IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
No. 3:22-cv-191

KANAUTICA ZAYRE-BROWN, Plaintiff, v. NORTH CAROLINA DEPARTMENT OF ADULT CORRECTION, et al., Defendants.	**DEFENDANTS' RESPONSE TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT**

Defendants' motion for summary judgment reveals why summary judgment should be granted in their favor. In their summary judgment filing, Defendants explain how the record evidence in this case is insufficient to support Plaintiff's deliberate indifference claim, which requires more than a disagreement about medical care. Defendants also explain that Plaintiff wholly failed to establish any viable, novel disability claim. By contrast, Plaintiff seeks summary judgment in her own favor by taking key parts of the record out of context to suggest that the record establishes that the only reasonable course of care for Plaintiff's GD was surgery, and that, by denying her request for surgery, Defendants consciously disregarded an excessive risk of harm. In this response, Defendants will first identify the most glaring misrepresentations of the record. Then, Defendants will explain how, at bottom, the record establishes a dispute over the proper course of care, which, under the prevailing legal test, not only precludes summary judgment for Plaintiff but warrants summary judgment in Defendants' favor.

I. EXAMINATION OF THE RECORD EVIDENCE

Plaintiff's motion paints an inaccurate and incomplete factual picture by taking evidence out of context, ignoring other aspects of the record, and otherwise mischaracterizing the evidence.

First, Plaintiff ignores relevant aspects of the record related to the severity of her condition. Second, she makes misleading contentions regarding several aspects of the Department's process and consideration of her request for treatment. Third, Plaintiff overlooks key record evidence concerning the reasonable divergence of viewpoints about the purported necessity of surgery.

A. Record Evidence Concerning the Severity of Plaintiff's Symptoms

Plaintiff contends that Defendants agree about the severity of her symptoms. (DE-63 at 2)[1] This is incorrect and not supported by the record. Defendants do agree that Plaintiff has GD and that her records reflect fluctuations of some associated symptoms, but they nonetheless concluded that the patient's "mood and anxiety symptoms appear well controlled" … and that she "continues to demonstrate emotional and psychological stability with evidence of adequate coping skills." (DE-61-13 at 2; DE-61-27 at 2) This conclusion is fully consistent with the whole record.

1. Plaintiff's Expert's Own Testing

Plaintiff does not mention that her own expert, Dr. Ettner, performed three tests on Plaintiff: (1) the Trauma Symptom Inventory (TSI); (2) Beck's Anxiety Inventory; and the (3) Beck's Depression Inventory (Resp. Ex. 1 at 19-20) On the TSI, Plaintiff only had one elevated scale, which is "associated with a tendency to avoid" traumatic events[.]" (Resp. Ex. 1 at 19) And Plaintiff's scores on the BAI and BDI were in the mild range. (Resp. Ex. 1 at 20) Thus, Dr. Ettner's tests confirm that Plaintiff was not demonstrating objective signs of notable depression or anxiety.

2. Plaintiff's Own Testimony and Medical Records

Additionally, the Department's conclusion that Plaintiff's mood and anxiety symptoms were well controlled and that she demonstrated emotional and psychological stability with adequate coping skills, is also supported by Plaintiff's own testimony, which indicates that she was

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[1] Page references to Plaintiff's brief (DE-63) and other exhibits (excluding depositions), refer to the ECF page number.

doing relatively well. (DE-61-3 at 27-28, 44, 129-33, 137, 140-43, 146, 149, 174-75, 178)[2] Similarly, Plaintiff's comprehensive set of medical records—which reflect regular contact with providers—do not demonstrate any significant history of anxiety, depression, loss of interest, hopelessness, or other indications of significant or worsening symptoms, including suicidal ideation or thoughts of self-harm. (DE-61-33; DE-61-34; DE-61-35; DE-61-9 at 193; DE-61-8 at 129-130; *see also* DE-60 at 9-13)

3. Record Evidence Concerning Specific Events and Timeframes

Plaintiff's brief also offers an incomplete accounting of the record with respect to several events and her reports of symptoms at certain times. Additionally, her brief omits other evidence that is necessary for a full appreciation of these events, Plaintiff's overall presentation, and the Department's determination on her request for surgery.

a. August 2019 Emergency Room Episode

For instance, Plaintiff's contention that in August 2019 her mental health deteriorated so badly that she was sent to the ER and placed on suicide watch (DE-63 at 12) is misleading and overlooks other pertinent evidence. The contemporaneous records demonstrate that this event was directly related to Plaintiff's anxiety about her impending transfer to a female facility and not the status of her request for surgery or her GD generally. (DE-61-30 at 3, 6) Additionally, Plaintiff falsely implies that her being placed on suicide watch was related to her GD symptoms—it was not. Rather the records clearly show that she was placed on precautions when she returned from the hospital after she threatened self-harm *expressly because* she did not want to go back into

[2] Page references to depositions refer to the transcript page number and not ECF page number.

restrictive housing. (DE-61-30 at 36-39) Additionally, the next day Plaintiff denied any suicidal ideation or self-injurious behavior. (DE-61-30 at 40-41; *see also* DE-60 at 10-11)

b. The December 2020 Transfer to the North Carolina Correctional Institute for Women.

Plaintiff contends that in December 2020, following an altercation with another prisoner, she became so upset that she was admitted to an inpatient facility because she expressed an urge to self-mutilate. (DE-63 at 12-13) This contention lacks context and is incomplete. Indeed, Plaintiff was temporarily transferred to the North Carolina Correctional Institute for Women ("NCCIW") following an altercation and her expressing thoughts of self-harm to her therapist. (DE-63 at 13-14; DE-61-31 at 1-5; DE-61-9 at 221-24) However, Plaintiff fails to acknowledge that her transfer for further evaluation was immediate upon mentioning thoughts of self-harm. (DE-61-31 at 1-5) Importantly, Plaintiff fails to mention that starting the day after her transfer, she consistently denied thoughts of self-harm or suicidal ideation. (DE-61-31 at 5-18) Although, after learning that she would be sent back to Anson (because she did not qualify for admission to the inpatient unit at NCCIW), Plaintiff *then* started threatening self-harm and even expressed a preference for going to a male facility over returning to Anson. (DE-61-31 at 16-19) She was ultimately transferred back to Anson without incident. (DE-61-31 at 20-24; *see also* DE-60 at 11-12)

c. Period Leading up to a February 2021 Grievance

As another example of Plaintiff's inaccurate treatment of the record, she contends that in February 2021, when she submitted an emergency grievance, her mental health was "again deteriorating because of her inadequately treated gender dysphoria." (DE-63 at 14) However, the contemporaneous medical records from this period (January and February 2021) do not support this contention. Instead, these records show that while she remained concerned over the scheduling

of the consult with Dr. Figler, and was upset over her return to Anson, she "coped relatively well" with her return, had no significant mental health concerns, and that her mood had improved with Zoloft. (Resp. Ex. 2 at 1-5) Plaintiff did report that her GD "needs acute medical treatment and its causing depletion of her mental health" and she made reference to suicide rates. (Resp. Ex. 2 at 7) However, in the subsequent self-injury risk assessment, Plaintiff reported anxiety and frustrations with communication from medical staff but denied any current plan of self-injury or suicidal ideation and spoke positively of her future. (Resp. Ex. 2 at 8-9)[3] And just two days before submitting the grievance that she referenced in this contention, on February 19, 2021, despite reporting that she had thoughts of self-harm at times in the past, she denied any current thoughts of self-harm and reported to her therapist that her "main issue continue[d] to be frustration" that the consultation with Dr. Figler had not been scheduled. (Resp. Ex. 2 at 11)

d. Symptoms in the Spring of 2021

Plaintiff also maintains that she was enduring growing distress, but this assertion, too, cannot be supported by the record. Plaintiff contends that from March through May 2021, she became "increasingly distressed" and "[b]egan to experience thoughts of self-harm more frequently as a result of her gender dysphoria and receiving no information regarding her requests[.]" (DE-63 at 14) Plaintiff does not provide any record citation to support this contention, in contravention of Local Rule 7.1(c). Thus, the Court should disregard this assertion.

