No. 26A416

IN THE

Supreme Court of the United States

DONALD J. TRUMP, PRESIDENT OF THE UNITED STATES, ET AL.,

Applicants,

—— V.——

ALISHEA SOPHIA KINGDOM, ET AL.,

Respondents.

TO THE HONORABLE JOHN G. ROBERTS, CHIEF JUSTICE OF THE SUPREME COURT OF THE UNITED STATES AND CIRCUIT JUSTICE FOR THE DISTRICT OF COLUMBIA CIRCUIT

SUPPLEMENTAL APPENDIX

Aditi Shah
Michael Perloff
AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF THE DISTRICT OF COLUMBIA
529 14th Street NW, Suite 420
Washington, D.C. 20045

Shawn Thomas Meerkamper
Dale Melchert
Megan Z. F. Noor
TRANSGENDER LAW CENTER
P.O. Box 70976
Oakland, CA 94612

Carmen Iguina González
Maria V. Morris
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
915 15th Street NW
Washington, DC 20005

Lynly S. Egyes
TRANSGENDER LAW CENTER
594 Dean Street, Suite 11
Brooklyn, NY 11238

Li Nowlin-Sohl*
Counsel of Record
Leslie Cooper
Chase Strangio
Shana Knizhnik
Priyanka Menon**
James D. Esseks
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, 18th Floor
New York, NY 10004
(212) 549-2500
lnowlin-sohl@aclu.org

Cecillia D. Wang
Corene T. Kendrick
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
425 California Street, Suite 700
San Francisco, CA 94104

**admitted only in Washington*
***admitted only in Maryland*

Counsel for Respondents

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiffs, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691 **DECLARATION OF DR. CATHY THOMPSON**

I, Cathy Thompson, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

INTRODUCTION AND SCOPE OF WORK

1. I am a licensed clinical psychologist and recently retired Federal law enforcement officer with more than 20 years' experience working in correctional settings. My experience includes providing direct mental health services to incarcerated individuals inside prison and jail facilities. I later served as a national administrator for the Department of Justice's Federal Bureau of Prisons (BOP) and therefore have extensive experience in developing programs and services and drafting and implementing policies specific to the safety and treatment of individuals in BOP custody. I was involved in the development and implementation of BOP's procedures for managing transgender inmates. I retired from federal service effective September 23, 2023, and I now work as a consultant.

2. I have been retained by counsel for Plaintiffs in the class action complaint for declaratory and injunctive relief in *Kingdom v. Trump* (Trump Administration and BOP's categorical ban on gender-affirming health care for people with gender dysphoria in the custody of the Federal Bureau of Prisons), Case No.: 1:25-cv-00691. I have been asked to provide expert testimony about BOP policies and practices for transgender people prior to the executive order, and my expert opinion on the current and future impact of BOP's recent policy changes pertaining to treatment and management of transgender individuals in BOP custody.

3. My opinion, which is explained in further detail below, addresses the history of BOP's approach to managing and treating transgender people and the ways in which the recent guidance and policy issued by the BOP 1) cause harm to both those individuals and the staff who work with them, and 2) are not consistent with standards and accepted practices applicable to BOP.

4. It is my understanding that since January 2025, the BOP has rescinded its policy about transgender individuals, issued guidance prohibiting accommodations for transgender people, and directed medical staff to cease provision of gender affirming care, including hormones for all persons in custody.

5. It is my opinion that (1) a blanket ban on treating individuals who are transgender or have gender dysphoria is neither safe nor consistent with accepted practices, and (2) providing gender affirming care promotes security efforts.

PROFESSIONAL BACKGROUND

6. In 2000, I obtained my doctorate in Clinical Psychology from Texas Tech

University. As part of this degree, I completed an internship with the BOP during 1999-2000. After graduating, I continued my career with the BOP which spanned over 23 years until my retirement in 2023.

7. During more than two decades with BOP, I held positions of increasing responsibility in both prisons and administrative offices across the United States wherein I not only practiced psychology, but worked collaboratively and closely with other disciplines to meet the agency's mission of operating facilities that were safe while also delivering quality, evidence-based services.

8. For approximately the first decade, I promoted through positions located inside prisons. I provided treatment to men and women with a wide range of presenting issues. I provided supportive counseling to individuals struggling with issues of gender identity and more intensive psychological interventions for comorbid gender dysphoria and depressive disorders, posttraumatic stress disorder (PTSD), or anxiety disorders. Consistent with the standards mandated by the Prison Rape Elimination Act (PREA), I conducted assessments and provided treatment to incarcerated victims of sexual abuse.

9. In 2009, I was chosen for my first administrative oversight position within the BOP. In this capacity, I began to not only provide safe treatment and management directly, but to start giving guidance to others on how to create and maintain proper correctional environments through reliance on policy and accepted practices.

10. Five years later, I was promoted to a national level mental health position. My primary responsibility was the oversight, development, and implementation of substance use and mental health treatment programs. My work included ensuring these

services were relevant and beneficial to all individuals in BOP custody and addressing the care of transgender individuals was a large part of that work.

11. I had primary responsibility for ensuring BOPs residential treatment programs operated as modified therapeutic communities (MTCs). This is an evidence-based approach to residential substance use treatment designed to maximize the positive benefits of a supportive community that welcomes all members.[1]

12. While serving in this role, I was asked to be the acting national administrator for psychology services. During this time, BOP's policies regarding transgender inmates advanced significantly, and I was part of those efforts. I advised both my supervisors and institution staff on the accepted practices in caring for this population. I also provided input on policy development, and as it was implemented, I provided consultation and expertise to BOP's Transgender Executive Committee (TEC) regarding placement for transgender people that maximized opportunities for access to mental health treatment, reentry programming, and personal safety. I collaborated with other subject matter experts to develop lesson plans for annual training provided to all BOP staff on a wide range of psychological issues, including the accepted practices in the management of transgender people in secure settings. Most importantly, I was in a national leadership role advising on the importance of providing individualized and affirming services to transgender people, and I saw the benefits of this approach firsthand.

[1] De Leon, George. (2000). *The Therapeutic Community*. Springer Publishing Company.

13. Throughout the course of my BOP career, I remained engaged in scientific research which I published and presented outside the agency. I also taught courses at the college level. I retired in 2023 and do part-time consulting and treatment work. **My resume is attached as Exhibit A**.

14. I am being compensated at the rate of $500 per hour for my time completing this declaration.

BASES FOR OPINIONS

15. In preparing this report, I have relied on my training; my years of experience working in correctional settings and my specific experience within the BOP making care decisions about individuals who are transgender; my knowledge of the policies and practices surrounding these issues in both BOP and other correctional systems; and my knowledge of the relevant literature and standards.

16. In addition, in preparing this report, I have reviewed the following information to inform my opinion: the class action complaint filed March 10, 2025 and the two associated exhibits. I also reviewed publicly available materials as cited in this document.

BRIEF HISTORY OF BOP'S TRANSGENDER PRACTICES AND STANDARDS

17. As part of operating safe facilities, over the last several decades correctional systems have begun to have a better understanding of how to provide care to transgender inmates, just as they have provided care to individuals with any other

medical, mental health, learning, or other need. These efforts are supported by data demonstrating transgender individuals are both more likely to become involved in the justice system, and also more likely to experience sexual assault while incarcerated.[2] [3] Thus, in service to operating a safe facility and meeting the agency mission, sound correctional practices have long included provision of individualized health care and accommodations to transgender or intersex persons.

18. In 2003, the Prison Rape Elimination Act (PREA) was signed into law, and in 2012, the Department of Justice published the PREA Final Rule, which included standards for implementing the statute.[4] [5] PREA drew national attention to the needs of the incarcerated transgender population, and was the first federal law identifying best care practices. Five standards specify requirements addressing transgender persons in carceral settings.

19. One of those standards, PREA standard 115.42(c) establishes the necessity of individualized assessments, stating, "the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems." The Department of Justice

[2] Grant, Jaime M.; Mottet, Lisa A.; Tanis, Justin; Harrison, Jack; Herman, Jody L.; Keisling, Mara (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey (PDF) (Report). Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.
[3] Beck, A. J., & Shandler, S. (2013). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-2012*. U.S. Department of Justice, Bureau of Justice Statistics.
[4] 28 CFR Part 115 National Standards To Prevent, Detect, and Respond to Prison Rape; Final Rule.
[5] Prison Rape Elimination Act (PREA) of 2003 (P.L. 108-79).

also determined assigning housing to a transgender person based solely on genitalia is a violation of PREA.[6]

20. Mental health and medical treatment of transgender individuals was improving through the establishment of standards or accepted practices while PREA standards were being developed and issued. Research indicates, for example, that transgender individuals are at higher risk for suicide than non-transgender persons.[7] In 2015, the American Psychological Association issued guidance on working with transgender and non-binary individuals, including a key principle that "Psychologists strive to recognize the influence of institutional barriers on the lives of [transgender] people and to assist in developing [transgender]-affirmative environments."[8] [9] Similarly, the American Medical Association has made a number of public statements supporting the importance of and right to access gender affirming interventions.[10]

21. Meanwhile, BOP along with correctional systems across the country and world were developing procedures to ensure appropriate care for transgender inmates.

BOP POLICY AND PROCEDURES IMPACT

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[6] National PREA Resource Center. (2016). *FAQ: Does a policy that houses transgender or intersex inmates based exclusively on external genital anatomy violate Standard 115.42(c) & (e)*.
[7] Marshall E, Claes L, Bouman WP, et al. (2016). *Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature*. Int Rev Psychiatry. 28, 58–69.
[8] American Psychological Association. (2015). *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*. American Psychologist, 70 (9), 832-864. Retrieved from https://www.apa.org/practice/guidelines/transgender.pdf
[9] *Id.,* at 840.
[10] *See* https://transhealthproject.org/resources/medical-organization-statements/american-medical-association-statements/

22. The BOP is the largest correctional system in the United States and operates 122 prison facilities across the country. Facilities are classified into four security-level categories, and men and women are housed in separate units or facilities. Over 35,000 employees work for BOP.

23. BOP, like most correctional systems, utilizes policy and training as dual methods to ensure staff are complying with the law and using the most accepted and safest practices available. Any policy is developed in response to a need for guidance and grounded in science, law, and safety.

24. Going back to the beginning of my BOP career in 1999, BOP has recognized that individuals who are transgender or intersex may not easily fit into BOP's housing structure. Thus, senior officials at the agency have made decisions about the most appropriate housing for these persons, based on the safety of both the individual and others. Yet, BOP did not have a policy, and while transgender people did receive treatment and in some cases were housed in accordance with their gender identity, , the lack of agency directive raised questions as to how to best make such decisions.

25. Following the passage of PREA in 2003, BOP updated its policy on sexual abuse to ensure it was compliant with the statute and standards.[11] In particular, the policy included language from the PREA standards and explained to staff in clear language the importance of individualized decision-making about the safety of transgender inmates.

26. While staff became familiar with these standards and recognized the

[11] DOJ-BOP. (2015). Program Statement 5324.12, Sexually Abusive Behavior Prevention and Intervention.

benefits of the individualized approaches, questions also arose as to how to make the best, fairest, and safest decisions with regard to housing and health care treatment. Many staff, particularly in remote locations, were not well acquainted with transgender terminology, for example, or were not familiar with external guidance documents, such as the standards from the World Professional Association for Transgender Health (WPATH).[12] Further, BOP data demonstrated a significant over-representation of transgender persons in restrictive housing settings, often for safety instead of disciplinary reasons.

27. Individuals with gender dysphoria experience significant clinical distress and, as noted previously, are at increased risk for suicide. Before BOP implemented national policy that was consistent with the accepted practices in the care and management of transgender people in prison settings, it was my experience that transgender individuals in BOP custody were more likely to require services to manage mental health crises than incarcerated individuals who are not transgender. In cases of severe gender dysphoria, risks included attempts at self-surgery and suicide.

