (100)	34390 (100)

^{*}Percentages do not add to 100% due to overlapping categories.

[†]Based on at least two diagnoses in the EMR.

[‡]Combined diagnoses of self-inflicted injury, self-inflicted injury/poisoning and possible self-inflicted injury.

[§]HIV status ascertained from disease registries in Kaiser Permanente health plans located in Northern and Southern California and from two or more International Classification of Diseases codes in the EMR in Kaiser Permanente health plan located in Georgia.

EMR, electronic medical record; STRONG, Study of Transition, Outcomes and Gender; TF, transfeminine.

(eg, transgender) referring not to the patient, but to the patient's relative or partner. In other situations, the keywords of interest were used as part of standard text, such as when listing indications for hormone use. Natal sex and/or gender identity was successfully determined for all but 89 (1.4%) of the transgender cohort members.

The transgender cohort was matched to 127608 enrollees with no evidence of transgender status. Of those 63825 were women and 63783 were men.

Figure 3 displays proportions of transgender enrollees over time at each of the three participating sites. In 2006, the prevalence estimates (95% CIs) per 100000 enrollees were 3.5 (1.9 to 6.3), 5.5 (4.8 to 6.4) and 17 (16 to 19) in KPGA, KPSC and KPNC, respectively. By 2014, the corresponding estimates increased to 38 (32 to 45) in KPGA, 44 (42 to 46) in KPSC and 75 (72 to 78) in KPNC. The composition of the transgender population has also changed. Whereas in 2006, the TF:TM ratio among newly

identified cohort members was approximately 1.7:1, in 2014 the same ratio was 1:1.

As shown in table 3, about 60% of all participants were from KPNC, 38% were from KPSC and less than 3% were from KPGA. With respect to race and ethnicity, blacks and Asians each comprised about 8% of the study population, 19% were Hispanics and 55% were non-Hispanic whites. Compared with TF, TM subjects were younger (76% vs 53% under the age of 36) and included a greater proportion of subjects who were obese (31% vs 22%). Proportions of smokers, insurance status and area-based measures of education were similar in TM and TF study subjects.

Nearly two-thirds of the transgender cohort had some evidence of gender-affirming treatment (table 4). Approximately 55% of all transgender cohort members had evidence of HT received at KP. This proportion was slightly higher (58%) in TF than in TM participants (52%).

Table 6 Frequency of health outcomes in the STRONG TM cohort relative to comparison groups

Health outcomes	TM cohort, n (%) [*]	Reference males, n (%) [*]	Reference females, n (%) [*]
Cardiovascular disease			
Venous thromboembolism	45 (1.6)	266 (0.9)	356 (1.2)
Stroke	42 (1.5)	360 (1.3)	250 (0.9)
Myocardial infarction	17 (0.6)	210 (0.7)	88 (0.3)
Peripheral artery disease	38 (1.3)	309 (1.1)	242 (0.8)
Unstable angina	20 (0.7)	215 (0.8)	123 (0.4)
Mental health[†]			
Anxiety	1323 (46)	3583 (13)	6089 (21)
Depression	1594 (55)	3806 (13)	6813 (24)
Self-inflicted injury [‡]	121 (4.2)	109 (0.4)	181 (0.6)
Suicidal ideation	193 (6.7)	160 (0.6)	186 (0.7)
Substance abuse disorder	418 (14)	2391 (8.4)	1523 (5.3)
Cancer primary site			
Breast	20 (0.7)	¶	217 (0.8)
Cervix	7 (0.2)	0 (0.0)	172 (0.6)
Melanoma	8 (0.3)	109 (0.4)	71 (0.2)
Other chronic conditions[†]			
HIV [§]	9 (0.3)	117 (0.4)	10 (0.0)
Diabetes	153 (5.3)	1329 (4.7)	1213 (4.2)
Vital status			
Alive	2853 (99)	28237 (99)	28366 (99)
Dead	39 (1.3)	283 (1.0)	183 (0.6)
Total	2892 (100)	28520 (100)	28549 (100)

^{*}Percentages do not add to 100% due to overlapping categories.

[†]Based on at least two diagnoses in the EMR.

[‡]Combined diagnoses of self-inflicted injury, self-inflicted injury/poisoning and possible self-inflicted injury.