In any event, the records during this period do not support Plaintiff's contention that she was experiencing increased symptoms or thoughts of self-harm. In March 2021, Plaintiff does

[3] This record indicates "a history of swallowing pills which was labeled by the prison system as a suicide attempt[.]" (Resp. Ex. 2 at 9) But contemporaneous records do not substantiate this characterization. Plaintiff's March 2019 trip to the ER was only self-characterized as a suicide attempt long after the event actually took place. (DE-60 at 10, citing DE-61-29 at 1; DE-61-3 at 150-51)

report some anxiety, "bad feelings", and feeling like she is not her "authentic self[.]" (Resp. Ex. 3 at 1, 4) But Plaintiff also described her mood as "a be all you can be mood," and one mental health provider noted her response to treatment as "positive[.]" (Resp. Ex. 3 at 1, 4) Another provider noted that there was "much improvement in [Plaintiff's] mood and outlook" and that "her depression appears to have improved" (Resp. Ex. 3 at 4) The next record is the April 28, 2021, note that captured the reported band incident, which was characterized "as a protest." (DE-61-32) The next record is from May 17, 2021, which described Plaintiff's affect as "mildly dysphoric (frustrated)" and notes that "[Plaintiff] denied any current thoughts, intent, and/or plan to hurt herself including thoughts to engage in self-mutilation[.]" (Resp. Ex. 3 at 6) The provider also notes that Plaintiff's "judgment and insight appear intact … but … may wax and wane secondary to heightened emotions and situational stressors." (Resp. Ex. 3 at 6) Thus, the contemporaneous records do not support Plaintiff's assertion that in the spring of 2021 she grew "increasingly distressed" and "began to experience thoughts of self-harm more frequently." (DE-63 at 14)

e. Reported Incident in April 2021

Plaintiff's reference to the April 2021 band episode similarly lacks context and is incomplete. Plaintiff contends that Dr. Hahn believed the band incident was motivated by her GD. (DE-63 at 14) However, Plaintiff ignores that Dr. Hahn specifically described the reported placement of the band around her phallus "as a protest" over not receiving an update on the status of her consultation. (DE-61-32) The health record also notes that after Plaintiff received an update on the status of the consultation, she left the room, returned and reported that she removed the band. (DE-61-32) Beyond Plaintiff's self-report, there is no other evidence concerning the band incident. Additionally, Plaintiff's contention that the self-reported April incident was one of four

such instances where she put band on her phallus (DE-63 at 14) is supported only by her post-litigation affidavit and not corroborated by any contemporaneous records.

f. Events Surrounding a May 2021 Email

The implication of Plaintiff's contention concerning an email received by Ms. Catlett in May 2021, in which a family member communicated concerns about Plaintiff's mental health, (DE-61 at 14) lacks critical context and overlooks other record evidence. On May 17, 2021, Ms. Catlett received an email from Plaintiff's husband, in which he communicated concerns regarding her mental health. (Resp. Ex. 4 at 1-2) One minute after receipt, Ms. Catlett forwarded that email to the Chief Psychiatrist and Director of Behavioral Health, Drs. Sheitman and Peiper, respectively. (Resp. Ex. 4 at 1) That same day, Dr. Peiper communicated with other mental health staff to ensure that Plaintiff was seen that day, which she was. (Resp. Ex. 4 at 3, 9; Resp. Ex. 3 at 6-7) That visit was discussed in Section I(A)(3)(d) above. The upshot of these records is that the Department acted promptly to check on Plaintiff and manage any acute distress, and the Department confirmed that she was not experiencing thoughts of self-harm.

g. Reporting of Symptoms in Fall and Winter 2021

Plaintiff also contends that as she waited for additional information regarding her request in the fall and winter of 2021, "she continued to voice a desire to self-harm[.]" (DE-63 at 17) This contention is not supported by the record, including the two documents specifically referenced by Plaintiff. The first document that Plaintiff relies on here (DE-62-20) does not contain an indication that Plaintiff voiced a desire to self-harm. Instead, that medical record says that "Ms. Brown currently denied suicidal ideation and thoughts of self-injurious behavior, both intent and plan." (DE-62-20) Additionally, while she got tearful when discussing her surgery, which she thought was denied, Plaintiff's mood is described as "mildly dysphoric[.]" (DE-62-20) Also, while this

record is dated almost five months *after* the reported band incident (DE-61-32), the health record notes that Plaintiff "admitted that she had briefly *considered* putting a rubber band around her phallus as a means of forcing surgical intervention." (DE-62-20) (emphasis added)

The second document (DE-62-21) that Plaintiff relies on here (*see* DE-63 at 17) does not support her contention that in the fall and winter of 2021 "she continued to voice a desire to self-harm[.]" That record shows that Plaintiff made a threat to self-harm "within 45 days" and "by Christmas" if she did not hear anything about her surgery. (DE-62-21 at 1) In that health record, the provider, Dr. Bowman, wrote "that [n]o risk assessment [was] indicated at the time due to projected intent/contingency attached ('within the next 45 days' and 'by Christmas' specified in her verbal statement). (DE-62-21 at 1) Dr. Sheitman testified that he understood Dr. Bowman's notation to mean that Dr. Bowman determined that Plaintiff did not present as a risk. (Resp. Ex. 5 at 85-86) Dr. Bowman further noted that she would address this with Plaintiff at their next therapy session. (DE-62-21 at 1) Moreover, at that next session, Plaintiff "admitted" that her "threats to self-mutilate" were made "out of frustration, and [she] and denied any thoughts, plan or intent to act on those statements." (DE-61-37 at 1)

h. Reported Symptoms After April 2022

Plaintiff's contention that after the surgery was denied, she continued to experience "severe and ongoing pain" (DE-63 at 21) lacks any independent corroborating support and is based solely on statements in her second declaration in support of her summary judgment motion. Plaintiff's medical records indicate that after her surgery request was not approved, she repeatedly denied having any concerns with sleep, appetite, energy level, or thoughts of self-harm or suicidal ideation. (DE-61-33 at 27-31) Additionally, during this time Plaintiff reported that "she [was] doing well" and her therapist noted that her "[m]ood was euthymic[.]" (DE-61-33 at 28-31)

i. Contentions Regarding Impact of GD on Other Activities

Lastly, Plaintiff contends that her GD has prevented her from participating in social, recreational, and other major life activities, and has caused her to fixate on the receipt of care to the exclusion of other important concerns. (DE-63 at 34) However, the evidence cited by Plaintiff does not support that assertion – nor does the larger record. First, Plaintiff references page 20 of her brief, which in turn references testimony concerning her preoccupation with the surgery request crowding out her other mental health concerns. (DE-63 at 21) This testimony does not indicate that Plaintiff has been prevented from participating in any activities. Second, Plaintiff cites to her own deposition. (DE-63 at 21) However, the cited portion of testimony is about Plaintiff's clothing and recreation options, her feeling self-conscious without bottom surgery, and, importantly, concerns her experiences in the time before prison. (DE-62-3 at 48-50) These record cites do not support her contention that GD has prevented her from participating in social, recreational, and other major life activities while incarcerated.

Indeed, the record evidence actually shows that despite her GD, Plaintiff's mood and anxiety symptoms appear well controlled and that she continues to demonstrate emotional and psychological stability with evidence of adequate coping skills. (DE-61-13 at 2; DE-61-27 at 2) She has worked while incarcerated, completed educational program, and has plans to continue her education. (DE-61-3 at 27-28, 178) Additionally, she was promoted to minimum custody and reports good familial relationships (DE-63 at 23; DE-61-3 at 15, 44)

B. Record Evidence Regarding the Evaluation and Denial of Plaintiff's Request for Surgery

Plaintiff also makes a series of contentions regarding the Department's evaluation of her request and its decision not to approve surgery that are incorrect, not supported by the record, or dependent on incomplete references to the evidence.