28. Thus, in 2016, BOP began to develop national policy and guidance on the management and treatment of transgender persons in custody. This meant that, consistent with BOP labor relationships agreements, agency leadership began meeting with union representatives to develop what would be published in January 2017 as the Transgender

[12] World Professional Association for Transgender Health. Standards of care. Retrieved from https://wpath.org/publications/soc8/

Offender Manual (TOM).[13] [14]

29. Until recently, all policies issued by BOP underwent significant negotiation and review by both management and bargaining unit staff. Following several months of this review, the first TOM provided a great deal of information and direction to BOP staff. In addition to providing definitions, the policy set requirements for training, accommodations, pronoun usage, medical treatment, and housing placement.

30. I worked alongside the person leading TOM policy development, providing input specific to treatment and later helping her ensure implementation. Speaking about policy development, she described it as, "just a safe practice that comported with the law."[15] The key components of the policy were identifying how to implement accepted practices and ensuring any gender affirming services were provided based on individual need.

31. The TOM also established clear parameters around a decision-making body, known as the Transgender Executive Council (TEC). Membership on this body included senior leaders from the Women and Special Populations Branch as well as the senior psychologist, psychiatrist, security expert, and medical administrator in the

[13] DOJ-BOP. (2017, 2018, 2020). Program Statement 5200.08, Transgender Offender Manual.
[14] The TOM was updated two times. The first update clarified factors in placement and the second elucidated surgery processes. The BOP has since deleted all versions of the TOM from its website as a result of President Trump's Executive Order. The most recent version, dated Jan. 13, 2022, is preserved and available at https://perma.cc/4BP6-YWRP and **is attached as Exhibit B**.
[15] Schwartzapfel, B. (January 23, 2025). *Trump's Order Takes Aim at Transgender People in Prison*. The Marshall Project.

agency.

32. Although BOP had provided mental health and medical care before the TOM was issued, once the policy was in place, national administrators began to roll out training and supports for staff to ensure implementation was done with fidelity. Training was delivered to all employees, and advanced continuing education sessions were delivered to clinicians who delivered therapy or prescribe hormones.

33. In keeping with these efforts to ensure treatment was tied to evidence and that guidance was available, the BOP's Health Services Division also created a Transgender Clinical Care Team (TCCT) made of experienced medical professionals who could offer guidance to prescribers working in the prisons who may not have expertise in endocrinology or the prescription of hormones. Importantly, clinical assessments for hormone medication or other medical treatments included assessments by both psychologists and medical providers for the presence of gender dysphoria. In other words, to receive medical treatment, a person must actually have a condition warranting such an approach. Hormones or surgeries were provided only based on individual clinical need. **Attached as Exhibit C** are the most recent version of the clinical guidelines for health care staff, dated June 2023. Again, these guidelines were taken down from the BOP website after President Trump's Executive Order, but are also preserved at https://perma.cc/U5UT-S9PN. These clinical guidelines were an update of the previous guidelines from health care staff that had been operative since December 2016.

34. At the same, mental health procedures were developed to guide psychologists in the best ways to treat transgender people. While psychologists do not

prescribe medication in BOP, they were taught the benefit of gender affirming care, including hormones, in improving safety and wellbeing. This same information was conveyed to all staff because gender affirming care can reduce distress.

35. Support groups and other types of mental health treatment were also developed, eventually becoming part of BOP's list of approved programs under the First Step Act.

36. Accommodations were also described in policy, again as ways to better care for and manage the inmate population. Accommodations included allowing for the use of preferred pronouns and the provision of undergarments to match gender identity. Individuals were also given the option to purchase gender affirming items other than medication and undergarments that were allowed inside prison but required the use of personal funds (such as make-up). As noted, these items were intended to improve individual functioning, decrease crises, and therefore not only improve individuals' health but also make prisons safer.

37. Finally, the TOM created clear processes and benchmarks for a transgender individual to potentially be housed at a facility that aligns with their gender identity. The TOM took an approach grounded in safety where decisions were made by the TEC based on a number of factors and requirements.

38. Within a few years of the TOM's issuance in January 2017, BOP staff had fully implemented the policy. Gender affirming care was consistently available when indicated, and transgender people were afforded greater opportunities for engagement and positive programming that reduced psychological distress, reduced sexual

victimization, increased personal and institutional safety, and improved reentry outcomes. Agency policies direct consistent practice across all components and are reinforced by positive outcomes, and the TOM was no different.

DISCUSSION AND ANALYSIS OF RECENT BOP POLICY CHANGES

39. In early 2025, BOP abruptly rescinded a number of policies, including the TOM, following a Presidential Executive Order. BOP staff were suddenly operating without a policy but no guidance about what services or practices were supposed to replace the policy.

40. On February 21, 2025, Dana DiGiacomo, Acting Assistant Director of the BOP Reentry Services Division, and Shane Salem, Assistant Director of the BOP Correctional Programs Division, two individuals with whom I worked at BOP, issued a memo clarifying that BOP had been temporarily blocked by legal action from removing medical and mental health care from transgender persons in custody, but was proceeding with other restrictions. (This memo is filed with the Court at Docket 1-1.) Specifically, the aforementioned accommodations of gender affirming pronouns, undergarments, and purchased personal items were to cease. Additionally, programs for transgender persons and training on accepted practices with them stopped. Finally, the TEC itself was renamed and repurposed. Despite being authored by two individuals with no professional expertise on transgender care and no clinical degrees, the memo also indicated the TEC would no longer refer people for surgery.

41. A week later, Chris Bina, a pharmacist who leads BOP's Health Services Division, issued a memo stating no BOP funds could be used to treat any transgender

person in a way that validates their gender identity. It specifically states that "no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex." (This memo is filed with the Court at Docket 1-2.)

42. The blanket ban on gender affirming care, is not only inconsistent with PREA and professional association guidance, it is also unsafe.

43. First, BOP's TOM was consistent with the law and medical standards. It served not only as a guide for BOP, but for other systems because it was effective.[16] The TOM was tied to PREA, whereas the new BOP approach is inconsistent with the individualized approach to housing required under PREA. Similarly, the new BOP approach is not consistent with psychological or medical association positions on the importance of delivering individualized gender affirming care and treatment to transgender persons who have a clinical need for that care.

44. Not only are these new BOP directives incompatible with accepted practices and law, they can cause significant harm and danger. Denying gender-affirming hormones to patients with a clinical need for such treatment has negative consequences, including causing or exacerbating distress and depression. Additionally, denying hormone therapy and access to other accommodations and treatments for gender dysphoria will bring about the return of the dysphoric symptoms, potentially causing

[16]Murphy, M., Et. al. (2023). *Implementing Gender-Affirming Care in Correctional Settings: A Review of Key Barriers and Action Steps for Change*. Journal of Correctional Health, 29(1).

attempts to self-castrate, self-harm, suicide, and aggression. All of these create safety concerns not only for people who are transgender, but for everyone who works or is incarcerated in the entire system. And with BOP's staffing crisis, there simply are not enough clinicians to manage the increased suicide watches and crisis, which could be deadly.[17]

45. Instead, BOP's former approach of providing gender affirming health care when indicated, as well as accommodations that support social transition under the TOM, was effective in maintaining transgender individuals' health and promoting institutional safety. Providing this care improves the agency goals of security and rehabilitation. Prohibiting such care undermines these goals.

CONCLUSION

46. BOP has the responsibility of managing and treating everyone in its custody, which means individuals with all sorts of health issues and conditions, including people who have gender dysphoria.

47. Treatment and care in BOP involves evidence-based approaches, and has

[17] Separate from the changes specific to transgender policies, BOP for years has experienced a crisis of custody and health care staffing shortages. Staffing shortages are evident across every job type, from psychologists to correctional officers. Moreover, under the new Administration, BOP announced that it will "greatly reduce, and in some cases eliminate, retention incentives across the agency, effective March 23, 2025." *See* Testimony of Kathleen Toomey, BOP Associate Deputy Director, before the U.S. House Appropriations Subcommittee on Commerce, Justice, Science, and Related Agencies during a hearing on Oversight of the Federal Bureau of Prisons, Feb. 26, 2025, at https://docs.house.gov/meetings/AP/AP19/20250226/117920/HHRG-119-AP19-Wstate-ToomeyK-20250226.pdf. This cut in salaries is likely to worsen staffing problems. As a result of these staffing shortages, all incarcerated individuals – not only those who are transgender - are likely to receive less medical and mental health care than they need.

always been individualized. Not only does it comport with the law, but it is also an accepted practice to provide treatment and accommodations based on individual factors. Prisons that support individual needs are safer and have fewer crises. I have grave concerns about the well-being of transgender individuals in BOP custody and the continued safe operations within BOP, should its ban on providing individualized care to transgender persons continue.

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

Executed on this 17th day of March, 2025.

Cathy Thompson, PhD.

Dr. Cathy Thompson

EXHIBIT A

EXHIBIT A – RESUME OF CATHY THOMPSON

EDUCATION

Ph.D. in Clinical Psychology – Texas Tech University (APA Accredited), 2000
Dissertation: Gender Effects, Consistency, and Assessment in Coping
Licensed Clinical Psychologist – Texas State Board of Examiners of Psychologists (Since 2002)

M.A. in Clinical Psychology – Texas Tech University (APA Accredited), 1996

B.A. in Psychology (Summa Cum Laude) – Texas Tech University, 1992
Minor: Family Studies
Member of Psi Chi & National Golden Key Honor Society

PROFESSIONAL EXPERIENCE

2025 - Present
Consultant
AMM Solutions
Washington D.C.

Provide consultation, training and subject matter expertise to include investigative support, litigation support and expert witness testimony on a wide range of correctional and mental health topics. Analyze complaints to develop mitigation reports or strategy guidance. Deliver workshops and design curricula and interventions.

2024 - Present
Clinical Psychologist, Owner
Thompson & Associates Psychological Services, PLLC
North Richland Hills, TX

Provide comprehensive psychological services to a diverse client population. Administer psychological assessments to inform diagnosis and individualized treatment planning. Conduct individual therapy sessions for clients dealing with anxiety, depression, trauma, and relationship issues using evidence-based interventions. Offer expert guidance on substance use treatment, stress management, and behavioral interventions.

2024 - Present
Trainer and Consultant
The Change Companies
Carson City, NV

Develop and deliver training on evidence-based interventions, program fidelity, and best practices in behavioral health treatment. Consult with organizations and professionals to enhance the implementation of evidence-based practices in behavioral health and substance use treatment. Facilitate workshops and provide expert guidance on treatment effectiveness, compliance, and program development strategies.

2018 - 2023
National Chief of Drug Treatment Programs/Acting National Psychology Services Administrator
Federal Bureau of Prisons (Department of Justice)
Washington, D.C.

Responsible for coordinating and evaluating all services and activities of the agency's substance use treatment programs (both residential and non-residential) for federal offenders incarcerated in over 120 correctional facilities. Coordinated a system of technical assistance and training to ensure compliance with policy and best standards of clinical practice as related to all facets of correctional psychology. Analyzed information and provided recommendations for the formulation, establishment, or modification of program objectives, plans, and policies. Managed a $15M+ budget and supervised a diverse team of psychologists, clinicians, and administrative staff. Responded to high-level inquiries from various oversight bodies, including the Government Accountability Office (GAO) and the Office of the Inspector General (OIG). Served as senior agency psychologist on Transgender Executive Committee.

2015 - 2018
Supervisory Psychology Treatment Program Coordinator
Federal Bureau of Prisons (Department of Justice)
Washington, D.C.