[§]HIV status ascertained from disease registries in Kaiser Permanente health plans located in Northern and Southern California and from two or more International Classification of Diseases codes in the EMR in Kaiser Permanente health plan located in Georgia.

[¶]Counts <5 are suppressed.

EMR, electronic medical record; STRONG, Study of Transition, Outcomes and Gender; TM, transmasculine.

About 23% of the transgender cohort had some evidence of gender affirmation surgery. Top surgery receipt at KP was far more common among TM cohort members than among their TF counterparts (12% vs 0.3%). Similar proportions of TM and TF cohorts had genital surgeries (4%–5%) or procedures aimed at altering other secondary sex characteristics (11%).

Tables 5 and 6 present the number of cases for various health outcomes in the STRONG population through the end of 2016. These frequencies should not be interpreted as evidence of increased or decreased risk because they do not account for person-time of follow-up, time ordering of the conditions and transgender status and do not take into consideration exposures to cross-sex hormones or surgical procedures. Nevertheless, these data indicate that both TF and TM cohort members, as well as their corresponding referents, have sufficient numbers of cardiovascular events, mental health conditions, HIV, diabetes and several common cancers to permit meaningful analyses. Additional analyses will include changes in laboratory-based

endpoints including polycythemia and bone density. These analyses are beyond the scope of this communication, which is focused on the study methods rather than specific findings. The planned analyses will include comparisons of transgender and reference cohorts as well as within-transgender cohort examination of health status before and after surgery and initiation of HT.

STRENGTHS AND LIMITATIONS

In this communication, we describe STRONG, a health system-based observational study that was designed to examine the health status of transgender people and to evaluate the possible risks and health benefits of various gender-affirming treatments. STRONG aimed to overcome five previously described methodological challenges facing transgender health research.

Sample size and power considerations

Adequate sample size can be feasibly achieved with the use of large well-defined populations that offer an

adequate sampling frame.³⁸ In practical terms, at least in the USA, this can be done by basing the study in large integrated health systems with millions of members and comprehensive EMRs. The EMR data from the health systems allow assembling cohorts of hard-to-reach populations and ample options for selection of referent groups. The STRONG cohort, which included almost 6500 transgender people and nearly 130 000 referents, represents one of the largest studies of its kind available to date. Nevertheless, a number of important analyses by different subtypes of gender affirmation treatment may not be feasible due to sparse stratum-specific data.

Systematic identification of eligible study participants

We demonstrated that by using a relatively simple algorithm—based on standard codes and supplemented with analysis of digitised provider notes—it is possible to comprehensively identify transgender enrollees of large community-based health plans. The use of keyword-containing text strings enhanced cohort ascertainment relative to ICD code-alone-based approaches. On the other hand, reliance on keywords without text validation would have erroneously included a substantial number of persons who are not transgender. A review of records to confirm transgender status added considerable time and resources; however, it is still more efficient and more comprehensive than the traditional unstructured chart review. In conducting cohort validation, we reviewed up to three clinical note excerpts on 11 325 people. This task was accomplished within 6 months.

A comprehensive identification of all transgender people in the KP population (with and without evidence in the medical records) would require contacting more than 8 million members to inquire about their natal sex and gender identity; this does not appear feasible at this time.

Determination of natal sex and/or gender identity

Our study definitively ascertained natal sex and/or gender identity for nearly 99% of cohort members. We obtained information on TM/TF status from three sources: keyword text strings, pharmacy records and procedure codes. In most instances, these sources were in agreement; however, in some cases the results were discordant. Each disagreement was used as an opportunity to check data accuracy and allowed reducing misclassification, which would have been substantial if STRONG relied on demographic data in the EMR. For example, among adult TF study subjects, 41% were documented as 'female' and 59% were documented as 'male'. The corresponding proportions of people classified as 'female' and 'male' among adult TM cohort members were 59% and 40%, respectively, with 1% recorded as unknown in the EMR. By contrast, in 96% of persons under the age of 18, the demographic variable reflected natal sex.

A limitation of the current data is the inability to accurately identify persons who reject binary gender categories. These individuals are likely to be found among cohort

members who do not have a transgender-specific diagnosis and receive no HT or surgical treatment; however, at the present time EMRs alone are not sufficient for determination of non-binary gender identity. This will be possible in the near future after KP introduces new data capture systems with separate fields for natal sex, gender identity, preferred pronouns, organ inventory and history of gender-affirming procedures.