1. Process of Evaluating Plaintiff's Request

Plaintiff's contentions that the consideration of her surgery request was delayed and cursory, and her denial was "all-but preordained" (DE-63 at –11-12, 15, 29, 35) are not supported by the record. First, the contentions of unreasonable delay are not supported by citation to any record evidence and should be disregarded per Local Rule 7.1(c). Moreover, the record shows that UNC had requirements for the consultation process that took time to fulfill, and UNC temporarily paused accepting new patients. (DE-61-10 at 12; DE-61-9 at 85, 134; DE-61-22; Resp. Ex. 4 at 9) The evidence also suggests that delays were at least in part due to the pandemic. (Resp. Ex. 6 at 45, 62-63, 74-75) Also, the DTARC only met approximately quarterly. (DE-61-12 at 108)

Plaintiff's contention that despite Defendants' policy providing for case-by-case review, Dr. Campbell's analysis specific to her was cursory and automatic (DE-63 at 29), ignores key record evidence. The clinicians on the DTARC (Drs. Campbell, Sheitman, and Peiper) all testified extensively regarding their review of Plaintiff's individual records and her presentation as well as their assessment that she was relatively well adjusted and did not require surgery now. (DE-61-9 at 193-95; DE-61-5 at 182-84; DE-61-12 at 27-29, 49, 113-16) The record further shows detailed review of the medical literature related to Plaintiff's requested surgery by Dr. Campbell and an independent review by Dr. Sheitman. (DE-61-9 at 203-05; DE-61-13 at 2-5; DE-61-12 at 50-51, 57-58, 119-21) Moreover, the record shows that the DTARC discussed her case and collectively

concluded that surgery was not medically necessary. (DE-61-13 at 1-2; DE-61-27; DE-60 at 7-13) This evidence shows that the DTARC's consideration and denial of her request were not cursory but rather based on considerable effort and the clinical judgment of the DTARC—namely Drs. Campbell, Sheitman, and Peiper.

In another example of an attempt to portray the Department's review of her request for surgery as cursory and without basis, Plaintiff contends that Drs. Campbell and Junker identified no risks that Plaintiff specifically would experience from gender-affirming surgery ("GAS"). (DE-63 at 29) This is an incomplete assessment of the risk-benefit analysis. Dr. Campbell testified that the DTARC considered both sides of this risk-benefit analysis, including risks and benefits of not proceeding. (Resp. Ex. 7 at 80-81) Moreover, all surgery has risk, and the risks of this procedure were known to the DTARC. (DE-61-12 at 98; DE-61-13 at 1; DE-61-23)

Similarly, to support the contention that the Department's consideration of her request was cursory and preordained, Plaintiff incorrectly asserts that Dr. Campbell "admitted that his analysis" was based on his concerns and considerations regarding GAS, and his "position statement [that] asserts that [GAS] is never medically necessary." (DE-63 at 19) This contention is inaccurate and ignores other record evidence. Dr. Campbell testified that he does not believe that surgery is *never* medically necessary, and he further testified that the position statement was never intended to be read that way. (DE-61-5 at 205-08) Additionally, Drs. Peiper and Sheitman testified that neither recall Dr. Campbell ever proposing a blanket ban or understood that as his position. (DE-61-9 at 204-05; Resp. Ex. 5 at 146-48) Moreover, the citations referenced by Plaintiff do not support her assertion; rather, those citations refer to portions of Dr. Campbell's testimony about the overlap between his position statement and the case summary. (DE-63 at 19)

Additionally, in another attempt to imply that the Department's conclusion was pre-

ordained, Plaintiff contends that the Department "falsely asserted" that she had "successfully completed gender reassignment surgically." (DE-63 at 13) This reference is from a 2019 record and does not relate to the DTARC's 2021 determination. Aside from this contention being wholly beside the point, it also lacks important context. This particular language appears to have been imported from a pre-incarceration medical record from the surgeon that performed Plaintiff's orchiectomy. (Resp. Ex. 8 at 3, 6; DE-61-4 at 1)

2. The DTARC's Decisionmakers

Plaintiff makes misleading contentions regarding the members of the DTARC and their role in the determination. For example, Plaintiff contends that of the DTARC members, "only Defendants Campbell, Peiper, and Sheitman reviewed Mrs. Zayre-Brown's medical records[.]" (DE-63 at 17) As an initial matter, to the extent that Plaintiff implies an incomplete review because some DTARC members did not review her medical records, this misses the point. The three clinicians that thoroughly reviewed her health records shared their assessments of the same with the larger DTARC—as is intended by the process. (DE-61-9 at 88-89, 142-43, 208-09; DE-61-5 at 50, 170-72, 179, 187-89; DE-61-12 at 114-16)

Additionally, Plaintiff contends that Drs. Peiper and Sheitman deferred to Dr. Campbell regarding the medical necessity determination. (DE-63 at 17-18) But this contention is not supported by the record. Dr. Sheitman testified that he separately reviewed Plaintiff's records and determined that Plaintiff's condition was "reasonably controlled," such that she "didn't really stand out … as excessively dysphoric, depressed, anxious." (DE-61-12 at 27-29, 49, 113-16; DE-60 at 9-10) Dr. Sheitman also discussed his own understanding of medical necessity throughout his deposition (DE-61-12 at 35-36, 44, 50, 73, 111) Plaintiff's citation to page 131 of Dr. Sheitman's deposition to support her assertion (DE-63 at 17-18) is not validated by the testimony. There, Dr.

Sheitman was specifically answering a question about the position paper that Dr. Campbell authored, and he specifically testified that "Dr. Campbell brought the medical input into the DTARC committee … and I also contributed[.]" (DE-61-12 at 131)

In support of the assertion that Dr. Peiper simply deferred to Dr. Campbell, Plaintiff cites pages 103 to 105 of the 30(b)(6) deposition. (DE-63 at 17-18) But this portion of the deposition does not support Plaintiff's assertion. Instead, there, Dr. Peiper testified about how the DTARC would address a disagreement, whether any one member has final say, and whether all members must be present. (DE-61-9 at 103-105) Moreover, Dr. Peiper testified that he reviewed Plaintiff's records and determined that she was "remarkably well adjusted," that "[s]ucidality wasn't a concern," and that "she was [not] at significant risk" without the procedure. (DE-61-9 at 193)

3. Role of the Recommendations of Other Clinicians

Plaintiff's contentions regarding Drs. Figler and Caraccio, and Ms. Dula, and the deference she contends that the Department should afford their recommendations (DE-63 at 15-17, 28) ignores the broader context demonstrated in the record. First, the DTARC referred Plaintiff to Dr. Figler to assess whether she met UNC's criteria for eligibility for surgery (which tracks WPATH's criteria) before the Department determined whether the surgery was medically necessary. (DE-61-9 at 73-74, 79-80) The Department did not refer Plaintiff to UNC for a medical necessity determination—that determination is for the Department to make. (DE-61-5 at 174-78; DE-61-9 at 149) Second, Dr. Caraccio is an endocrinologist who provides endocrinology care to transgender patients referred to his clinic by the Department. (DE-62-18 at 2) The Department did not request a medical necessity assessment from Dr. Caraccio. Third, Jennifer Dula is a Licensed Clinical Social Worker who provided mental health services to the Department as a contractor for approximately eight months. (DE-62-19 at 2) The Department did not request a medical necessity

assessment from Ms. Dula. Indeed, there is no evidence that Ms. Dula, who is not a physician (DE-61-25; DE-62-19), is qualified to offer medical necessity opinions. (*See* Resp. Ex. 1 at 3-5, 33-34)

Additionally, there is no record evidence that either Drs. Figler or Caraccio conducted a review of Plaintiff's mental health history or assessed her overall mental health symptoms. (DE-61-23; DE-61-26; DE-62-17; DE-62-18) Similarly, it is unclear what kind of assessment of Plaintiff's overall presentation Ms. Dula undertook. (DE-61-25; DE-62-19) By contrast, the DTARC thoroughly assessed Plaintiff's overall presentation over time, including a review of all of her records and concluded from that comprehensive review that she was not experiencing severe mental health distress. (DE-61-8 at 58-60; DE-61-5 at 50, 179, 182-84; DE-61-12. 27-29, 49, 113-16; DE-61-13 at 1-2; DE-61-27 at 2; DE-61-9 at 193-95; 208-209) In any event, in conducting their review, the DTARC was aware of and considered the statements contained in their records. (DE-61-5 at 168-77; DE-61-9 at 146-51; DE-61-13; DE-61-12 at 70-81, 118-19)[4]