Led teams of subject matter experts who provided on-site technical assistance and training to ensure compliance with policy and best standards of clinical practice as related to all facets of correctional psychology. Supervised a multidisciplinary team, including psychologists, clinicians, and administrative personnel. Spearheaded a major update of the agency's data analysis system to enhance tracking and ensure program utilization targets were met.

2013 - 2015 Psychology Treatment Program Coordinator
Federal Bureau of Prisons (Department of Justice)
Annapolis Junction, MD

Provided on-site technical assistance and training to ensure compliance with policy and best standards of clinical practice as related to all facets of correctional psychology. Served as the Employee Assistance Program Coordinator for Regional Office staff,

providing support and resources to enhance employee well-being. Engaged in staff recruitment efforts to attract and retain top talent within the agency.

2009 - 2013
Transitional Drug Abuse Program Coordinator
Federal Bureau of Prisons (Department of Justice)
Annapolis Junction, MD

Responsible for the procurement and administration of over 45 contracts for community-based substance use, mental health, and sex offender treatment, ensuring compliance with regulations, performance standards, and fiscal accountability. Managed a $15M+ budget and supervised a diverse team of clinicians and administrative staff.

1999 - 2009 Additional Roles

Federal Bureau of Prisons (Department of Justice)

Internship Program Coordinator – Developed and implemented a pre-doctoral psychology internship program, gaining agency approval. Coordinated site registration, designed training rotations, and authored the Internship Brochure and Training Manual. Managed application reviews, interview processes, and applicant ranking. Provided clinical and administrative supervision of interns and psychologists.

Challenge Program Coordinator – Managed a large residential treatment program for high- security male offenders, addressing substance use and mental health needs. Provided therapy, crisis intervention, psychological evaluations, and suicide risk assessments for all incarcerated individuals, including women, transgender people, and veterans. Provided clinical and administrative supervision of subordinate staff.

Step-Down Program Coordinator – Managed a large residential treatment program for severely mentally ill male offenders. Provided therapy, crisis intervention, psychological evaluations, and suicide risk assessments for all incarcerated individuals, including special populations such as transgender people and veterans. Provided clinical and administrative supervision of subordinate staff.

Drug Abuse Program Coordinator – Managed a non-residential drug abuse program at a medium-security federal prison. Provided individual and group therapy, crisis intervention, and suicide risk assessments. Served as a Mental Health Consultant for the Hostage Negotiation Team. Provided clinical and administrative supervision of subordinate staff.

Post-Doctoral Psychologist – Conducted individual and group psychotherapy for male offenders. Completed forensic evaluations to determine competency and responsibility.

Managed the Suicide Prevention Program, conducted extensive audits of departmental operations, delivered staff training, and consulted with Human Resources regarding hiring of qualified personnel.

TEACHING EXPERIENCE

Contributing Faculty – Adtalem Global Education (2004–Present)
Responsible for instructing graduate foundational and advanced graduate psychology courses, serving as dissertation committee member, and overseeing practicum/internship field experiences.

Adjunct Instructor – South Plains Junior College (1995–1999)
Responsible for all phases of teaching undergraduate General Psychology and Human Growth and Development courses, including the preparation and administration of lectures, construction and administration of examinations, and the computation and assignment of course grades. Lecture format with approximately 25 undergraduate students per semester. Fourteen sections taught.

Adjunct Instructor – Texas Tech University (1995–1997)
Responsible for all phases of teaching a senior-level undergraduate Abnormal Psychology course, including the preparation and administration of lectures, construction and administration of examinations, and the computation and assignment of course grades. Lecture format with approximately 50 undergraduate students per semester. Five sections taught.

PROFESSIONAL AFFILIATIONS

Member, American Psychological Association (APA) (Since 1995)
Member, APA Division 18: Psychologists in Public Service (Since 2000)

PUBLICATIONS & PRESENTATIONS

Publications:
Cook, S. W., Thompson, C. L., & Coca-Lyle, V. A. (2000). The psychology of stress and coping. In Management of Stress and Eating Disorders for Women and Children
(2nd ed.), CRC Press.

Selected Presentations:
Thompson, C. L. (2023, August). Substance use disorders and treatment options for justice-involved populations. Presentation given at the 2023 National Pretrial Services Leadership Conference.
Thompson, C. L. (2022, August). Meeting the needs of incarcerated women: Best

practices. Presentation given at the American Psychological Association National Convention, Minneapolis, MN.

Thompson, C. L. (2021, November). Treatment of substance use and associated mental illness in the federal prison system in the United States. Presentation given at the United Nations Office on Drugs and Crime technical consultation.

Thompson, C. L. (2019, August). Federal Bureau of Prisons: Drug abuse programs. Presentation given at the American Psychological Association National Convention,
Chicago, IL.

Thompson, C. L. (2012, May). Evolving perspectives on reentry. Presentation given at the 2012 Mid-Atlantic Regional Contractors Conference, Nashville, Tennessee.

Thompson, C. L., & Cook, S. W. (2000, August). Dispositional versus situational assessment, consistency, and gender effects in coping. Poster presentation given at the American Psychological Association National Convention, Washington, DC.

KEY SKILLS & EXPERTISE

Clinical Psychology & Mental Health

Licensed clinical psychologist with over 20 years of experience

Expertise in psychological assessments, therapy, and crisis intervention

Expertise in special populations, including women, veterans, and transgender people

Specialized in substance use treatment, trauma, and evaluations

Corrections & Criminal Justice

Extensive career in the Federal Bureau of Prisons, holding leadership roles

Developed and managed residential and non-residential treatment programs for incarcerated individuals

Expertise in correctional policy, reentry programs, and offender rehabilitation

Program Development & Administration

Designed and implemented large-scale treatment programs for diverse correctional populations and settings

Managed budgets exceeding $15M and supervised multidisciplinary teams

Developed training curricula for behavioral health professionals

Ensured policy compliance and program effectiveness through auditing and technical assistance

Leadership & Executive Management

Served as National Chief of Drug Treatment Programs for the Federal Bureau of Prisons

Led national teams of psychologists, clinicians, and administrative staff

Provided expert consultation and support in correctional psychology
Experienced in soliciting, awarding, and managing federal contracts

Teaching & Academic Contributions
Contributing faculty member for graduate psychology programs since 2004
Extensive experience in curriculum development and dissertation advisement
Taught undergraduate and graduate courses in psychology for multiple institutions

Public Speaking & Expert Testimony
Speaker at national and international conferences on substance use, reentry, and correctional psychology
Presented at the American Psychological Association National Convention and United Nations Office on Drugs and Crime
Provided expert witness testimony and consultation on legal cases involving mental health and corrections

Publications & Research
Published works in psychology and behavioral health, focusing on stress, coping, and substance use disorders
Conducted research on gender effects in coping and correctional psychology

Dr. Thompson's expertise spans clinical psychology, correctional mental health, program administration, and policy development, making her a leader in the field of correctional psychology and behavioral health treatment.

EXHIBIT B

U.S. Department of Justice
Federal Bureau of Prisons

P R O G R A M S T A T E M E N T
OPI: RSD/WASPB
NUMBER: 5200.08
DATE: January 13, 2022

Transgender Offender Manual

/s/
Approved: M.D. Carvajal
Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

To ensure the Bureau of Prisons (Bureau) properly identifies, tracks, and provides services to the transgender population.

a. Program Objectives. Expected results of this program are:

- This policy provides guidance to staff in dealing with the unique issues that arise when working with transgender inmates.
- Institutions ensure transgender inmates can access programs and services that meet their needs as appropriate, and prepare them to return to the community.
- Sufficient resources will be allocated to deliver appropriate services to transgender inmates.
- Staff will complete training, enabling them to work effectively with transgender inmates.
- To enhance staff's understanding of the increased risk of suicide, mental health issues and victimization of transgender inmates.

b. Summary of Changes

Rescinded P5200.04 CN-1 Transgender Offender Manual (5/11/2018)

This reissuance incorporates the following modifications:

- Clarified duties and responsibilities of various staff.
- Added an institution requirement for maintaining a copy of the Case Management Activity (CMA) Assignment form BP-A1110, Consent Form for Transgender Inmates. Inmates can no longer request to have a CMA assignment removed, and then re-added at a later date.
- Clarified transfer, consultation, and program requirements.

- Updated guidance regarding initial designation and redesignation procedures for transgender offenders.
- Added information about gender affirming surgery.

c. **Institution Supplement**. None required. Should local facilities make any changes outside changes required in national policy or establish any additional local procedures to implement national policy, the local Union may invoke to negotiate procedures or appropriate arrangements.

2. DEFINITIONS

Gender – a construct used to classify a person as male, female, both, or neither. Gender encompasses aspects of social identity, psychological identity, and human behavior.

Gender identity – a person's sense of their own gender, which is communicated to others by their gender expression.

Gender expression – includes mannerisms, clothing, hairstyle, and choice of activities.

Gender nonconforming – a person whose appearance or manner does not conform to traditional societal gender expectations.

Transgender – the state of one's gender identity not matching one's sex assigned at birth. For the purposes of this policy, a transgender inmate is one who has met with a Bureau Psychologist and signed the form indicating consent to be identified within the agency as transgender. This step allows accommodations to be considered.

Cisgender – the state of one's gender identity matching one's sex assigned at birth.

Sexual orientation – the direction of one's sexual interest towards members of the same, opposite, or both genders (e.g., heterosexual, homosexual, bisexual, asexual). Sexual orientation and gender identity are not related.

Gender Dysphoria (GD) – a mental health diagnosis currently defined by DSM-5 as, "A strong and persistent cross-gender identification. It is manifested by a stated desire to be the opposite sex and persistent discomfort with his or her biologically assigned sex." Not all transgender inmates will have a diagnosis of GD, and a diagnosis of GD is not required for an individual to be provided services.

Intersex – a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical physiological definitions of male or female. Not all intersex people identify as

transgender; unless otherwise specified, this policy does not apply to intersex people who do not identify as transgender.

Transition – measures that change one's gender expression or body to better reflect a person's gender identity.

Gender Affirming – describes behaviors or interventions that support the gender identity of a person.

3. STAFF RESPONSIBILITIES

The following Bureau components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for transgender offenders.

a. Central Office

(1) The **Women and Special Populations Branch (WASPB)** is the agency's primary source and point of contact on accommodation/transition, classification, management, and intervention/treatment programs and practices for transgender inmates in Bureau custody. The Branch is responsible for the following functions as they relate to transgender inmates:

- Engaging stakeholders, including serving as the primary point of contact on issues affecting transgender inmates with external entities including judges, congress, and advocacy groups.
- Ensuring the Bureau offers appropriate services to transgender inmates.
- Preparing budget requests to deliver national and pilot programs or services affecting transgender inmates.
- Providing guidance and direction to staff and institution, region, and agency leadership on transgender issues.
- Developing and implementing staff training on transgender issues.
- Building a research-based foundation for the Bureau's work with transgender inmates, including implementation support and intervention services.
- Presenting at internal and external conferences/events regarding the agency's transgender inmates' practices.
- Developing and monitoring monthly reports on the transgender population and institutional programs.
- Conducting an annual survey of transgender inmates in the Bureau and sharing results with internal and external stakeholders.
- Providing national oversight of pilot programs and initiatives serving transgender offenders.
- Overseeing the Transgender Executive Council (TEC).
- Ensure that a National Program and Policy Coordinator is assigned to each Region who will meet quarterly to discuss staffing and programming needs of transgender inmates.

(2) The **Health Services Division** oversees all medical and psychiatric guidance and treatment as it applies to transgender inmates. Clinical guidance on the most current research-driven clinical medical and psychiatric care of transgender inmates will be provided at the direction of the Medical Director. The Medical Director only receives referrals from the TEC and determines whether gender affirming surgery requests will be referred to a surgeon.

(3) The **Psychology Services Branch** oversees all mental health programs and services as they apply to transgender inmates, to include providing advice and guidance on identification and evaluation of transgender inmates, and making recommendations for treatment needs of transgender inmates and/or inmates with GD.