Assessment of current and past gender affirmation treatment

Although the information on gender affirmation received within the KP system is high quality, one of the main limitations of STRONG data is the lack of information on HT and surgical treatment received outside the KP system. This restricts our ability to identify a subcategory of transgender cohort members with no history of gender affirmation treatment of any kind. For this reason, the most definitive analyses are limited to people who initiated therapy at KP. These individuals can be identified among those STRONG participants whose EMR demonstrates a gap between index date and the first prescription for HT. This 'HT initiation' group represents about 35% of TM and 32% of TF subjects.

The broadening of coverage for gender affirmation services at KP occurred relatively recently. As the proportion of transgender people among enrollees has been increasing and many patients now initiate and receive gender affirmation therapy exclusively within the system, it is important to both expand the cohort and extend the follow-up of current participants.

Engagement of patient and physician stakeholders

A critical feature of STRONG is patient-centredness. During the study implementation, we held monthly stakeholder calls and had three inperson Stakeholder Advisory Group meetings. These interactions had direct impact on study design and implementation. For example, the list of keywords used for STRONG cohort ascertainment was proposed, pilot-tested and refined in close consultation with the study stakeholders. Following advice from stakeholders, we expanded eligibility criteria to include transgender and gender non-conforming youth (persons under 18 years of age). This change allowed a number of additional analyses and offers important opportunities for future follow-up. STRONG stakeholders also helped to develop a comprehensive list of hormonal medications and procedures used for gender affirmation. The publications describing our formative research,^{24 43–45} the current communication and the reports in preparation, all include stakeholders as coauthors.

CONCLUSIONS

Although the body of literature addressing transgender health issues has been growing,⁴⁶ most studies focus on substance use, sexual health, sexually transmitted infections and, to a lesser extent, mental health conditions.⁴⁷ By contrast, limited data are available on general health

status, or the incidence of chronic age-related conditions including cardiovascular disease, endocrine disorders and cancer.

To date, most data on morbidity and mortality in transgender populations come from clinical centres in Europe.^{19 48–50} These studies are characterised by detailed clinical data; however, they are limited by relatively small sample sizes.

In terms of overall design and size, STRONG is comparable to US-based studies that used the Veterans Health Administration (VHA) data.^{22 51} Unlike our study, however, the VHA data did not distinguish between TF and TM subjects and were limited to transgender persons identified via ICD-9 codes, without keywords.

We recognise that transgender people enrolled through an integrated healthcare system will yield a cohort of persons with health insurance. Weighing against this concern is the demonstrated ability to cost-effectively identify a large cohort of transgender subjects and referents with high degree of internal validity. The availability of a well-defined underlying population with detailed EMR ensures that participation does not require subject opt-in and allows selecting a complete cohort (rather than a sample) of eligible subjects. Moreover, as KP now provides ‘one-stop’ delivery of transgender care, the likelihood of capturing full details of gender affirmation treatment is increased. These internal validity advantages weigh heavily as a counter against concerns about representativeness.

In summary, STRONG is well positioned to fill existing knowledge gaps and make important contributions to the current literature. Lessons learnt while conducting this project provide support to future transgender health-related research. The methodology can be implemented at other healthcare institutions with EMRs, particularly in organisations participating in the Healthcare Systems Research Network (total population of almost 20 million) with little site-specific customisation. With extended follow-up and expanded cohort size, the data will permit additional analyses of rare health endpoints across various categories of surgical procedures, and different HT formulations, routes of administration and doses.

Author affiliations

¹Department of Research & Evaluation, Kaiser Permanente Southern California, Pasadena, California, USA

²Department of Epidemiology, Rollins School of Public Health, Emory University, Atlanta, Georgia, USA

³Division of Research, Kaiser Permanente Northern California (emerita), Oakland, California, USA

⁴Center for Clinical and Outcomes Research, Kaiser Permanente Georgia, Atlanta, Georgia, USA

⁵The Rockway Institute, Alliant International University, San Francisco, California, USA

⁶Division of Research, Kaiser Permanente Northern California, Oakland, California, USA