4. Purported Barriers to Care.

a. Stability

Plaintiff contends that because stability is one of WPATH's criteria for surgery and because the only reason the Department denied the surgery is because she is "stable" and "resilient," then the Department created a situation where Plaintiff could never qualify for surgery. (DE-63 at 3) But this issue is a red herring because it conflates two different concepts: (1) presentation of GD symptoms and (2) stability of any existing significant mental health conditions. The record shows that the former is what formed the basis of the Department's determination that surgery was not

[4] As discussed below, under the relevant legal test, courts focus solely on the risks actually perceived by the defendants and not on risks that should have been perceived. *See Parrish v. Cleveland*, 372 F.3d 294, 303-04 (4th Cir. 2004). Thus, the additional statements made by these individuals in their declarations (DE-62-17-19) were not known to, and thus could not have been considered by, Defendants at the time they made their determination.

medically necessary (DE-61-13; DE-61-27) and the latter is what is referred to in the WPATH guidance. (DE-62-4 at 31, 67-68, 110-12)

Defendants explained that if Plaintiff's GD symptoms were severe and surgery was found to be necessary, she could still meet WPATH's stability criteria if she was free from other psychological co-morbidities that needed management prior to surgery. (DE-61-10 at 12; Resp. Ex. 9 at 226-227; *see also* Resp. Ex. 10 at 200-01) Thus, Plaintiff's contention that there is some sort of catch-22 regarding a patient's stability and surgery (DE-63 at 3, 29), is incorrect and misleading.

Relatedly, Plaintiff's contention that she "must become even more seriously ill to satisfy Dr. Campbell" (DE-63 at 29-30) is misleading. Defendants are not withholding treatment until Plaintiff's condition worsens—she has received and will receive treatment that the Department deems medically necessary and appropriate to what she is experiencing. (DE-61-3 at 95-96, 105; DE-61-17; DE-61-33 at 30-31; DE-61-40 ¶ 40; DE-61-18 at 2 DE-61-13 at 1; DE-27) The record demonstrates that the Department would have the ability to approve GAS as medically necessary if conditions changed or the other treatments could no longer manage her condition. (DE-61-1 at 5-7; DE-61-5 at 112; DE-61-10 at 12; DE-61-11 at 55-56, 71- 72, 86, DE-61-12 at 35, 44, 50)

b. The Existence and Structure of DTARC

Plaintiff also makes several contentions comparing the Department's handling of other medical issues to the way it handles requests for gender-affirming care to suggest that it is harder to get gender-affirming care. Such contentions are misleading and not supported by the record.

First, Plaintiff's contention that unlike all other medical issues, the Department does not use the Utilization Management (UM) process and instead has a separate process (DE-63 at 9), is misleading. DTARC is part of the UM process. (DE-61-5 at 103) And this is done because GD is

a unique condition that requires a more comprehensive approach that involves medical, mental health, and custody perspectives. (DE-61-9 at 49, 60-61, 69-79; DE-61-5 at 108-09) This multidisciplinary approach is in line with WPATH and other state correctional agencies. (DE-62-4 at 30-34, 47; Resp. Ex. 10 at 8, 11-17)

Second, Plaintiff's contention that while the Department generally employs uniform protocols to treat all other conditions and seeks to provide community-consistent care, it has created exceptions and created obstacles that exist only for individuals suffering from gender dysphoria (DE-63 at 35), is unsupported by the record. The citation provided by Plaintiff (pages 6-10 of her brief) does not reference any record evidence of "exceptions" or "obstacles[.]" Instead, the section merely characterizes the Department's process for evaluating requests. As noted, the use of the DTARC as part of the UM process is necessary, as GD is a multifaceted condition involving medical and mental health, and the requests are not always clinical. Thus, the DTARC includes custody personnel. (DE-61-9 at 49, 60-61, 69-79; DE-61-5 at 108-09; DE-61-7 at 42-43)

Third, Plaintiff's contention that the Department would provide procedures such as "mammoplasty, hysterectomy, and gonadectomy – when medically indicated for conditions other than gender dysphoria but has never approved a request for GAS for the treatment of GD" (DE-63 at 4-5) lacks context. Dr. Campbell testified that those procedures (*i.e.*, mammoplasty, hysterectomy, and gonadectomy) are approved when they are deemed medically necessary. (DE-61-5 at 144) Importantly, Dr. Campbell testified that the determination of whether a procedure is medically necessary for GD as compared to some other condition is "not different" and that "the same risk-benefit analysis" is performed. (DE-61-5 at 145) Additionally, the record shows that the Department acknowledges that GAS could be considered medically necessary if there was

indication that, without the surgery, the patient would likely experience severe mental health harm. (DE-61-1 at 5-7; DE-61-10 at 12; DE-61-11 at 71-72, 84-86, DE-61-12 at 35, 43-44 61-10 at 12)

Additionally, Plaintiff's suggestion that the Department is unaware of any instance in which an outside specialist and a direct care provider both recommended a procedure, but that procedure was not subsequently approved (DE-63 at 7-8) is misleading. Under the hypothetical scenario posed to him, Dr. Campbell testified that such a procedure would likely be approved if it was in line with the Department's own medical necessity analysis. (DE-61-5 at 77-78)

Lastly, Plaintiff's contention that no other medical procedure requires such high-level review (DE-63 at 10) is an exaggeration. The UM policy specifically provides that the Deputy Medical Director is responsible for case specific review of certain UR requests. (DE-61-6 at 3-4) Other officials like the Medical Director, Director of Behavioral Health, Chief of Psychiatry, and the Director of Health and Wellness, and others who serve in a supervisory role, are available for direction and consultation, and are the ultimate arbiters of matters in their respective disciplines. (DE-61-6 at 7) And the Medical Director is the final authority on appeals. (DE-61-6 at 9)

C. Record Evidence Regarding Disagreement Over the Need for Surgery

Plaintiff's brief creates an impression that all knowledgeable and reasonable persons agreed on the need for surgery. However, the record, accurately portrayed, does not support that interpretation.

1. Defense Witnesses Did Not Concede the Need for Surgery.

a. Drs. Sheitman and Peiper

Plaintiff contends that Dr. Sheitman agreed that surgery was necessary because he testified that "[Plaintiff's] treatment had been helpful but not sufficient, she was still dealing with some issues, and that surgery would have been helpful to manage her gender dysphoria" (DE-63 at 18)

But Dr. Sheitman testified that it was possible that Plaintiff would benefit from the surgery in that not having undergone the surgery would no longer be an issue and that it was possible that surgery could reduce her GD. (DE-61-12 at 101-102) Dr. Sheitman also testified that her existing interventions have been successful in that she seems to be doing better. (Resp. Ex. 5 at 127-28)

Similarly, Plaintiff's contention that Dr. Peiper testified that at the time of the DTARC meeting "[i]t continued to be confirmed" that Plaintiff suffered clinically significant distress, depression, or anxiety associated with her GD, and "that level of distress continued to exist[]"(DE-63 at 18-19), is beside the point. Dr. Peiper testified that Plaintiff continued to have clinically significant distress associated with her GD as indicated by the relevant criteria of the DSM-V. (Resp. Ex. 11 at 91) This is merely a statement that Plaintiff continued to meet the diagnostic criteria. This is different, however, from a concession that Defendants were subjectively aware that Plaintiff was experiencing severe and uncontrolled symptoms or an excessive risk of harm.

Both Drs. Peiper and Sheitman clearly testified that they concurred with the DTARC's determination that surgery was not medically necessary because: 1) Plaintiff was doing well and her symptoms were well controlled; and 2) the medical literature on the efficacy of surgery was mixed. (DE-61-13 at 2; DE-61-27 at 2; DE-61-8 at 58-60; DE-61-5 at 182; DE-61-12 at 114-15; DE-61-9 at 203-05; DE-61-13 at 2-5)

b. Dr. Boyd

Plaintiff's contention that Dr. Sara Boyd, one of Defendants' experts, testified that surgery was necessary to treat Plaintiff's GD (DE-63 at 2), is misleading. Dr. Boyd's testimony was nuanced. She testified that surgery would likely be a necessary component of treatment at some point in time, but Dr. Boyd further testified that when and in what context surgery would likely provide maximal psychological benefit was a different matter. (Resp. Ex. 12 at 156-168) Moreover,

this contention regarding Dr. Boyd's position omits one very critical conclusion of her report—that from a psychological standpoint, her evaluation of Plaintiff did not reveal significant findings that would counsel in favor of the surgery as an immediate intervention, (Resp. Ex. 1 at 34)

Plaintiff's contention that Dr. Boyd agreed that GAS is "necessary" to cure Plaintiff's gender dysphoria, and that Plaintiff "cannot be cured of her gender dysphoria" while she continues to have male genitalia (DE-63 at 23), is not only an incorrect interpretation of Dr. Boyd's position—it is flatly contradicted by her testimony and report. As shown below, Dr. Boyd absolutely does not agree that surgery is necessary to "cure" Plaintiff's GD.