(4) **Central Office Branches** of Correctional Services, Psychology Services, Education, Correctional Programs, Reentry Affairs, Residential Reentry Management, Health Programs, Litigation, Chaplaincy Services, Intelligence and Counter Terrorism Branch, and Trust Fund meet annually with the Women and Special Populations Branch to discuss transgender population needs and evaluate current gender-responsive services. The National Union and the Central Office LGBT Special Emphasis Program Manager will be invited to attend these meetings.

(5) The **Transgender Executive Council (TEC)** will consist of senior level staff members (GS-14 and above) from the Women and Special Populations Branch, the Psychology Services Branch, Health Services Division, and the Designation and Sentence Computation Center (DSCC). The team is led by the Senior Deputy Assistant Director, Reentry Services and also includes the Senior Deputy Assistant Director, Correctional Programs Division (DSCC), and the Senior Deputy Assistant Director, Health Services. The TEC is the agency's official decision-making body on all issues affecting the transgender population. It will meet a minimum of monthly to offer advice and guidance on unique measures related to treatment and management needs of transgender inmates and/or inmates with GD, including training, designation issues, and reviewing all transfers for approval. Staff or inmates may raise issues on specific inmates to the TEC through the Women and Special Populations Branch. The Office of General Counsel is consulted as needed.

b. Regional Offices

- Provide oversight to institutions regarding services and other relevant trends managing transgender inmates.

c. Institutions

The Warden will establish a multi-disciplinary approach to the management of transgender inmates. The Associate Warden of Programs is the primary point of contact in the institution for transgender issues and will consult as needed with the Chief Psychologist, Captain, Clinical

Director, Unit Manager, or other individuals as appropriate; and specifically to:

- Ensure transgender inmates have access to services.
- Enter tracking information for self-identified transgender inmates by updating SENTRY CMA assignments and other databases (e.g., PDS).
- Maintain a copy of the Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110) in the Central File and Psychology Data System (PDS).
- Provide appropriate reentry resources that may be specific to the population.
- Advise the Local Union of transgender inmate management issues.
- Consult and refer transgender inmates to the TEC.
- Provide programming developed by the Reentry Services Division for transgender inmates.

4. STAFF TRAINING

Staff are provided specialized training in working with unique issues when managing transgender inmates as part of annual training. Institutions housing transgender inmates should provide additional training.

The Women and Special Populations Branch is responsible for developing training materials and current information on the management of transgender inmates. This information will be made available to staff via the Bureau's intranet.

In addition, the Prison Rape Elimination Act (PREA) regulations incorporated into the BOP Program Statement, **Sexually Abusive Behavior Prevention and Intervention Program** have training requirements concerning pat searches and communication skills for transgender inmates. See 28 C.F.R. § 115.15(f) and 115.31 (a) (9). Please refer to this Program Statement regarding implementation of those training requirements.

Staff will be provided adequate time to complete these trainings during duty hours. Staff will be provided proper relief to complete the training.

5. INITIAL DESIGNATIONS

The PREA regulations (section 28 C.F.R. § 115.42 (c)), incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program**, state:

"In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates…the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems."

Upon receipt of information from a Pre-Sentence Report, court order, U.S. Attorney's Office, defense counsel, the offender, or other source that an individual entering BOP custody is

transgender or intersex, designations staff will refer the matter to the TEC.

Institution staff managing pretrial or holdover offenders must also refer cases to the TEC for review. Any TEC recommendations concerning pretrial inmates will be coordinated with the appropriate United States Marshals Service District Office.

The TEC will consider factors including, but not limited to, an inmate's security level, criminal and behavioral/disciplinary history, current gender expression, programming, medical, and mental health needs/information, vulnerability to sexual victimization, and likelihood of perpetrating abuse. The TEC may also consider facility-specific factors, including inmate populations, staffing patterns, and physical layouts (e.g., types of showers available). The TEC will consider the wellbeing of all inmates while exploring appropriate options available to assist with mitigating risk to the inmate, to include but not limited to cell and/or unit assignments, application of management variables, programming missions of the facility, and security of the institution.

It will be documented on all SENTRY designation notes for transgender inmates that the TEC reviewed the inmate for appropriate institution designation.

6. HOUSING AND PROGRAMMING ASSIGNMENTS

During Initial Classification and subsequent Program Reviews, unit management staff will review the inmate's current housing unit status and programming available for transgender inmates. This review will be documented by Unit Management staff in the inmate central file and for holdovers in the holdover file, with institution oversight by the Associate Warden.

The reviews will consider on a case-by-case basis that the inmate placement does not jeopardize the inmate's wellbeing and does not present management or security concerns.

In making housing unit and programming assignments, a transgender or intersex inmate's own views with respect to his/her own safety must be given serious consideration.

Transgender inmates shall be given the opportunity to shower separate from other inmates when individual shower stalls are unavailable.

The agency shall not place transgender or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status. The only exception is if such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

Wardens will consult with WASPB prior to submitting a designation request to the DSCC for the redesignation of transgender inmates when the designation is related to the individual's

transition. The DSCC and Office of Medical Designations will consult with WASPB prior to the designation or redesignation of all transgender inmates.

In situations where the transfer request is related to progressing the individual inmate's transition (i.e., transfer to a different sex facility) the TEC will consider the case. Prior to considering the case, the Warden will submit documentation to the TEC showing the inmate has met the minimum standards of compliance with programs, medications and mental health treatment, and meeting hormone goal levels. Ordinarily, inmates will not be submitted to the TEC for consideration until they have maintained one year clear conduct for 100 and 200 series incident report sanctions, though they may be considered for submission on a case-by-case basis by the Warden, as appropriate.

It will be noted in all SENTRY designation notes that the TEC reviewed the inmate for appropriate institution designation.

7. DOCUMENTATION AND SENTRY ASSIGNMENTS

The PREA regulations in 28 C.F.R. part 115, Subpart A, incorporated into the Program Statement **Sexually Abusive Behavior Prevention and Intervention Program** and the Program Statement **Intake Screening,** address intake screening. Screening of transgender inmates will be conducted in accordance with these policies and all other applicable policies and procedures.

a. Medical and Mental Health Information. Medical and mental health information for transgender inmates will be maintained in the current electronic recordkeeping system or health record system in accordance with the Program Statements **Health Information Management and Psychology Services Manual**. Medical and mental health information is considered confidential, and may only be released in accordance with appropriate laws, rules, and regulations.

b. Initial Screening. For initial designations, staff will assign Case Management Activity (CMA) SENTRY assignments if information in the PSR or other documentation indicates a likely transgender identity. The screening codes are:

SCRN M2F – inmate should be screened for male to female transgender identification.
SCRN F2M – inmate should be screened for female to male transgender identification.

Any inmate arriving at the designated institution with a screening code is to be referred to the Chief Psychologist or designee for review within 14 days. If the code was assigned in error, the screening code will be removed by the Psychologist. If the inmate identifies as transgender, the psychologist will replace the screening code with an identifying code, as indicated below. Holdover facilities are exempt from this initial screening requirement, as limited available

records and brevity of stay do not typically allow for a comprehensive screening.

Any inmate who arrives without a screening code but identifies as transgender during intake, or at any time during the incarceration period, is referred to the Chief Psychologist or designee and interviewed within 14 days of the inmate notification. Inmates in pretrial status at Bureau facilities may also receive a transgender screening CMA SENTRY assignment.

c. Notification to Staff and Tracking. After consultation with Psychology Services, and if the inmate affirms his/her transgender identity, the screening code will be updated to a permanent assignment by a Psychologist:

TRN M2F – inmate identifies as male to female transgender (transgender female).
TRN F2M – inmate identifies as female to male transgender (transgender male).

The inmate must request to Psychology Services staff that the Case Management Activity (CMA) assignment be entered, and the inmate consents that all staff will therefore be notified that the individual is transgender. The inmate's request will be documented on a Case Management Activity (CMA) SENTRY Assignment Consent Form for Transgender Inmates (BP-A1110). Psychology Services shall maintain the form in the electronic mental health record.

Staff should consult the transgender CMA assignment when interacting with the inmate; e.g., use of pronouns and access to accommodations. All inmates have access to transgender treatment, regardless of assignment.

If there are questions about the need to continue a CMA assignment, the Warden will contact the WASPB. Inmates may request in writing to have CMA assignments removed. If this occurs, ordinarily the assignment will not be re-added at a later date.

8. HORMONE THERAPY AND MEDICAL TREATMENT

Hormone therapy or other medical treatment may be provided after an individualized assessment of the requested inmate by institution medical staff. Medical staff will request consultation from Psychology Services regarding the mental health benefits of hormone or other medical treatment. If appropriate for the inmate, hormone treatment will be provided in accordance with the Program Statement **Patient Care** and relevant Clinical Guidance. Questions concerning hormone treatment may be referred to the WASPB or the Health Services Division.

In the event this treatment changes the inmate's appearance to the extent a new identification card is needed, the inmate will not be charged for the identification card as is standard practice.

9. SURGERY

While not all inmates who identify as transgender may be interested in seeking surgical intervention, such a decision does not preclude them from obtaining other accommodations as described in this Program Statement. For transgender inmates in Bureau custody, surgery may be the final stage in the transition process and is generally considered only after one year of clear conduct and compliance with mental health, medical, and programming services at the gender affirming facility. Once that period elapses, an inmate may submit a request to his or her Warden requesting surgical consideration. The Warden will forward the request to the TEC. The TEC is the sole body who may determine that all milestones and individual goals for surgical consideration have been met. When this occurs, the case is referred to the agency's Medical Director for medical consideration. He or she may review existing records and/or interview the inmate, institution staff, and members of the TEC. After this individualized assessment, the Medical Director will determine if the surgery is medically appropriate for referral to a gender affirming surgeon.

10. OTHER MENTAL HEALTH SERVICES

Bureau Psychologists provide assessment and treatment services for transgender inmates, as appropriate. Guidance on assessment procedures is available on the Psychology Services intranet page.

If an inmate identifies as transgender, the Psychologist will provide the inmate with information regarding the range of treatment options available in the Bureau and their implications. In addition, based upon the Psychologist's preliminary assessment and the inmate's expressed interest, a referral to the Clinical Director and/or Chief Psychiatrist may be generated. While the initial interview must be scheduled within 14 days, an assessment may take longer in some instances.

In addition to a referral for medical services, a transgender inmate may be offered individual psychotherapy. Individual psychotherapy goals might include: (1) helping the inmate to live more comfortably within a gender identity and deal effectively with non-gender issues; (2) emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin; (3) seeking to define and address issues that may have undermined a stable lifestyle, such as substance abuse and/or criminality; and (4) addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may also be present; any effective treatment plan will fully address these symptoms. Group treatment may also be recommended.

Common concerns of transgender inmates, which can be addressed effectively in a group setting, include self-esteem issues and relationship issues.

Psychologists who provide mental health treatment for transgender inmates address all mental health needs, including suicide risk, if present. If an inmate who identifies as a transgender harms, attempts to remove, or removes his or her genitalia or other gender-specific anatomy, a suicide risk assessment is conducted consistent with the Program Statement, Suicide Prevention Program. In addition, the treating psychologist notifies the Chief Psychologist who in turn notifies the Regional Psychology Services Administrator and the Psychology Services Branch.

Psychologists working with transgender inmates are encouraged to consult the Reentry Services Division in Central Office for additional resources.

11. SPECIAL POPULATIONS SERVICES

Some facilities have Special Populations Coordinators on staff. These individuals are responsible for delivering First Step Act and other programs, which includes programs developed specifically for inmates who identify as transgender. In the absence of such staff, the Warden will seek consultation from WASPB regarding the delivery of group interventions and services.