⁷School of Public Health, Georgia State University, Atlanta, Georgia, USA

⁸The Permanente Medical Group, Kaiser Permanente Northern California, Oakland, California, USA

⁹Emory University School of Medicine, Atlanta, Georgia, USA

¹⁰The Atlanta VA Medical Center, Atlanta, Georgia, USA

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Contributors VPQ and MG prepared the original draft of the manuscript. RN conducted data analyses and put together tables and figures. RC and LC were responsible for the preparation and application of data collection programs and ascertainment of study variables. EH, VPQ, DG, MJS and DT led study implementation at participating sites and were actively involved in study planning and design. TAB-C, AM and BR were responsible for the day-to-day project management at each site. DR and TLL provided methodological input on various aspects of study design, including identification of sources of bias and ways of addressing threats to validity. VT and JS provided input on clinical aspects of the study and were responsible for adjudication of study eligibility, gender identity and gender affirmation. KW developed, pilot-tested and supervised the cohort validation and gender identity ascertainment review protocols and programming. SG, CV and SW are members of the Stakeholder Advisory Group who assisted with the development of inclusion and exclusion criteria, assessment of gender identity and interpretation of the data. All authors provided critical review of the manuscript for important intellectual content and approved the final version.

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Data sharing statement Once the initial data analyses are complete, we will be open to collaborations with outside investigators as permitted by the IRBs of participating sites as well as by local, state and federal laws and regulations. In particular, we will encourage collaborations with researchers whose expertise is under-represented on our research team. To become a collaborator, a researcher will be required to submit an application, which will undergo both a scientific and an IRB review. In view of the complexity of the database, interested investigators will be asked to form a collaborative arrangement with the STRONG investigators rather than simply receive the data themselves. No additional data are available.

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EXHIBIT C



ENVIRONMENTAL PROGRESS

NATURE, PEACE & FREEDOM FOR ALL

The WPATH Files

Pseudoscientific Surgical and Hormonal Experiments on Children, Adolescents, and Vulnerable Adults.

EXECUTIVE SUMMARY

The World Professional Association for Transgender Health (WPATH) enjoys the reputation of being the leading scientific and medical organization devoted to transgender healthcare. WPATH is globally recognized as being at the forefront of gender medicine.

However, our report shows that the opposite is true. Newly leaked files from WPATH's internal messaging forum, as well as a leaked internal panel discussion, demonstrate that the world-leading transgender healthcare group is neither scientific nor advocating for ethical medical care. These internal communications reveal that WPATH advocates for arbitrary

medical practices, including hormonal and surgical experimentation on minors and vulnerable adults.

While there is a place in medicine for risky experiments, these can only be justified if there is a reliable, objective diagnosis, no other treatment options are available, and the outcome for a patient or patient group is dire.

However, contrary to WPATH's claims, the best available evidence suggests that gender medicine does not fall into this category. Risky experiments can also only be justified when patients give true informed consent. Yet the leaked messages in our report reveal that WPATH-affiliated doctors are knowingly violating bedrock principles of medical ethics and informed consent.

Our report will prove that WPATH is promoting unethical medical experiments on children...{and that} WPATH members are fully aware that children and adolescents cannot comprehend the lifelong consequences of “gender-affirming care.”

As such, our report will prove that WPATH is promoting unethical medical experiments on children, adolescents, and vulnerable adults. The report will show that, as is revealed by its own internal communications, WPATH does not meet the standards of evidence-based medicine, and members frequently discuss improvising treatments as they go along. Our report will further show that members are fully aware that children and adolescents cannot comprehend the lifelong consequences of “gender-affirming care,” and in some cases, due to poor health literacy, neither can their parents.

In the WPATH Files, members demonstrate a lack of consideration for long-term patient outcomes despite being aware of the debilitating and potentially fatal side effects of cross-sex hormones and other treatments. There is also evidence that patients with severe mental health issues, such as schizophrenia and dissociative identity disorder, are being allowed to consent to life-altering hormonal and surgical interventions without members making any attempt to first address these underlying issues.

Moreover, the Files provide evidence of how far off the rails this experiment has gone, with discussions about surgeons performing non-binary surgeries to create body

types that do not exist in nature. These extreme body modification desires are framed as medically necessary healthcare, even though the surgeries do not meet the definition of being experimental. The Files also show that autonomy, a bioethical concept that was once a shield to protect patients from being experimented on against their will by doctors, is now used by WPATH members as a sword - in its name, there is nothing a doctor can deny a patient seeking hormonal and surgical interventions.