Throughout her deposition and report, Dr. Boyd discusses her position that she often does not think of conditions or symptoms being cured, but rather that they can be improved and sometimes (in the extreme case) fall below the diagnostic threshold. (Resp. Ex. 12 at 82-83) Also, Dr. Boyd is critical of Dr. Ettner's assertion that surgery will cure Plaintiff's GD. (Resp. Ex. 12 at 112-120) In fact, Dr. Boyd testified that "it's usually not the case that there's a single intervention that's sort of like a magic bullet[.]" (Resp. Ex. 12 at 156-157) This is because GD has a "diverse manifestation and is inextricably bound up in aspects of a person's life and circumstances that go far beyond … physical appearance[.]" (Resp. Ex. 1 at 34) Thus, throughout Dr. Boyd's report she is critical of the notion that any particular intervention alone can be curative of GD.

Accordingly, Dr. Boyd does not believe that psychologists, like she and Dr. Ettner, can "reasonably predict with confidence that a particular intervention will be curative of a condition such as [GD]." (Resp. Ex. 12 at 156-157) Moreover, Dr. Boyd writes that Dr. Ettner's testing results suggest that Plaintiff's "trauma-related symptoms are a likely contributor to her suicidality. Thus, it cannot be stated with confidence that Mrs. Zayre-Brown's Gender Dysphoria alone is fully explanatory with regard to her psychological distress generally, and her suicidality specifically.

Likewise, surgical intervention alone is not likely to be curative, and may not substantially ameliorate her suicidality." (Resp. Ex. 1 at 20) Simply put, Plaintiff's contention that Dr. Boyd agrees that surgery would be curative is contradicted by her testimony and report.

c. Dr. Penn

Plaintiff's contention that Dr. Joseph Penn, another defense expert, testified that Plaintiff faces at least some ongoing risks of self-harm if she does not receive surgery (DE-63 at 23), is misleading. First, elimination of risk is not the standard—nor is it a realistic expectation, even if it is a noble aspiration. In any event, Dr. Penn was simply testifying that as long as Plaintiff has a phallus there is at least "some risk" that she could try to harm herself. (Resp. Ex. 10 at 210-11) This does not, however, mean that he agrees that she faced an excessive risk of harm without the surgery—he does not. (Resp. Ex. 13 at 29-35)

d. Drs. Hahn and Bowman

Plaintiff's contention that Dr. Hahn testified that during her time treating her, Dr. Hahn believed GAS was a necessary treatment from a mental health perspective and that Plaintiff needed the surgery to live (DE-63 at 18), takes her testimony out of context. Dr. Hahn specifically testified, "I'm not speaking exactly towards Ms. Brown with this. But some people if they don't – there's a high level of suicide in the transgender population. I -- you just never know what will tip somebody over to committing suicide." (DE-62-15 at 158) Ultimately, Dr. Hahn testified that she thinks Plaintiff has had a mental health need for surgery. (DE-62-15 at 211) But Dr. Hahn did not testify that Plaintiff's life would be in danger without GAS, nor do other cites in the record support that proposition. (DE62-15 at 157-158, DE-63 at 21)

Similarly, Plaintiff's contention that Dr. Bowman testified that "based off of her knowledge of" Plaintiff, she could not imagine that she will stop experiencing gender dysphoria without

surgery (DE-63 at 21), is taken out of context. Dr. Bowman says she cannot imagine Plaintiff not expressing her GD. (Resp. Ex. 13 at 119) The cited testimony is not a concession of any kind regarding the need for surgery. To the contrary, Dr. Bowman testified that Plaintiff did not seem to be at any significant risk of self-harm or to be experiencing severe anxiety, depression, or other distress, and Dr. Bowman found that Plaintiff was functioning normally. (DE-61-39 at 53-57, 68-74, 78-82, 90-97)

2. Defendants' Experts Support the DTARC's Determination that Surgery Was Not Medically Necessary.

Defendants designated and presented reports from three expert witnesses. Sara Boyd, Ph.D., is a clinical and forensic psychologist with experience conducting forensic mental health assessments of transgender and gender diverse people in correctional settings. (Resp. Ex. 1 at 1-3) Joseph Penn, M.D., is the Director of Mental Health Services of the university-based correctional health care system that provides health services to prisoners in Texas. (Resp. Ex. 13 at 1-2) Dr. Penn has almost thirty years of correctional medical experience and oversees the statewide clinical evaluation and treatment program for patients who seek treatment for GD in Texas state prisons. (Resp. Ex. 13 at 1-2) Fan Li, Ph.D., is a biostatistician and a nationally leading expert on statistical methods for causal inference and comparative effectiveness research.[5] (Resp. Ex. 15 at 1-2)

Each of Defendants experts support the DTARC's conclusions as follows. While Dr. Boyd did not address medical necessity (she believes doing so is beyond a psychologist's scope of expertise), she did conclude that her evaluation of Plaintiff did not reveal anything that would counsel in favor of the surgery as an immediate intervention, from a psychological standpoint. (Resp. Ex. 1 at 34) Dr. Penn concluded that the DTARC's decision was appropriate and reasonable,

[5] In medicine, the type of research used to evaluate the effects and safety of an intervention is broadly referred to as "comparative effectiveness" research. (Resp. Ex. 15 at 5)

because there was no clinical indication that surgery was necessary to protect life, prevent clinically significant illness or significant disability, or alleviate severe pain. (Resp. Ex. 13 at 29-32, 35) Lastly, Dr. Li conducted a detailed review of the studies cited by Dr. Ettner and WPATH and concluded that there is a lack of high-quality research indicating the long-term efficacy of GAS. (Resp. Ex. 15 at 25) Dr. Penn concurs with Dr. Li on this point. (Resp. Ex. 13 at 32-35)

D. WPATH is Merely Guidance and was Considered by the Department.

Plaintiff contends that WPATH is authoritative but was not treated as such by Defendants. (DE-63 at 2, 9, 35) Specifically, Plaintiff suggests that, for GD alone, the Department has ignored guidance (WPATH) despite its policy requiring "that clinicians look to clinical practice guidelines from professional medical associations to establish the standard of care." (DE-63 at 35) This contention is misleading, as there is nothing out of the ordinary about the way the Department considers the WPATH guidance. Dr. Campbell testified at length that while clinical recommendations and approvals are informed by reference to various evidence-based practice guidelines or other relevant guidance, such recommendations and approvals are always based on individualized clinical judgment. (*See* DE-61-5 at 57-61, 92-98; Resp. Ex. 17 at 16-35, 69-72)

Dr. Campbell does note his concerns regarding aspects of WPATH in his position statement (DE-61-14) Notably, Dr. Campbell is not alone in these concerns. Indeed, the Ninth Circuit acknowledged concerns raised by defense experts, including that WPATH "represents a self-selected subset of the mental health professions … [and] does not capture the clinical experiences of others" and that WPATH's purported professional consensus regarding standard of care "exists only within its confines." *Doe v. Snyder*, 28 F.4th 103, 109, 112 (9th Cir. 2022).