12. PRONOUNS AND NAMES

Staff interacting with inmates who have a CMA assignment of transgender, shall either use the authorized gender-neutral communication with inmates (e.g., by the legal last name or "Inmate" last name) or the pronouns associated with the inmate's identified gender. Deliberately and repeatedly mis-gendering an inmate is not permitted.

The name entered on the inmate's Judgment and Commitment Order is the official committed name for all Bureau records (incident reports, progress reviews, sentence calculations, etc.). An official committed name change while in BOP custody must be done consistent with the Program Statement **Correctional Systems Manual.** Any additional names or aliases should be entered into SENTRY, as appropriate.

13. PAT SEARCH ACCOMMODATIONS

Pat searches of transgender inmates will be conducted in accordance with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

Pat search information refers only to individuals at male facilities who identify as female. The Bureau does not offer "male only" pat searches.

Unless there is a history of inappropriate sexual behavior suggesting approval poses risks to staff, requests are ordinarily approved by the Warden's Office. Inmates may request denials be reviewed by the TEC through the Administrative Remedy Program. Inmates who are granted this exception under policy may have it reversed by the Warden if found to have violated

institution rules concerning contraband.

In exigent circumstances, any staff member may conduct a pat search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

14. VISUAL SEARCHES

For purposes of a visual search, inmates will be searched in accordance with the gender of the institution, or housing assignment, to which they are assigned. The visual search shall be made in a manner designed to ensure as much privacy to the inmate as practicable. Staff should consider the physical layout of the institution, and the characteristics of an inmate with a transgender CMA assignment, to adjust conditions of the visual search as needed for the inmate's privacy.

Transgender inmates may also request an exception to be visually searched by a staff member of the inmate's identified gender. The exception must be pre-authorized by the Warden, after consultation with staff from Health Services, Psychology Services, Unit Management, and Correctional Services. Exceptions must be specifically described (e.g., "visual search only by female staff"), clearly communicated to relevant staff through a memorandum, and reflected in SENTRY (or other Bureau database). Inmates should be provided a personal identifier (e.g., notation on identification, etc.) that indicates their individual exception, to be carried at all times and presented to staff prior to visual searches.

Inmates request an exception by submitting an Inmate Request to Staff (BP-A0148) to the Warden. The Warden will consult with the departments listed above, and the memo approving or denying the request will be generated by the Warden's Office. Inmates may request denials be reviewed by the TEC through the Administrative Remedy Program. Inmates who are granted this exception may have it reversed by the Warden if found to have violated institution rules concerning contraband.

Transgender inmates placed at an institution or in a housing unit that does not correspond with their identified gender, and who are granted an exemption as indicated above, will be searched by staff of the inmate's identified gender who consent to participate in the search, or Health Services clinical staff.

Transgender inmates placed at an institution or in a housing unit of their identified gender will be searched by staff of the inmate's identified gender who consent to participate in the search or medical staff.

Institutions should consider using available body scanning technology in lieu of visual searches of transgender inmates.

In exigent circumstances, any staff member may conduct a visual search of any inmate consistent with the Program Statement **Searches of Housing Units, Inmates, and Inmate Work Areas**.

15. CLOTHING, COMMISSARY ITEMS, AND OTHER ACCOMMODATIONS

Consistent with safety and security concerns, inmates with the CMA assignment of transgender will have the opportunity to have undergarments of their identified gender even if they are not housed with inmates of the identified gender. Institutional laundry will have available institutional undergarments that fulfill the needs of transgender inmates. Undergarments will not have metal components.

Standardized lists of Commissary items for transgender inmates are available in accordance with the Program Statement **Trust Fund/Deposit Manual** and the information on the RSD intranet page.

Additional items based on an individualized assessment of the transgender inmate population may be approved by the Warden. Additional items may be provided by the institution or purchased by the inmate, as appropriate. Any concerns regarding such items are directed to the WASPB.

Inmates who purchase and/or are provided items under this section will be subject to disciplinary sanctions, including the removal of these items, if they are found to have violated institution rules relating to the possession of these items.

Any other accommodation requests are discussed with the TEC through the WASPB.

16. REENTRY NEEDS

In accordance with the Program Statement **Release Preparation Program**, institution staff assist transgender inmates in addressing reentry issues prior to release or placement in a Residential Reentry Center/Home Confinement.

During Initial Classification and Program Reviews, unit management formulates a pre-release plan that assists transgender inmates in obtaining identification, finding housing and employment, and providing community resources to assist with reintegration into the community.

The Reentry Affairs Coordinator will assist staff with identifying these resources. Community Treatment Services staff or Institution and/or Regional Social Workers may be contacted concerning the continuity of medical care.

The WASPB can be contacted to provide guidance and resources for any additional reentry

needs of transgender inmates. All accommodation and treatment decisions for inmates in community custody are made by the Residential Reentry Management Branch in consultation with the TEC.

17. ADMINISTRATIVE REMEDIES

Inmates who wish to seek formal review of any issue relating to this policy may use the procedures in the Program Statement **Administrative Remedy Program**.

REFERENCES

Program Statements

P1330.18	Administrative Remedy Program (1/6/14)
P4500.12	Trust Fund/Deposit Fund Manual (3/15/18)
P5100.08	Security Designation and Custody Classification Manual (9/4/19)
P5290.15	Intake Screening (3/30/09)
P5310.17	Psychology Services Manual (08/25/16)
P5310.16	Treatment and Care of Inmates with Mental Illness (5/1/14)
P5322.13	Inmate Classification and Program Review (5/16/14)
P5324.08	Suicide Prevention (4/5/07)
P5324.12	Sexually Abusive Behavior Prevention and Intervention Program (6/4/15)
P5325.07	Release Preparation Program (8/15/19)
P5521.06	Searches of Housing Units, Inmates, and Inmate Work Areas (6/4/15)
P5800.15	Correctional Systems Manual (9/23/16)
P6031.04	Patient Care (6/3/14)
P6090.04	Health Information Management (3/2/15)

Federal Regulations

28 CFR part 115

Additional Resources For Clinicians

Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version. World Professional Association for Transgender Health (WPATH) standards.

ACA Standards

■ American Correctional Association Standards for Adult Correctional Institutions, 5th Edition: 5-ACI-1C-09, 5-ACI-1D-12, 5-ACI-1D-13, 5-ACI-2C-02, 5-ACI-1D-08, 5-ACI-3D-05, 5-ACI-3D-08(M), 5-ACI-3D-09, 5-ACI-3D-10, 5-ACI-3D-11, 5-ACI-3D-12, 5-ACI-3D-13, 5-ACI-3D-14, 5-ACI-3D-15, 5-ACI-3D-16, 5-ACI-6A-21(M), 5-ACI-6A-32(M), 5-ACI-6C-14(M)

■ American Correctional Association Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2A-29, 4-ALDF-2A-32, 4-ALDF-2A-34, 4-ALDF-6B-03, 4-ALDF-2C-03, 4-ALDF-4C-22M, 4-ALDF-4C-30M, 4-ALDF-4D-22, 4-ALDF-4D-22-1, 4-

ALDF-4D-22-2, 4-ALDF-4D-22-3, 4-ALDF-4D-22-4, 4-ALDF-4D-22-5, 4-ALDF-4D-22-6M, 4-ALDF-4D-22-7, 4-ALDF-4D-22-8, 4-ALDF-7B-08, 4-ALDF-7B-10, 4-ALDF-7B-10-1.

- American Correctional Association Standards for Administration of Correctional Agencies, 2nd Edition: None.
- American Correctional Association Standards for Correctional Training Academies: None.

Records Retention

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on Sallyport.

EXHIBIT C

GENDER-AFFIRMING CARE OF TRANSGENDER AND GENDER NONBINARY PERSONS

Federal Bureau of Prisons

Clinical Guidance

June 2023

Federal Bureau of Prisons (BOP) Clinical Guidance is made available to the public for informational purposes only. The BOP does not warrant this guidance for any other purpose and assumes no responsibility for any injury or damage resulting from the reliance thereof. Proper medical practice necessitates that all cases are evaluated on an individual basis and that treatment decisions are patient-specific. Consult the BOP Health Management Resources Web page to determine the date of the most recent update to this document: http://www.bop.gov/resources/health_care_mngmt.jsp.

WHAT'S NEW IN THIS DOCUMENT

This guidance on *Gender-Affirming Care of Transgender and Gender Nonbinary Persons* is an update to the BOP Clinical Guidance on *Medical Management of Transgender Inmates*, issued in December 2016. Significant changes were made throughout this document to more closely align with community standards and the World Professional Association for Transgender Health (WPATH) *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* published in 2022. While WPATH Standards of Care were referenced when updating this guidance, deviations due to the unique correctional environment were made when necessary. The key revisions include:

- Addition of *Transition Pathway for Transgender Inmate Patients* for guidance in patient care decisions found in *Section 4* and *Appendix 1.*
- Added language in *Section 5* to describe the process for requesting designation to a cross/gender reaffirming institution according to BOP policy.
- New sections created with emphasis on care in correctional environment:
  - Preventative Health Screening (*Section 13*)
  - Minimally or Non-Invasive (*Section 14*) and Invasive [Surgical] Procedures (*Section 15*)
    - Information regarding facial hair removal expounded *(Facial Hair Removal)*
    - Including description of the use of Transgender Utilization Review Advisory Group
  - Transitions of Care (*Section 16*)

DOCUMENT ORGANIZATION

- The **ABBREVIATIONS** are now listed in a new section, *Key to Abbreviations*, preceding the appendices. (This list does not replace the list of *Definitions* in *Section 2*.)
- The appendices summarizing **HORMONE TREATMENT** have been renumbered, as follows:
  - *Appendix 2. Summary Charts for Feminizing Hormone Therapy*
  - *Appendix 3. Summary Chart for MASCULINIZING Hormone Therapy*
- The main body of the **MEDICATION MONITORING** guidance is now in two new appendices:
  - *Appendix 4. Monitoring During FEMINIZING Hormone Therapy*
  - *Appendix 5. Monitoring During MASCULINIZING Hormone Therapy*
- The items in the *References* section are now listed alphabetically by author or source.

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1. PURPOSE

The Federal Bureau of Prisons (BOP) Clinical Guidance for *Gender Affirming Care of Transgender and Gender Nonbinary Persons* provides recommendations for the medical management and treatment of transgender and gender nonbinary federal inmates, referred to in this guidance as *transgender* and/or *gender nonbinary* and *individual(s)*, *patient(s)*, or *person(s)*.

2. DEFINITIONS

BISEXUAL: Refers to a person attracted to both sexes.

BIGENDER: Refers to those who identify with two genders or multigender.

BOP TRANSGENDER CLINICAL CARE TEAM: A group of physicians (primary care and psychiatrists), pharmacists, and social workers devoted to advocating and advancing the treatment options for this population. The team provides education and the tools to institutional staff to develop clinical treatment plans for the TG and gender nonbinary population. This team has no authority to review, approve or disapprove gender affirming surgery referrals.

BOP TRANSGENDER EXECUTIVE COUNCIL (TEC): A group of BOP management personnel who mitigate executive level administrative gender affirming issues.

BOP TRANSGENDER UTILIZATION REVIEW ADVISORY GROUP : A group of BOP physicians, psychiatrists, pharmacists, and social workers assigned by the Medical Director to provide clinical review of gender-confirming surgical requests.

CISGENDER: denoting or relating to a person whose sense of personal identity and gender corresponds with their sex assigned at birth.

COMPLEX AND INVASIVE GENDER CONFIRMING PROCEDURES: complex and invasive medical procedures will almost always require general anesthesia, and a surgeon with advanced skills. Most of these procedures carry the inherent risk for blood loss, infection, pain, multi-day hospitalization, and post-operative complications; in this guidance, these terms refer to all procedures listed in *Table 5*, which require the approval of the Medical Director.