The contents of the WPATH Files are of utmost importance because WPATH has broken the chain of trust in gender medicine. Trust in professional training grounded in robust scientific evidence is crucial for doctors, who face time constraints that prevent exhaustive investigation of every treatment protocol. Influential organizations such as the American Academy of Pediatrics and The Endocrine Society rely on WPATH’s “Standards of Care” when developing policy and practice guidelines for the treatment of gender dysphoria. Similarly, parents and vulnerable patients depend on clinicians influenced by WPATH. The truth about WPATH, as revealed in the Files, is therefore essential for patients, including parents of trans-identified minors, to make informed decisions about their medical treatment.

**WPATH FILES EXCERPTS:
EXPOSING THE REALITIES OF
GENDER MEDICINE**



**ENVIRONMENTAL
PROGRESS**

NATURE, PEACE & FREEDOM FOR ALL

PREFACE

WPATH, and gender clinicians and activist groups more generally, insist that gender medicine is “settled science.” They present puberty-blockers, cross-sex hormones and genital surgeries as “evidence-based” life-saving care and suicide prevention. Rachel Levine, the US Assistant Secretary for Health, claims there is “no argument among medical professionals – pediatricians, pediatric endocrinologists, adolescent medicine physicians, adolescent psychiatrists, psychologists, etc. – about the value and the importance of gender-affirming care.”

But when gender clinicians and lobbyists think no one else is listening, what they say can be quite different – and shocking. They:

1. Make clear they give cross-sex hormones and surgeries to people with limited or no capacity to consent, including people with major mental illnesses and minors
2. Acknowledge that minors do not understand the long-term consequences of “gender affirmation,” including sterility
3. Discuss extreme body-modification surgeries, such as removing genital organs entirely or creating a neovagina alongside a penis, with no medical justification
4. Frame detransition and post-treatment regret as trivial
5. Claim that minors should be given life-changing hormones and surgeries because otherwise they will kill themselves – despite no evidence that such interventions make suicide rarer
6. Describe serious side effects (including fatal ones) and common sub-optimal outcomes

All the quotes come from WPATH members, in posts on the WPATH members’ forum or during internal panel discussions. The full materials will be made available to journalists.

An Unethical Approach to Consent Among Adults with Comorbidities

Patients with dissociative identity disorder are regarded as having the capacity to consent to hormones:

"One client who had [dissociative identity disorder], we worked on all alters giving consent to HRT before it was started. They had alters who were both male and female gender and it was imperative to get all the alters who would be affected by HRT to be aware and consent to the changes. Ethically, if you do not get consent from all alters you have not really received consent and you could be sued later, if they decide HRT or surgery was not in their best interest."

Gender therapist

So are patients with severe mental health issues.

In reply to a nurse practitioner who is struggling with how to handle a patient with PTSD, major depressive disorder, observed dissociations, and schizoid typical traits who wishes to go on hormone therapy:

"I'm missing why you are perplexed... The mere presence of psychiatric illness should not block a person's ability to start hormones if they have persistent gender dysphoria, capacity to consent, and the benefits of starting hormones outweigh the risks... So why the internal struggle as to 'the right thing to do?'"

Dr. Dan Karasic, lead author of WPATH Standards of Care 8 mental health chapter

Mentally ill and homeless people are regarded as suitable for referring for genital surgery:

"I have also intervened on behalf of people who have been diagnosed with major depressive disorder, cPTSD, homeless and got at least an orchiectomy... In the last 15 years I had to regrettably decline writing only one letter, mainly b/c the person evaluated was in active psychosis and hallucinated during the assessment session. Other than that - nothing - everyone got their assessment letter, insurance approval, and are living (presumably) happily ever after."

Gender therapist

There is a lack of concern regarding young people regretting sacrificing their fertility:

"Some of the Dutch researchers gave some data about young adults who had transitioned and [had] reproductive regret, like regret, and it's there, and I don't think any of that surprises us."