Nonetheless, consistent with how it treats guidance for other conditions, the Department does recognize WPATH as guidance that can inform individualized clinical judgments. (DE-61-7

at 28, 152; DE-61-8 at 124; DE-61-at 90-91) And as an information source, it only provides guidance and does not dictate when a particular procedure is considered medical necessary. (Resp. Ex. 12 at 20-25) Indeed, the WPATH guidance itself acknowledges its intended use as a guide: "[t]he overall goal … is to provide clinical guidance for health professionals to assist[.]" (Resp. Ex. 12 at 25) Thus, the WPATH guidance does not purport to set out standards for determining medical necessity. In fact, the portion of the guidance that relates specifically to people confined to institutions does not attempt to set out a medical necessity standard. (Resp. Ex. 12 at 23)

Similarly, Plaintiff's contentions regarding other health insurance coverage (DE-63 at 7) are not relevant here. The *Kadell* case that Plaintiff refers to is an equal protection case that involves a very different legal question and is currently under review. *Kadel v. Folwell*, No. 22-1721, 2023 U.S. App. LEXIS 8744 (4th Cir. Apr. 12, 2023) The record does not contain additional information about how various health plans treat this issue, and that is a separate question from whether an individualized determination constitutes deliberate indifference.

II. APPLICATION OF THE RECORD APPLIED TO PLAINTIFF'S CLAIMS

As discussed in Defendants' opening brief, the standard for establishing a deliberate indifference claim is high. Given that high standard, it is not surprising that Defendants are aware of only a single case (involving an extreme circumstance) in which the Fourth Circuit affirmed summary judgment in favor of plaintiff on an Eighth Amendment deliberate indifference claim[6] and no other such cases throughout the circuit. On this record, Plaintiff's motion for summary judgment fails, as the evidence cannot support an inference that she faced an "objectively,

[6] The Fourth Circuit affirmed summary judgment for the plaintiffs in their Eighth Amendment challenge to the conditions of confinement on Virginia's death row. *Porter v. Clarke*, 923 F.3d 348, 353 (4th Cir. 2019).

sufficiently serious" risk of harm because of the denial of her requested surgery. Nor can the record support an inference that Defendants were aware of such a risk and consciously disregarded it.

Indeed, a fair and accurate accounting of the record establishes that Defendants specifically assessed Plaintiff's risk of harm and determined that her presentation did not warrant any further intervention beyond that already provided, and that the medical literature is mixed as to outcomes. Plaintiff's contentions to the contrary merely amount to a disagreement over the correctness of those conclusions, and thus a disagreement over the proper course of care. As articulated below and in Defendants' summary judgment briefs, such disagreements cannot support a deliberate indifference claim. Moreover, Plaintiff's argument and contentions do not establish a disability claim never previously recognized. Accordingly, not only is Plaintiff not entitled to summary judgment on this record, the evidence and case law demonstrate that Defendants are entitled to summary judgment on all Plaintiff's claims. *See* DE-60, which is incorporated herein by reference.

A. Plaintiff is Not Entitled to Summary Judgment Because She Cannot Satisfy the Objective Prong of her Deliberate Indifference Claim.

Plaintiff incorrectly assumes that the objective prong merely requires the showing of a "serious medical condition" (*see* DE-63 at 25) The case law clearly establishes that the objective prong requires a showing that the medical care at issue (*i.e.*, the challenged condition of confinement) has caused or risks causing an "objectively, sufficiently serious" harm. *Thorpe*, 37 F.4th at 940; *see also Farmer v. Brennan*, 511 U.S. 825, 834 (1994). To be sure, in the Fourth Circuit, there are a handful of cases that appear to suggest that simply demonstrating the existence of a "serious medical condition" may be sufficient to satisfy the objective component of a

deliberate indifference claim.[7] However, in those cases, the objective prong was conceded, and, thus, none of those cases contain any substantive analysis on the issue of whether demonstrating a "serious medical condition" alone is sufficient to satisfy the objective component. Thus, none of those cases overtake the many other cases which clearly articulate that the objective prong requires some showing that the challenged condition **caused** "objectively, sufficiently serious" risk of harm.

The case law plainly provides that the critical inquiry on a deliberate indifference claim "[a]sks … whether the conditions of confinement **inflict** harm that is, objectively, sufficiently serious to deprive a prisoner of minimal civilized necessities." *Thorpe*, 37 F.4th at 940 (emphasis added) (cleaned up). This is because to constitute "pain of a constitutional magnitude […] there must be evidence of a serious medical and emotional deterioration **attributable** to the challenged condition." *Lopez v. Robinson*, 914 F.2d 486 (4th. Cir. 1990) (emphasis added) (cleaned up). Thus, if a prisoner has not suffered serious or significant physical or mental injury **as a result** of the challenged condition," his Eighth Amendment rights have not been violated. *Strickler v. Waters*, 989 F.2d 1375, 1381 (4th Cir. 1993) (emphasis added).

Indeed, in describing the objective component, the Supreme Court stated that "[t]he deprivation alleged must be objectively, sufficiently serious, [and that] a prison official's act or omission **must result** in the denial of the minimal civilized measure of life's necessities[.]" *Farmer*, 511 U.S. at 834 (emphasis added) (cleaned up). This requirement has repeatedly been applied in the context of medical deliberate indifference claims. *See e.g.*, *Moss v. Harwood*, 19 F.4th 614, 624 (4th Cir. 2021); *Scinto v. Stansberry*, 841 F.3d 219, 228 (2016); *Harden v. Green*,

[7] *See e.g., Pfaller v. Amonette*, 55 F.4th 436, 448 (4th Cir. 2022) *Pledger v. Lynch*, 5 F.4th 511, 524 (4th Cir. 2021*); Langford v. Joyner*, 62 F.4th 122, 124 (4th Cir. 2023); *Gordon v. Schilling*, 937 F.3d 348, 356 (4th Cir. 2019); *Jackson v. Lightsey*, 775 F.3d 170, 178 (4th Cir. 2014); *Johnson v. Quinones*, 145 F.3d 164, 168 (4th Cir. 1998); *Heyer v. U.S. Bureau of Prisons*, 849 F.3d 202, 210 (4th Cir. 2017); *Smith v. Smith*, 589 F.3d 736, 738 (4th Cir. 2009).

27 F. App'x 173, 177 (4th Cir. 2001) (unpublished). Other circuits similarly highlight that the objective component requires a determination of whether the treatment (or lack thereof) has caused an objectively sufficiently serious risk of harm. *See e.g.*, *Salahuddin v. Goord*, 467 F.3d 263, 279-80 (2d Cir. 2006); *Colwell v. Bannister*, 763 F.3d 1060, 1066 (9th Cir. 2014). Accordingly, in the instant case, Plaintiff must present evidence that the denial of her requested surgery has caused "objectively, sufficiently serious" harm or risks of the same.

As argued in Defendants' motion for summary judgment (DE-60 at 19-20), there is simply no record evidence that can support an inference that the denial of surgery **has caused** any "objectively, sufficiently serious" risk of harm. (DE-61-33 at 27-3; DE-61-8 at 57-67; DE-61-5 at 182; DE-61-12. 94-97, 114-15; DE-61-13 at 1-2; DE-61-3 at 137, 178) Plaintiff has received treatment and her condition is well controlled. (DE-61-3 at 95-96, 105; DE-61-17; DE-61-33 at 30-31; DE-61-40 ¶ 40; DE-61-18 at 2 DE-61-13 at 1; DE-27) Given the lack of evidence necessary to show that the denial of surgery has caused any "objectively, sufficiently serious" risk of harm, Plaintiff's motion for summary judgment must fail and Defendants' should be granted.

B. Plaintiff is Not Entitled to Summary Judgment Because She Cannot Satisfy the Subjective Prong of her Deliberate Indifference Claim.

Plaintiff's deliberate indifference claims also fails on the subjective prong for two reasons. First, the record evidence demonstrates that Defendants were not subjectively aware of an excessive risk of harm that they consciously disregarded—instead the record shows that after purposely assessing whether Plaintiff's condition warranted further treatment, they determined that her presentation did not warrant further intervention, and that the literature was mixed as to outcomes. Second, Plaintiff's contentions and arguments simply highlight that her claim turns on

a disagreement over the clinical judgments of the Department, which, as a matter of law, is insufficient to support her claim.

1. The Record Does Not Demonstrate that Any Defendant Was Subjectively Aware of an Excessive Risk of Harm and Purposely Ignored the Same.