FEMALE-TO-MALE (FTM): Refers to a biological female who identifies as, or desires to be, a member of the male gender. The term **transgender male**, or **trans male** for short, is used to refer to the **GENDER IDENTITY** of a person who is **FTM**. (See the definition of **TRANSGENDER** below.)

GAY: Refers to a person who is romantically or sexually attracted to persons of the same gender. The term is mostly used to describe males. (See the definition of **LESBIAN** below.)

GENDER-AFFIRMING HORMONES: Hormonal therapy utilized to facilitate physiological change(s) during **TRANSITION** (see definition below). The term **CROSS-SEX HORMONES** is often utilized in the medical literature, but it is falling out of use.

GENDER-AFFIRMING SURGERY/GENDER-CONFIRMING SURGERY: The surgical component of an individual's **TRANSITION** (see definition below); these terms have replaced the outdated terminology of **SEX REASSIGNMENT SURGERY**.

GENDER BINARY: A system of viewing gender as consisting solely of two, opposite categories of gender, termed "male and female"

GENDER CONFORMITY: Behavior and appearance that adheres to the social expectations of a particular **GENDER**. (See the definition of **GENDER NONCONFORMITY** below.)

GENDER DYSPHORIA (GD): The condition of feeling that one's emotional and psychological identity as male or female is different from one's biological sex assigned at birth. **GD implies that there is a state of distress or anxiety directly related to this conflict.** In the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, released in May 2013, people whose assigned sex at birth is contrary to the one they identify with *and* who are experiencing a state of distress should be diagnosed with **GD**.

- *This diagnosis of **GD** is a revision of the criteria in the DSM-IV for **GENDER IDENTITY DISORDER (GID)** and is intended to better characterize the experiences of affected individuals. The DSM-5 no longer uses the term **GID**.*
- *A Gender Dysphoria diagnosis may be necessary in some regions to access transition-related care.*

GENDER EXPRESSION: Includes mannerisms, clothing, hair style, and choice of activities that individuals use to express their **GENDER IDENTITY**.

GENDER FLUID: A changing or "fluid" gender identity.

GENDER IDENTITY: How one identifies oneself: female, male, both, or neither. **GENDER** encompasses aspects of social identity, psychological identity, and human behavior.

GENDER NONBINARY: someone who does not identify as exclusively male or female

GENDER NONCONFORMITY (ALSO KNOWN AS GENDER NONBINARY): Behavior or appearance that does not adhere to the social expectations of a particular **GENDER**.

GENDER QUEER: Denoting or relating to a person who does not subscribe to conventional gender distinctions but identifies with neither, both or a combination of male and female genders.

INFORMED CONSENT: A patient's ability to understand the risks, benefits, alternatives, unknowns, limitations, and risks of treatment pertaining to a specific healthcare intervention.

INTERSEX: Refers to a person whose sexual/reproductive anatomy or chromosomal pattern does not seem to fit the typical biological definition of male or female.

LESBIAN: Refers to a female who is romantically or sexually attracted to other females.

MALE-TO-FEMALE (MTF): Refers to a biological male who identifies as, or desires to be, a member of the female gender. The term **transgender female**, or **trans female** for short, is used to refer to the **GENDER IDENTITY** of a person who is **MTF**. (See the definition of **TRANSGENDER** below.)

MINIMALLY INVASIVE GENDER AFFIRMING PROCEDURES: minimally invasive medical procedures are usually same day office or hospital-based procedures that may require anesthesia and break skin or enter an organ; in this guidance, this term refers to professional facial hair removal services, and other procedures typically labeled as aesthetic in a non-trans population.

NON-INVASIVE GENDER AFFIRMING TREATMENT MODALITIES: non-invasive medical modalities typically do not break skin or enter a body part; in this guidance, this term refers to treatment modalities such as voice and communication training.

PATIENT-CENTERED CARE: Care in which patients are partners with their health care providers and health care decisions are driven by the patient's specific health needs and desired health outcomes.

SEX: A biological classification based on chromosomal composition, reproductive anatomy (primary sex characteristics), and the phenotypic characteristics that develop during pubertal maturation (secondary sex characteristics).

SEXUAL ORIENTATION: The direction of one's sexual interest. It is not defined by the person's gender identity. People of the same gender identity may have different sexual orientations.

TRANSGENDER (TG) (ALSO KNOWN AS TRANSSEXUAL) OR TRANS SPECTRUM: An umbrella term used for individuals whose **GENDER IDENTITY** does not conform to the typical expectations associated with the gender they were assigned at birth. It is important to note that terminology changes often and the latter term is falling out of use.

TRANSPHOBIA: Dislike of or strong prejudice against transgender people with attitudes such as fear, discomfort, distrust, or disdain.

TRANSITION: The period during which **TG** individuals change their physical, social, and legal characteristics to the gender with which they identify. **TRANSITION** may also be regarded as an ongoing process of physical change and psychological adaptation. Individuals may want to proceed to different stages of transition.

3. INTRODUCTION & GENERAL CONSIDERATIONS

TRANSGENDER (**TG**) people are those whose gender identity is different from the sex which they were assigned at birth. **GENDER DYSPHORIA** (**GD**)—previously known as **GENDER IDENTITY DISORDER** (**GID**)—is the *discomfort or distress* caused by a discrepancy between a person's gender identity and that person's gender assigned at birth.

- TG people have many of the same health needs as the general population. They may also have other special healthcare needs.
- Not all TG person(s) will be diagnosed with GD, and a diagnosis of GD is not required for access for all TG services. According to the American Psychological Association's guidelines (see *References* section), an individual's identification as **TG or GENDER NONBINARY** can be healthy and self-affirming and is not considered pathological.
- However, some **TG or GENDER NONBINARY** individuals experience distress associated with their gender identity, their body, or their sex assigned at birth. There is also distress associated with

societal stigma and discrimination. A systematic review of studies by Valentine, et al (2018) indicates significantly higher rates of mental health morbidity compared with the general population—particularly anxiety, depression, and suicidality.

- **Gender-affirming health care involves supporting individuals through social, psychological, behavioral, or medical (including hormonal treatment or surgery) treatments—to support and affirm an individual's experienced gender identity.**

The **BOP TRANSGENDER CLINICAL CARE TEAM** . The team provides education and the tools to institutional staff to develop clinical treatment plans for the TG and gender nonbinary population. This team has no authority to review, approve or disapprove gender affirming surgery referrals. This team is composed of physicians (primary care physicians and psychiatrists), pharmacists, and social workers who are available to help institution providers. For example, when patients have medical contraindications (relative or absolute) to hormone treatments, consultation with the TCCT may be helpful. Institution staff may refer to their Regional Medical Director for a list of current team members and their contact information.

STIGMA

Stigma and prior negative experiences in institutions can contribute to healthcare disparities. Stigma commonly leads to prejudice and discrimination, which may also exacerbate mental health concerns in transgender and gender-nonconforming individuals.

Respect and trust are essential to the provider-patient relationship. Respectful language and terms should always be used, affirming the patient's experienced gender identity. Once an individual has identified as **TG**, use of pronouns or salutations preferred by the **TG** individual is appropriate, especially for those patients with a Case Management Activity (**CMA**) Sentry assignment of **TRANSGENDER** (either TRN M2F or TRN F2M; see ***TABLE 1*** below). This practice is more likely to facilitate a cooperative relationship between the **TG** individual and others, and generally reduces the stress of gender transition.

- *Using this informal approach is distinct from a legal name change while in BOP custody; a legal name change must conform to the policy requirements in the **Program Statement 5800.15 Correctional Systems Manual** (or the most recent version).*

MENTAL HEALTH CONCERNS AND SUICIDALITY

As reported by Valentine, et al (2018), a higher prevalence of depression, anxiety, and suicidality is seen among TG adults compared to the general population. It has been suggested these elevated rates are linked to complex trauma, stigma, violence, and discrimination. A recent study by Baker, et al (2021) suggests that appropriate gender-affirming care, including medical and surgical care, can lessen psychiatric symptoms. Transgender adults with **GD** are at an increased risk of suicidal ideation and suicide prior to initiation of their gender transition, regardless of the clinical endpoint of their transition - whether that endpoint is living as the psychologically identified gender, hormone therapy, cosmetic treatments, breast augmentation/removal, and/or gender-affirming surgery (Wolford-Clevenger et al 2018). For many individuals, the risk of suicide may decrease after receiving the appropriate, individualized treatment (Turban et al 2022).

COMORBID CONDITIONS

- **Anxiety and Depression:** The most common mental health conditions seen in **TG** adults are anxiety and depression. A significant interdisciplinary approach between Psychology and Health Services is always required for **TG** patient care.
  - ➔ *See BOP Program Statement 5310.16, Treatment and Care of Inmates with Mental Illness, available at https://www.bop.gov/policy/progstat/5310_16.pdf.*
- **HIV Infection:** Epidemiologic studies indicate a higher prevalence of HIV in the **TG** populations, specifically among **transgender male** persons. HIV services for TG people should address the specific biological, pathological, and social needs of this population (i.e., antiretroviral therapy, HIV prevention and care programs). Effective risk assessment requires obtaining an accurate sexual risk history, including anatomy-specific sexual behavior.
  - ➔ *See CDC's website on HIV and Transgender People, listed in the References section.*

PATIENT-CENTERED MULTIDISCIPLINARY TREATMENT APPROACH

A patient-centered multidisciplinary team approach is recommended for managing issues associated with the incarceration of TG individuals. Incarcerated individuals may present to an institution with a well-established gender identity or begin their transgender or gender nonbinary journey while incarcerated. It is important to have a system in place to allow for individualized treatment. Individuals requesting care for gender dysphoria should have access to a diverse range of treatment services. Patient-centered care explores individualized therapeutic options, which may differ from person to person.

The BOP offers **TRAUMA-INFORMED CORRECTIONAL CARE (TICC),** which incorporates an understanding that patient attitudes, behaviors, and concerns are likely to be affected by prior traumatic experiences. **TICC** includes both training and treatment programs, emphasizes the recognition of trauma in all forms, and incorporates the principle that all staff may have a role in reducing its impact.

HOUSING ASSIGNMENTS, PROGRAM ASSIGNMENTS, AND PAT SEARCHES

- ➔ *Refer to the current version of BOP **Program Statement 5324.12, Sexually Abusive Behavior Prevention and Intervention Program**, available at https://www.bop.gov/policy/progstat/5324_012.pdf*
- ➔ *Refer also to the BOP **Program Statement 5200.08 Transgender Offender Manual**, available at https://www.bop.gov/policy/progstat/5200-08-cn-1.pdf*

PRISON RAPE ELIMINATION ACT (PREA)

Per the national Prison Rape Elimination Act (PREA) Resource Center, *being transgender is a known risk factor for being sexually victimized in confinement settings.* Consequently, PREA regulations and BOP Program Statements provide ways to protect the transgender population through the following:

- **PREA** regulations, incorporated into **Program Statement 5324.12, Sexually Abusive Behavior Prevention and Intervention Program** (available at *https://www.bop.gov/policy/progstat/5324_012.pdf*), state that the intake screening shall assess the individual's risk of sexual victimization by considering, at a minimum, whether the individual is known or perceived to be gay, lesbian, bisexual, **TG**, intersex, or gender nonconforming.
- According to the PREA (*28 C.F.R. § 115.41 (h)*), *individuals may not be disciplined for refusing to answer, or for not disclosing complete information in response to,* [questions about being gay, lesbian, bisexual, **TG**, intersex, or gender nonconforming].
- According to the PREA (*28 C.F.R. § 115.15 (e)*), *staff shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined as appropriate during conversations with the inmate, by reviewing medical records, or, if necessary, learning that information as part of a broader medical examination conducted in private by a medical provider.*

4. TRANSITION PATHWAY FOR TRANSGENDER PATIENTS

Appendix 1 summarizes a pathway for TG patients to access gender-affirming mental health and medical care in the BOP. The order depicted in this table is not as important as the provision of individualized treatment, e.g., individuals may approach a medical professional before they approach a mental health professional and this should not preclude them or delay appropriate treatment if the medical provider is qualified in this area.