Dr. Daniel Metzger, Canadian endocrinologist

Minors Offered Life-Changing Interventions They Cannot Fully Understand

Concerning whether is it reasonable to expect children and young adolescents to grasp the effects of “gender-affirming care:”

“[It is] out of their developmental range to understand the extent to which some of these medical interventions are impacting them. They’ll say they understand, but then they’ll say something else that makes you think, oh, they didn’t really understand that they are going to have facial hair.”

Dianne Berg, child psychologist and co-author of the child chapter of WPATH Standards of Care 8

“We’re often explaining these sorts of things to people who haven’t even had biology in high school yet.”

Dr. Daniel Metzger, Canadian endocrinologist

Dr. Christine McGinn, American plastic surgeon, reported performing about 20 vaginoplasties on patients under 18 over a 17-year period and confessed that:

“not all... had perfect outcomes”

On the complexity of discussing fertility preservation with children and adolescents during an internal panel discussion:

“It’s always a good theory that you talk about fertility preservation with a 14-year-old, but I know I’m talking to a blank wall. They’d be like, ew, kids, babies, gross...”

“I think now that I follow a lot of kids into their mid-twenties, I’m like, Oh, the dog isn’t doing it for you, is it?” They’re like, ‘No, I just found this wonderful partner, and now want kids...’ So I think, you know, it doesn’t surprise me...”

“Most of the kids are nowhere in any kind of a brain space to really talk about [fertility preservation] in a serious way.”

Dr Daniel Metzger, Canadian endocrinologist

Extreme Body Modifications with No Medical Justification

"I've performed mastectomies without nipples, or have created chests with varying degrees of remaining breast tissue, or created incision patterns specific to my patient's wishes. For bottom surgery, I've performed minimal-depth vaginoplasties (vulvoplasties), phallus-preserving vaginoplasties, and nullification procedures. I'm quite comfortable tailoring my operations to serve the needs of each patient."

Dr. Thomas Satterwhite, California surgeon

"How do we come up with appropriate standards for non-binary patients? What best practices and standards are you following in your experience? I've found more and more patients recently requesting 'non-standard' procedures such as top surgery without nipples, nullification, and phallus-preserving vaginoplasty."

Dr. Thomas Satterwhite, California surgeon

"[Gender clinicians should provide care for] trans people whose embodiment goals do not fit dominant expectations, [such as those who want] mastectomies without nipples, mastectomies for people who do not want breasts from estrogen [and] vagina-preserving phalloplasties."

Activist law professor

"I think we are going to see a wave of non-binary affirming requests for surgery that will include non-standard procedures. I have worked with clients who identify as non-binary, agender, and Eunuchs who have wanted atypical surgical procedures, many of which either don't exist in nature or represent the first of their kind and therefore probably have few examples of best practices..."

Doctor

Detransition and Suicide Prevention

In reply to a post about a detransition study:

"acknowledgment that de-transition exists even to a minor extent is considered off limits for many in our community,"

WPATH President Marci Bowers

"individuals are entitled to make their own mistakes, and while medical systems and professionals can and should help them avoid mistakes, the power dynamic between a gender specialist and their patients, and between cis and trans people more generally, means that some mistakes are valued higher than others."

Researcher

"What is problematic is the idea of detransitioning, as it frames being cisgender as the default and reinforces transness as a pathology. It makes more sense to frame gender as something that can shift over time, and to figure out ways to support people making the choices they want to make in the moment, with the understanding that feelings around decisions [may] change over time."

Researcher

In reply to a therapist concerned about a 13-year-old "nonbinary" natal female with an eating disorder who is requesting testosterone, a pediatric endocrinologist recommended the child "be living as the other sex for 6-12 months" and have "at least one supportive parent." She added:

"it is very difficult to ask that they wait until 16 because by then they will be dealing with menstrual periods and complete breast development. Waiting appears to increase the rate of suicide attempts."

Serious side effects and common post-surgical complications

An exchange between two doctors about the severe, potentially fatal, side effects of testosterone use in natal females (testosterone is a known carcinogen):

"[16-year-old female patient] found to have two liver masses (hepatic adenomas) - 11x11cm and 7x7cm - and the oncologist and surgeon both have indicated that the likely offending agent(s) are the hormones... We are prepared to support the patient in any way we can (e.g. top surgery when medically stable, etc)."