Plaintiff seems to contend that Defendants' acceptance of her GD diagnosis, which is defined by certain symptoms, alone establishes deliberate indifference. That is incorrect. While Defendants do not dispute Plaintiff's GD diagnosis, (DE-61-15, DE-61-16 at 3, DE-61-8 at 46, 51; DE-61-27 at 3), the record demonstrates that the Defendants examined and assessed the severity of Plaintiff's symptoms—and determined that, with existing treatments, she was not experiencing severe symptoms associated with GD, and thus not at risk of severe harm. (DE-61-8 at 58-60; DE-61-5 at 50, 179, 182-84; DE-61-12. 27-29, 49, 113-16; DE-61-13 at 1-2; DE-61-27 at 2; DE-61-9 at 193-95; 208-209) Moreover, the record reflects that when Plaintiff did have a handful of temporary moments of elevated distress, Defendants responded appropriately to manage those situations. (*See e.g.*, DE-60 at 10-12; Resp. Ex. 4 at 3, 9; Resp. Ex. 3 at 6-7) Additionally, the record shows that Defendants also determined that the medical literature pointed to mixed conclusions as to the efficacy of GAS in treating the symptoms of GD. (DE-61-9 at 203-05; DE-61- at 2-5; DE-61-12 at 50-51, 57-58, 119-21)

a. Defendants' Experts Support the Department's Conclusion that Plaintiff's Presentation Did Not Warrant Further Intervention.

As noted in Defendant's summary judgment brief, the first basis for the Department's denial of the requested procedure was its determination that Plaintiff was relatively well adjusted and doing well with current treatments. (DE-61-5 at 149-50, 153-58, 182; DE-61-8 at 58-60; DE-61-9 at 147, 190-95; DE-61-12. 27-29, 49,109-17, 131-32; DE-61-13 at 1-2; DE-61-27) Dr. Penn reviewed Plaintiff's medical records, reviewed her deposition video and transcript, and watched a

video assessment of Plaintiff performed by Dr. Boyd, and opined that "there was no clinical indication that the surgery was necessary to protect life, to prevent clinically significant illness or significant disability, or to alleviate severe pain." (Resp. Ex. 13 at 1-2, 6-7, 35) Similarly, Dr. Boyd, concluded that a review of Plaintiff's records and an independent evaluation, "did not reveal any significant findings in her mental state that would counsel in favor of the surgery as an immediate intervention … from a psychological standpoint." (Resp. Ex. 1 at 1-3, 23, 34) Additionally, Dr. Boyd concluded that while Plaintiff "has some issues of note, [she] is relatively well adjusted[.]" (Resp. Ex. 1 at 23) Moreover, Dr. Boyd, concluded that "a clinical psychologist cannot reasonably predict with confidence that a particular intervention will be curative of a condition such as [GD] which has a diverse manifestation and is inextricably bound up in aspects of a person's life and circumstances that go far beyond the physical appearance of their genitals." (Resp. Ex. 1 at 3, 34)

b. Defendants' Expert Supports the Department's Conclusion that the Medical Literature is Mixed and Lacks High-Quality Research.

As noted in Defendant's summary judgment brief, the second basis for the Department's denial of the requested procedure was its determination that the medical literature regarding the efficacy of GAS as a treatment for GD is mixed in terms of outcomes. (DE-61-9 at 203-05; DE-61-13 at 2-5; DE-61-12 at 50-51, 57-58, 119-21) This conclusion is supported by Defendants' study design and comparative effectiveness expert, Dr. Li, who reviewed dozens of studies that Dr. Ettner and/or WPATH cite to support their assertions regarding the efficacy of GAS. (Resp. Ex. 15 at 4-5) Dr. Li concluded that these studies "fail to provide rigorous and consistent statistical evidence on the benefits in quality of life and well-being of" GAS. (Resp. Ex. 15 at 4-5)

In her report, Dr. Li discusses the hierarchy of study design, and notes that the randomized controlled trial is considered the highest quality, followed by prospective observational studies,

with standardized before and after measurements, and then retrospective observational studies, which are the lowest quality study design. (Resp. Ex. 15 at 8-10) Dr. Li noted that, among the more than 80 studies that Dr. Li reviewed (all of which were cited as support by Dr. Ettner and/or WPATH), none was a random controlled trial. (Resp. Ex. 15 at 3-4) Dr. Li further noted that there were only a few prospective studies cited by WPATH and Dr. Ettner, and those pointed to mixed conclusions. (Resp. Ex. 15 at 4) Additionally, Dr. Li noted that the vast majority of the studies cited in support of those assertions are of lower quality in terms of study design and statistical methodology because most were based on observational retrospective designs, which are prone to severe confounding bias, and have other methodological shortcomings including small sample size, nonresponse bias, non-representative population (i.e., selection bias), self-reported outcomes. (Resp. Ex. 15 at 4) Further still, the vast majority of these studies do not compare the results of GAS with alternative treatments, and thus do not provide evidence on the necessity or advantage of sex reassignment surgery over available alternative treatments. (Resp. Ex. 15 at 4) For these reasons, and as more specifically articulated in her report and in her deposition (*see* Resp. Ex. 16 at 24-45, 51-70, 100-147, 150-160), Dr. Li concluded, to a reasonable degree of statistical certainty, that these studies fail to provide rigorous and consistent statistical evidence on the benefits in quality of life and well-being of GAS.

Thus, on this record Plaintiff cannot establish that she is entitled to summary judgment on the subjective prong. Rather, as explained in their summary judgment brief (DE-60 at 9-13) the record establishes that Defendants determined that surgery was not medically necessary because, after assessing the severity of Plaintiff's symptoms, they concluded that she was not experiencing symptoms sufficient to warrant further intervention, and that the medical literature was mixed as to the efficacy of GAS treating GD. Moreover, these conclusions were not extreme or

unreasonable. To the contrary, they are robustly supported by Defendants' experts. Additionally, the record shows Defendants provided Plaintiff with treatment for her GD and responded to specific instances of elevated distress. (DE-61-3 at 95-96, 105; DE-61-17; DE-61-33 at 30-31; DE-61-40 ¶ 40; DE-61-18 at 2 DE-61-13 at 1; DE-27; DE-60 at 10-12; Resp. Ex. 4 at 3, 9; Resp. Ex. 3 at 6-7) Accordingly, on this record there is no genuine issue of material fact concerning the Defendants' subjective knowledge of Plaintiff's risk of harm, nor their actions based on their knowledge. Therefore, Plaintiff is not entitled to summary judgment and Defendants are entitled to summary judgment on her deliberate indifference claim.

2. Plaintiff's Attacks on the DTARC's Process and Conclusions Represent a Disagreement Over the Proper Course of Treatment.

As articulated in Defendants' summary judgment brief, disagreements over the proper course of medical care cannot support a deliberate indifference claim. (DE-60 at 23-25) This is because "a prisoner does not enjoy a constitutional right to the treatment of [their] choice," and the "essential test is one of medical necessity and not simply that which may be considered desirable[.]" *De'Lonta v. Johnson*, 708 F.3d 520, 526 n.4 (4th Cir. 2013). Thus, Plaintiff's disagreement with the conclusions that DTARC reached regarding the severity of her symptoms and whether further intervention was warranted amounts to a disagreement over the proper course of medical care that (1) does not preclude summary judgment for Defendants and (2) certainly does not justify summary judgment for Plaintiff.

Plaintiff claims that Dr. Ettner's evaluation of Plaintiff found that the Department's treatment of her gender dysphoria "falls far outside of what is recommended by" WPATH (DE-63 at 34) To further support this claim, Plaintiff also points to statements of Dr. Filger, Dr. Caraccio, and Ms. Dula, regarding their conclusions that surgery was medically necessary based on the

WPATH criteria. (DE-63 at 15-17, 28) Similarly, to support her deliberate indifference claim, Plaintiff points to Dr. Ettner's conclusions: that Plaintiff has "severe and persistent" gender dysphoria and continues to struggle with thoughts of self-harm; that previous treatments "have been ineffective in significantly alleviating or resolving[;]" that she "has met, and exceeded, all the requirements of the WPATH[;]" that her "resilience is rapidly eroding[;]" that without surgery, her "gender dysphoria will continue to intensify, with no means of relief[;]" and that Plaintiff "urgently requires" GAS for "her severe gender dysphoria." (DE-63 at 22-23)

However, as discussed above, the Department uses the WPATH guidance as it was intended—as a guide—and WPATH itself acknowledges that its recommendations are intended to be flexible and not a one-size fits all. (DE-61-7 at 28, 152; DE-61-8 at 124; DE-61-at 90-91; DE-62-4 at 8) In any event, even assuming the WPATH set a legal standard of care that is applicable to the Department, falling outside of a standard of care amounts to negligence, not deliberate indifference. *Jackson v. Lightsey*, 775 F.3d 170, 178 (4th Cir. 2014). And while the Fourth Circuit has recognized the WPATH standards, it has not held that WPATH either sets the constitutional requirement under the Eighth Amendment; nor has the Fourth Circuit held that WPATH's standards mandate GAS under these circumstances. Instead, the cases simply note that the WPATH guidance sets out "generally accepted protocols for treatment of [gender dysphoria]" and "outline appropriate treatments for persons with gender dysphoria[.]" *See De'Lonta*, 708 F.3d at 523; *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 596 (4th Cir. 2020). Thus, these cases do not stand for the notion that the WPATH guidance sets out inflexible rules.