A gender dysphoria (GD) diagnosis is not necessary for hormone treatment, and TG patients may not be interested in following up with a mental health professional. However, the reverse might also occur: TG patients may seek out a mental health professional for months before they are ready to be referred for a medical evaluation. Not all gender non-binary patients will require gender-affirming hormone treatment and treatment is individualized to the patient's needs.

5. DESIGNATION TO A CROSS/GENDER-AFFIRMING INSTITUTION

In accordance with ***Program Statement 5200.08 Transgender Offender Manual***, transgender individuals may ask their respective warden to be considered for designation to a gender-affirming institution. All requests for designation are reviewed by the Transgender Executive Council (TEC). The memo is submitted from the Warden to the TEC indicating the patient is requesting re-designation to an institution able to provide full-time gender affirming life experiences in identified gender.

6. PRESENTATION OF GENDER NON-CONFORMITY

Gender non-conformity status is based on an individual's experienced gender identity, role, or expression differing from societal norms assigned to a particular sex. When an individual self-identifies as TG and requests referral or evaluation for treatment, an evaluation is conducted according to PS5200.08, and further referrals may be made, as clinically appropriate, to fully evaluate the individual's treatment needs.

Discussion of the following areas may be useful in helping a person describe their gender identity:

- Persistent and marked differences between experienced gender and their biologic or natal sex.
- Strong feelings about primary or secondary sex characteristics.
- Strong feelings about being treated as or becoming another gender.
- Belief that one's actions, feelings, or mannerisms are more characteristic of another gender.

Gender non-conformity often (but not always) presents with gender dysphoria, which denotes the discomfort or distress that is caused by the nonconformity of a person's gender identity, and that person's sex assigned at birth. Gender nonconformity may present in a spectrum of expressed or desired gender affirmation needs. Patients may experience:

- Strong desires to be treated as the identified gender
- Strong convictions that one has feelings and reactions typical of the identified gender
- Strong inclinations to look in a way that affirms the identified gender

Clinicians must accurately assess and document the patient's individual presentation. Attention should be given as to whether the level of distress meets criteria for a formal diagnosis of gender dysphoria, and/or if there are other coexisting mental or medical health disorders.

7. GENDER-AFFIRMING MENTAL HEALTH ASSESSMENT

When TG individuals present to mental health professionals it is important to conduct a thorough mental health evaluation. The mental health professional is encouraged to affirm the individual's experienced gender and whether there is gender dysphoria. The mental health professional should conduct a thorough evaluation including assessing for any mental health diagnosis. The clinician will develop an individualized treatment plan for the TG patient and collaborate with the medical provider.

A mental health assessment for TG individuals typically includes:

- Obtaining a gender identity history and screening for **GD**
- Screening for other mental health disorders related to mood, anxiety, autism, eating, personality, psychosis, and substance use
- Identifying a history of abuse or neglect
- Assessing any current or past self-harm ideations or attempts
- Performing an assessment of affective, cognitive, and psychosocial functioning
- Psychosocial treatment recommendations; and/or
- Medical referral, if indicated.

➔ *Please also refer to the APA's Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, listed in the References section.*

Mental Health Treatment Considerations

The mental health team plays an important role in gender-affirming care. This can include screening for mental health disorders and assisting with treatment planning. Prior to engaging in treatment, conversations regarding the individual's realistic expectations of outcome are encouraged to identify realistic goals for treatment.

➔ *A collaborative approach with both mental health and medical services staff is highly recommended.*

Patients can also be referred to psychiatry services for mental health concerns or medication management of mental illness.

- **Psychotherapy:** This is a general term for treating mental health problems; it includes a broad variety of techniques to help individuals with emotional difficulties or coexisting mental illnesses. Psychotherapy can be used to learn about and treat an individual's moods, thoughts, and behaviors. It can also be supportive to individuals experiencing distressing thoughts, feelings and/or behavior.
- **Psychiatry Services:** Individuals can also be referred to psychiatry services for mental health concerns or medication management of other mental illness in conjunction with **GD**. Appropriate pharmacotherapy is considered when indicated to optimally manage co-existing mental health concerns prior to, or concurrently with, treatment of **GD**.

Gender Dysphoria (GD) Criteria

Individuals identifying as TG or gender nonbinary do not necessarily have GD. Although data regarding the prevalence rates of **GD** in the transgender population is limited, many clinicians anecdotally report that most **TG** individuals experience some degree of dysphoria in the absence of treatment.

Because untreated or under-treated **GD** is associated with increased morbidity and mortality (Jackson et al 2023), screening for **GD** in **TG** individuals is essential. Without treatment, this population may experience higher rates of depression, anxiety, self-harm, and suicidality. Gender-affirming treatment supports TG people throughout their lifespan. Treatment modalities are designed to meet the individual's unique goals and may include social supports, mental health treatment, and medical treatment (including hormone therapy and surgery). These interventions may improve medical and psychological health, increase social support, decrease **GD**, treat mental health comorbidities, and improve TG individuals' overall quality of life**.** The DSM-5 criteria may be used to make the diagnosis of GD.

➔ *Refer to The American Psychiatric Association A Guide for Working With Transgender and Gender Nonconforming Patients for guidance on diagnosis of GD.*

8. GENDER-AFFIRMING MEDICAL ASSESSMENT

A MEDICAL EVALUATION should include:

- **Thorough review of all co-occurring medical conditions and whether they are reasonably controlled.**
  - *Comorbidities are not necessarily a contraindication to therapy and must be assessed for each patient. See more about drug risks in* Table 2 *(Feminizing Therapy) and* Table 3 *(Masculinizing Therapy).*
- **Review of any mental health evaluations and coordination with mental health care providers.**
- **Physical Examination:** Healthcare providers should utilize a gender-affirming approach, including using the individual's preferred name and pronouns during each clinical encounter. This also includes using non-gender specific terminology (ex. genital instead of penis/vagina or chest instead of breast) for anatomical body parts or asking if the patient has a preferred term to be used. The physical exam should only be performed on parts of the body indicated for the medical reason for the specific visit.
- **Documentation of Previous Treatment:** Hormonal therapy, surgery, etc.
- **Informed Consent:** Individuals must be counseled on the risks and long-term effects of hormonal therapy. Use of gender-affirming hormones in the management of **TG** individuals is considered an off-label use and does not currently have FDA approval but is considered a community standard. Due to the irreversibility of some of the treatment options and the side effects, the individual's informed consent is required before initiating treatment and must be documented within the medical record.
  - *See Section 9. Patient Education & Informed Consent.*
- **Contraindications and Precautions to Hormone Therapy:**
  - *See also the Summary Charts for Hormonal Therapy in Appendix 2. Feminizing Hormone Therapy and Appendix 3. Masculinizing Hormone Therapy for medication-specific contraindications.*

  FEMINIZING THERAPY

  - **CONTRAINDICATIONS:** Current diagnosis of estrogen-sensitive cancer (e.g., breast cancer); current diagnosis of thromboembolic disease (may consider after subspecialty consultation)
  - **PRECAUTIONS:** History of estrogen-sensitive cancer or history of thromboembolic disease should prompt referral to expert specialist prior to initiation of therapy. Presence of liver, kidney, or heart disease/stroke (or risk factors for heart disease such as high cholesterol, diabetes, obesity, smoking); retinal vascular thrombosis, history of macroprolactinoma, strong family history of breast cancer or thromboembolic disease; gallbladder disease.

MASCULINIZING THERAPY

- **CONTRAINDICATIONS:** Pregnancy; breast feeding; trans men with current carcinoma of the breast
- **PRECAUTIONS:** Erythrocytosis (hematocrit >50%) History of breast or uterine cancer (testosterone may have anti-proliferative effects on most, but not all cancers-referral to expert specialist recommended prior to initiation of therapy). Androgen-sensitive epilepsy; migraines; sleep apnea; depression; cardiac failure; renal failure or severe hypertension susceptible to salt retention and fluid overload; significant liver disease; coronary artery disease (**CAD**) or risk factors for CAD; bleeding disorders (for injected testosterone); significant history of violent behavior.

ASSESSMENT & DOCUMENTATION OF ACCURATE EHR CODES

Appropriately diagnosing individuals as to their gender identity is imperative for accurate individual record keeping and continuity of care ensuring all individuals are receiving appropriate preventive and gender affirming care and management both as incarcerated individuals and upon release to their community. All BOP individuals who identify as **TG or gender nonbinary** or are identified by history or current presentation as **TG or gender nonbinary**, should be referred to appropriate mental health professionals and/or health service providers. Utilization of inclusionary diagnoses in the EHR helps clinicians provide patient-centered care and medical interventions specific to organs present and transgender care (e.g., a transgender male who has residual breast tissue or an intact cervix getting a mammogram or pap smear).

For purposes of providing appropriate medical treatment and management, all individuals who identify as **TG**—whether or not they are receiving hormone treatment—need to have an accurate diagnostic code entered into the EHR health problem list, as listed in *Table 1*.

TABLE 1. ICD-10 EHR DIAGNOSTIC CODES FOR TRANSGENDER AND GENDER NONBINARY INDIVIDUALS

BOP Transgender Determination	ICD-10 EHR Codes	Corresponding Sentry CMA Codes
Transgender/Gender Identity DO/Gender Dysphoria - male to female	F64.0F[1]	TRN M2F
Transgender/Gender Identity DO/ Gender Dysphoria - female to male	F64.0M[1]	TRN F2M
Transgender/Gender Identity DO-Other-questioning/queer	F64.8Q[2]	
Personal History of Sex Reassignment	Z87890[3]	

[1] Document the degree of distress or impairment in social, occupational, or other important areas of functioning.
[2] This respective code is to be applied to patients who may not have consolidated their gender identity (questioning), or who identified as gender fluid/queer.
[3] If an individual has undergone gender-affirming surgery, use code Z87890 (Personal History of Sex Reassignment) along with the appropriate F64 code above. Document the type of surgery in detail.

9. PATIENT EDUCATION AND INFORMED CONSENT

Patient education and informed consent are crucial to the treatment process.

- Consent forms for gender affirming hormone therapy are designed to guide counseling and can be found in *Appendix 6* and *Appendix 7*. The information in these appendices is not all-inclusive and providers may add information to this document as clinically appropriate. Individuals should be provided with ample time to review this information and have all questions addressed prior to signing the document. Informed consent must be documented within the EMR.
- Securing consent for gender affirming surgery is the responsibility of the surgeon. Once the individual is approved by the Medical Director for surgical intervention for the treatment of GD, surgeons are responsible for discussing different surgical techniques, advantages and disadvantages of each, limitations of the different procedures, and a frank discussion of all the inherent risks and complications to include their own complication rates with each procedure.

10. HORMONE THERAPY: ELIGIBILITY, GOALS, OVERVIEW

Hormone therapy is an important part of gender affirming care. Studies demonstrate improved satisfaction (in the range of 70–80%) as it relates to mental health, quality of life, and sexual function for **TG** individuals who are receiving gender affirming hormone therapy (Siira et al 2023).

After a thorough and individualized evaluation, the medical provider may initiate hormone therapy after the risks and benefits have been discussed with the individual.

➔ *Refer to the Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline for more detailed information.*

ELIGIBILITY AND READINESS FOR GENDER-AFFIRMING HORMONE THERAPY

Patients do not need to meet the DSM criteria for **GD** to initiate gender-affirming hormone therapy. The eligibility for gender-affirming hormone treatment can be achieved by confirming gender incongruence, verifying transition is clinically appropriate, and patient understands the risks, and benefits of treatment through completion of the *Mental Health Assessment* and/or the *Medical Assessment*.