Doctor

"I have one transition friend/colleague [sic] who, after about 8-10 years of [testosterone] developed [sic] hepatocarcinoma. To the best of my knowledge, it was linked to his hormone treatment... it was so advanced that he opted for palliative care and died a couple of months later."

Doctor

Speaking of a "young patient" who developed pelvic inflammatory disease after three years of testosterone:

"has atrophy with the persistent yellow discharge we often see as a result."

Nurse practitioner

And describing young natal females developing:

"pelvic floor dysfunction, and even pain with orgasm."

Doctor

"I used to have bleeding after penetrative sex. It would hurt to have an orgasm... My uterus atrophied also."

Trans-identified female emergency medical technician (paramedic)

Natal male patients on estrogen are described experiencing:

"[erections] feeling like broken glass."

Registered nurse

Poor outcomes are accepted as a fact of life:

"It would be great if every patient could be perfectly cleared prior to every surgical intervention, but at the end of the day it is a risk/benefit decision...if the patient can't follow the dilation schedule, they may lose depth, but as long as they're capable of making that decision of sound mind while informed of the risks, then that may be all you can do."

Doctor

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

SERVICE LIST

<p>Jason J. Curliano Ondrej Likar Vladimir Andrich J. Harvey Buty & Curliano LLP 516 - 16th Street Oakland, CA 94612 Tel: (510) 267-3000; Fax: (510) 267-0117 E-Mail: jcurliano@butycurliano.com E-Mail: olikar@butycurliano.com E-Mail: vandrich@butycurliano.com E-Mail: jharvey@butycurliano.com E-Mail: gcheng@butycurliano.com E-Mail: calendar@butycurliano.com E-Mail: service@butycurliano.com</p>	<p>Attorneys for Defendants <i>Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Lisa Kristine Taylor, M.D., Hop Nguyen Le, M.D., Susanne E. Watson, PhD, Lilit Asulyan, PsyD, and Ester Baldwin, LCSW, PhD</i></p>
<p>Kathleen R. Hartnett Zoe Helstrom Reece Trevor Jessica Taylor Hannah Pollack COOLEY LLP 3 Embarcadero Center, Floor 20 San Francisco, CA 94111 Tel: (415) 693-2000 E-Mail: khartnett@cooley.com E-Mail: zhelstrom@cooley.com E-Mail: rtrevor@cooley.com E-Mail: hpollack@cooley.com E-Mail: jtaylor@cooley.com E-Mail: mnarvaez@cooley.com E-Mail: emartin@cooley.com</p>	<p>Attorneys for Defendants <i>Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Lisa Kristine Taylor, M.D., Hop Nguyen Le, M.D., Susanne E. Watson, PhD, Lilit Asulyan, PsyD, and Ester Baldwin, LCSW, PhD</i></p>
<p>Yvonne M. Pierrou Caitlin Thompson Mark Palley MARION'S INN LLP 436 - 14th Street, Suite 1107 Oakland, CA 94612 Tel: (510) 451-6770 E-Mail: ymp@marionsinn.com E-Mail: caitlin@marionsinn.com E-Mail: mp@marionsinn.com</p>	<p>Attorneys for Defendants <i>Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Lisa Kristine Taylor, M.D., Hop Nguyen Le, M.D., Susanne E. Watson, PhD, Lilit Asulyan, PsyD, and Ester Baldwin, LCSW, PhD</i></p>
<p>Harmeet K. Dhillon John-Paul S. Deol Jesse Franklin-Murdock Rania Fahim Dhillon Law Group Inc. 177 Post Street, Suite 700 San Francisco, CA 94108 Tel: (415) 830-7400; Fax: (415) 520-6593 E-Mail: harmeet@dhillonlaw.com E-Mail: JPDeol@dhillonlaw.com E-Mail: JFM@dhillonlaw.com E-Mail: MHoesly@dhillonlaw.com</p>	<p>Co-Counsel for Plaintiff <i>Chloe E. Brockman</i></p>

E-Mail: rfahim@dhillonlaw.com	
Mark Trammell, Executive Director & General Counsel Center for American Liberty PO Box 200942 Pittsburgh, PA 15251-0942 Tel: (703) 687-6212 E-Mail: MTrammell@libertycenter.org E-Mail: jdixon@libertycenter.org	Co-Counsel for Plaintiff <i>Chloe E. Brockman</i>