Moreover, as explained in Sections (I)(A), (I)(B)(2), (I)(C)(1), (II)(B)(1) above, the DTARC (including Drs. Campbell, Sheitman, and Peiper), Plaintiff's therapists Drs. Bowman and Hahn, and defense experts Drs. Penn and Boyd, all reached different conclusions than Dr. Ettner

and WPATH regarding the severity of Plaintiff's symptoms and the need for further intervention. (DE-61-13 at 2; DE-61-27 at 2; DE-61-9 at 193-95; DE-61-5 at 182-84; DE-61-12 at 27-29, 49, 113-16; DE-61-38, DE-61-39; Resp. Exs. 1, 13, 15) The DTARC (including Drs. Campbell and Sheitman), and defense experts Drs. Penn and Li all reach different conclusions than Dr. Ettner and WPATH regarding the evidence on the efficacy of the requested surgery. (DE-61-9 at 203-05; DE-61-13 at 2-5; DE-61-12 at 50-51, 57-58, 119-21; Resp. Exs. 1, 13, 15)

Additionally, Plaintiff's statements of severe and ongoing pain and "clinically significant dysphoria" contained in her second declaration (DE-63 at 21, 23; DE-62-24 ¶¶ 1, 4, 8) are insufficient to support her motion for summary judgment or defeat Defendants' motion. This is because to survive summary judgment a party must set forth evidence of disputed fact that would be admissible at trial. Fed. R. Civ. P. 56. Accordingly, a party opposing summary judgment may not create a dispute of material fact simply by professing personal beliefs, opinion, or conclusory statements contained in an affidavit and unsupported by other record evidence. *See In re Family Dollar FLSA Litig.*, 637 F.3d 508, 512-13 (4th Cir. 2011) ("If a party who has been [deposed at length] could raise an issue of fact simply by submitting an affidavit contradicting his own prior testimony, this would greatly diminish the utility of summary judgment[.]") *Evans v. Techs. Applications & Serv. Co.*, 80 F.3d 954, 962 (4th Cir. 1996) (cleaned up) ("[S]ummary judgment affidavits cannot be conclusory[.]") Here, the referenced portions of Plaintiff's declaration are not supported by contemporaneous medical records nor her own testimony. (DE-61-3 at 27-28, 44, 129-33, 137, 140-43, 146, 149, 174-75, 178 DE-61-33; DE-61-34; DE-61-35; DE-61-9 at 193; DE-61-8 at 129-130; see also DE-60 at 9-13)

Plaintiff's contentions and arguments, when measured against the totality of the record, demonstrate that this case turns on a disagreement over the course of medical care—a dispute that

cannot support a deliberate indifference claim. As the Fourth Circuit has stated, where "the medical professionals in [a] case disagree about what the proper course of treatment should have been for [the plaintiff] … such a disagreement … is not sufficient to sustain a deliberate indifference claim." *Hixson v. Moran*, 1 F.4th 297, 303 (4th Cir. 2021). That is precisely the scenario in this case. Therefore, not only does the record and law mean that Plaintiff's motion for summary judgment fails, but it also means that Defendants are entitled to summary judgment.

C. Plaintiff is Not Entitled to Summary Judgment on Her State Constitutional Claim Because She Had an Adequate State Remedy.

Plaintiff claims that she has a valid *Corum* claim because an action in the North Carolina Industrial Commission is not an adequate state remedy since she asserts an Eighth Amendment deliberate indifference claim which has a higher standard than negligence. (*See* DE-63 at 4)

Plaintiff's argument is incorrect because it assumes adequacy requires the ability to assert particular causes of action—it does not. In determining whether a remedy is "adequate," the remedy must both address the constitutional injury and provide the plaintiff with an opportunity to "enter the courthouse doors." *See Taylor v. Wake Cnty*, 258 N.C. App. 178, 185, 811 S.E.2d 648, 654, 371 N.C. 569, 819 S.E.2d 394 (2018); *Craig*, 363 N.C. at 340, 678 S.E.2d at 355; *Wilcox v. City of Asheville*, 222 N.C. App. 285, 301-02, 730 S.E.2d 226, 239 (2012). The North Carolina Supreme Court held that "[t]he adequacy of a state remedy requires only the opportunity to be heard, and if successful to recover for the injuries alleged in the direct constitutional claim." *Taylor*, at 189, 811 S.E.2d at 656. Moreover, the question of adequacy of a remedy looks to a plaintiff's ability to recover for a particular harm and not the plaintiff's ability to recover against a particular defendant. *See, e.g., Wilcox*, 222 N.C. App. at 301-02, 730 S.E.2d at 238-39; *Phillips* v. *Gray,* 163 N.C. App. 52, 57-58, 592 S.E.2d 229, 233 (2004). Accordingly, whether the claim is based in

negligence or the Eighth Amendment, Plaintiff's claim for relief would stem from the same contentions (*i.e.*, alleged inadequate treatment of her GD). Thus, Plaintiff could seek relief based on those contentions in the North Carolina Industrial Commission, and therefore has an adequate state remedy and cannot pursue a State constitutional claim under *Corum*. Additionally, Plaintiff's state constitutional claim also fails for the additional reasons discussed above.

D. Plaintiff is Not Entitled to Summary Judgment on Her Disability Claim.

Plaintiff claims that she is entitled to summary judgment because the evidence demonstrates that: 1) she has a disability; 2) she is otherwise qualified for a government benefit or service; but 3) she was excluded from that benefit or service on the basis of her disability. (DE-63 at 32-35) Defendants concede that GD can be a disability. (DE-60 at 33) However, Plaintiff has not pointed to record evidence to support either of the last two elements—and there is none. As explained above, and in Defendants' summary judgment brief, the record shows that the surgery was denied not because of any disability but because it was determined not to be medically necessary. Moreover, Plaintiff relies on an intentional discrimination theory but fails to identify any case law to support her claim that an individualized assessment and denial of a specific intervention can support an ADA claim. The few cases that Plaintiff cites (DE-63 at 35) are not controlling nor persuasive, as they primarily discuss the plausibility of a prisoner's ADA claim due to a denial of requested care on a motion to dismiss.

In short, Plaintiff's assertion that prison officials are discriminating against her because they are denying her disability-related medical care, while providing care to others (DE-63 at 35), lacks merit. The record clearly establishes that she is receiving care for her GD. (DE-61-3 at 95-96, 105; DE-61-17; DE-61-33 at 30-31; DE-61-40 ¶ 40; DE-61-18 at 2 DE-61-13 at 1; DE-27) That she is not getting the type of care that she wants does not mean that she is being denied

disability-related care. *See Richardson v. Clarke*, 52 F.4th 614, 620 (4th Cir. 2022) On this record, not only has Plaintiff failed to establish that she is entitled to summary judgment on her disability claim, but the record also confirms that Defendants are entitled to summary judgment on Plaintiff's disability claim. *See* DE-60 at 30-35, which is incorporated fully herein.

CONCLUSION

For the reasons set forth herein, Defendants respectfully request that Plaintiff's Motion for Partial Summary Judgment be denied and that for the reasons set forth in DE-60, the Court enter summary judgment in their favor on all claims. Pursuant to Section II(c) of the Pretrial Order and Case Management Plan entered in this case, DE-28, Defendants respectfully request a hearing on the parties' cross motions for summary judgment.

This the 19th day of October 2023.

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