➔ *Gender-nonconformity is based on the individual's self-report. Therefore, the history or subjective component of the evaluation serves as the primary source for identifying a person as TG.*

➔ *An important aspect of eligibility and readiness for gender-affirming hormone therapy while incarcerated is the understanding that fertility may be affected permanently. According to BOP* ***Program Statement 6031 Patient Care****: Inmates are not authorized for fertility preservation services (sperm or egg/banking), even when infertility is an expected side effect of medically necessary treatment e.g., chemotherapy, pelvic radiation, or gender affirming treatment. Inmates are not authorized to donate sperm or eggs.*

GENERAL GOALS OF HORMONE THERAPY

The goal of hormone therapy is to reduce characteristics of the natal sex and induce those of the identified gender, allowing individuals to project their **GENDER IDENTITY**. Hormone therapy is focused on

affirming a person's gender identity, which is not always binary. Patient-centered therapy is focused on meeting the patient's needs.

11. FEMINIZING HORMONE THERAPY

The goal of feminizing hormone therapy is generally to suppress male secondary sex characteristics and the development of female secondary sex characteristics. Most clinical studies and guidelines recommend combined therapy with an anti-androgen, estrogen, and sometimes a progestin adjunct.

EXPECTATIONS OF FEMINIZING HORMONE THERAPY

Prior to beginning treatment, patients should be educated on realistic expectations of results, as well as the timeline of when to expect them. Every case is different, and slow change can lead to frustration.

➔ *It is important to discuss realistic expectations with the patient to avoid any attempts to self-increase the dosage in hopes of speeding up results.*

- Within the first six months of treatment, changes may be seen in body fat redistribution, loss of muscle mass, breast growth (usually to Tanner stage 2 or 3), testicular atrophy, decreased erections, decreased sperm production, and a slowing of body/facial hair growth.
- The maximum effect of treatment may not be seen for more than two years.
- Treatment does not provide voice alteration.
- Feminizing hormone therapy may also bring about changes in emotional and social functioning.
- Most treatment results are reversible upon cessation of treatment, but breast growth is permanent, and infertility may be irreversible.
- Refer to *Figure 1* on for a general timeline of listed effects.

FIGURE 1. FEMINIZING EFFECTS IN TRANSGENDER FEMALES

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y[a]
Scalp hair	Variable	—[b]
Voice changes	None	—[c]

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

[a]Complete removal of male sexual hair requires electrolysis or laser treatment or both.

[b]Familial scalp hair loss may occur if estrogens are stopped.

[c]Treatment by speech pathologists for voice training is most effective.

Note: Adapted from Table 13. Feminizing Effects in Transgender Females reprinted from Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline by W.C. Hembree, P.T. Cohen-Kettenis, L Gooren, S. E. Hannema, W. J. Meyer, M. H. Muran, S. M. Rosenthal, J.D. Safer, V. Tangpricha, G. G. T'Sjoen, 2017, The Journal of Clinical Endocrinology & Metabolism 102(11):1-35.

SERUM HORMONE LEVELS FOR FEMINIZING HORMONE THERAPY

GOAL LEVELS FOR MTF: Serum Estradiol 100-200 pg/ml and Serum Total Testosterone <50 ng/dl

- While the goal of gender affirming hormone therapy is to suppress male secondary sex characteristics, serum estradiol levels should not exceed those of a premenopausal cis female (200 pg/ml); doses used to achieve an adequate level may be significantly higher than those used in hormone replacement therapy in menopausal women.
- It is important to note there are individuals who do not require estradiol as part of their hormonal therapy regimen and do well on an anti-androgen therapy alone. Bone density considerations should be fully disclosed to the patient who is considering this approach.
- There are individuals who require very little estrogen to obtain desired body characteristics and adequately treat any presenting dysphoria/incongruence (in these cases, a specific hormone level is NOT the patient's goal. Hormone levels are monitored to assure the level does not exceed 200 pg/ml).
- **Patients should be treated with the lowest effective hormone doses.**
  - ***As stated above, estradiol levels should not routinely exceed a premenopausal level of 200 pg/ml.***
  - The same holds true for total testosterone levels. While the goal is <50 ng/dl, there is a subset of individuals who do poorly with levels below 35 ng/dl. The ideal levels for these individuals may be between 35–50 ng/dl.

➔ *Titration of dose is based on the individual's goals within the context of clinical response, hormone levels, and safety monitoring (e.g., risk factors such as smoking or renal function may warrant dose adjustments).*

The Endocrine Society recommends monitoring of hormone levels every 3 months, during the first year of therapy and/or when titrating treatment regimens or altering therapy before stabilization of dosages has been achieved. After the first year of therapy, hormone levels can be monitored every 6-12 months as clinically indicated.

➔ *The laboratory monitoring guide for feminizing hormone therapy is included in Appendix 4.*

DOSE TITRATION

The science and interpretation of serum hormone levels for TG individuals is evolving. Titration of hormone therapy doses should be driven by patient goals and clinical response per individual. Monitoring for potential medication sided effects and hormone levels are critical components of adjusting treatment.

- The recommended titration approach for patients includes increasing both estrogen and antiandrogen medication dosing to achieve desired physiological changes, but not to exceed the premenopausal cis female physiologic ranges (100–200 pg/mL).
- Another approach includes maintaining current physiologic estrogen dosing, titration of antiandrogen therapy, and the addition of a progestin, if appropriate.
- Regardless of initial dosing regimen utilized, dosages may be titrated upwards over 3–6 months.

FEMINIZING MEDICATIONS

➔ *See the Summary Tables for TRANSGENDER FEMALE Hormone Therapy in Appendix 2 for information on each of the medication groups below.*

ANTI-ANDROGENS

Anti-androgens reduce testosterone levels and allow estrogen therapy to be used in lower doses while still reaching a maximum effect. Medications with anti-androgen effects include spironolactone, finasteride, GnRH agonists, and progestins.

- **SPIRONOLACTONE** is a potassium-sparing diuretic that directly inhibits testosterone secretion and androgen binding to the androgen receptor. It is the most commonly prescribed anti-androgen for gender nonconforming individuals in the United States.
  - Spironolactone can suppress facial and body hair growth, male pattern baldness, libido, and sexually stimulated erections. It decreases symptoms of benign prostate hypertrophy (BPH) and can lead to modest breast growth.
  - Due to its diuretic effects, patients may also experience self-limited polyuria, polydipsia, or orthostatic hypotension.
  - ➔ *The use of spironolactone must be carefully monitored in renal insufficiency and is contraindicated in patients with a potassium value greater than 5.5 mEq/L. Spironolactone can cause severe hyperkalemia and hypotension. Caution should be used when prescribed in conjunction with angiotensin-converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs). It is important to monitor potassium levels and blood pressure of individuals taking spironolactone.*
- **5α-REDUCTASE INHIBITORS (**finasteride and dutasteride) inhibit 5-alpha reductase, the enzyme responsible for converting testosterone to its potent form, dihydrotestosterone.
  - Per WPATH SOC 8, data on the use of these medications in trans feminine populations is very limited: *It is unclear whether this class of medication could have any clinical benefit in trans feminine individuals whose testosterone and dihydrotestosterone levels have already been lowered with estrogen and an antiandrogen. We [WPATH] therefore do not recommend their routine use in trans feminine populations.* Rare use may be indicated in specific clinical circumstances such as for patients unable to tolerate spironolactone and which GnRH antagonists are not indicated or available.
- **GNRH AGONISTS** (goserelin, nafarelin, and leuprolide) suppress pituitary gonadotropin levels and gonadal steroids. They are most often used in adolescents for suppression of puberty but can be used to decrease testosterone levels and the amount of estrogen needed to achieve targeted physical effects.
  - Primary utilization in adult patients is for those who are unable to tolerate spironolactone due to hyperkalemia, increased frequency of urination, and/or a reduction in blood pressure or those who have some other contraindication to spironolactone use.
  - GnRH agonists do not carry a risk of thromboembolic disease, but use can result in osteoporosis if doses of estrogen given concurrently are insufficient.

- The high cost to the patient upon release should be considered in those with proximal release dates.
- In cases of persistent elevations of testosterone despite maximized spironolactone dosing, adherence must be thoroughly evaluated prior to consideration of a GnRH antagonist. Directly observed therapy should be considered. If complete adherence is determined to exist and levels are still elevated beyond reason, autonomous endogenous production (i.e., tumor) should be considered and appropriate evaluation should be conducted.

- **PROGESTINS** are a group of hormones that include medroxyprogesterone. Use of medroxyprogesterone is controversial and not routinely recommended. It is purported to aid in breast development at a cellular level as well as mood management, but its effect is mainly on the uterus. Evidence as an effective agent in gender-affirming hormone therapy is lacking. Per WPATH: *there is currently insufficient evidence the potential benefits of progesterone administration outweigh the potential risks.* Additionally, an association between progesterone use in transgender woman and VTE has also been identified.
  - *Medroxyprogesterone treatment comes with risk of developing mood disorders (depression/ irritability), lipid abnormalities, weight gain, and edema. There is also a concern of increased cardiovascular risk.*

ESTROGENS

Estrogens are used to provide feminization in the form of physical appearance and sexual characteristics. Effects include development of breasts, redistribution of body fat, softening of the skin, shrinkage of the testes, and testicular atrophy. Many formulations of estrogen are available, including parenteral, transdermal, sublingual, and oral. Estrogen may have positive health effects more generally, including increased high-density lipoprotein, decreased low-density lipoprotein, and preservation of bone mineral density. *Table 2* below lists conditions that can be exacerbated by gender-affirming estrogen therapy.

TABLE 2. MEDICAL CONDITIONS REQUIRING INCREASED MONITORING WITH ESTROGEN THERAPY

Contraindications	
• Current thromboembolic disease (may consider after subspecialty consultation) • Current diagnosis of estrogen-sensitive cancer	• Unstable ischemic cardiovascular disease
Precautions (Consider Subspecialist Consult)	
• History of prolactinoma • Breast cancer (non-estrogen dependent) • Severe liver dysfunction *(transaminases >3x upper limit of normal)*	• Coronary artery disease • Cerebrovascular disease • Severe migraine headaches • Retinal vascular thrombosis
Precautions (Recommend Increased Monitoring)	
• Obesity • History of cigarettes, tobacco, other nicotine use • Migraines or epilepsy • Diabetes • History of thromboembolic disease	• High cholesterol • High blood pressure • Heart, liver, kidney, or clotting disease • Hypoparathyroidism • Porpyria

- All estrogens come with a risk of thromboembolism, but lower doses and transdermal formulations are considered safer and should be used in populations at higher risk of thromboembolism (>40 years old, smoker, obese, etc.). Aspirin therapy may be considered for those at higher risk of thromboembolic disease.
- Intramuscular (IM) injections can cause greater peaks and troughs in estrogen levels, causing more mood disturbances than oral and transdermal preparations, making oral and transdermal preparations preferable for some patients. Reductions in peak and troughs can be partially mitigated by more frequent dosing of the injections.
- Use of estrogen should be individualized and adjusted regularly, based on serum estradiol levels and individual-specific goals or concerns. Estrogen should be started at low doses and titrated up as needed, based on hormone levels as well as individual tolerance and goals. If discontinuation is necessary, consider tapering therapy to alleviate mood disturbances.
- In patients scheduled for surgery or an immobilizing event, the treatment team (i.e., assigned surgeon) should be made aware of current hormone therapy. Limited evidence suggests low risk for thrombotic events whether therapy is continued or temporarily held (Totaro et al 2021). An individualized risk assessment should be performed in determining the appropriate treatment plan.
- Estrogens are partially metabolized by CYP3A4 and interactions may occur with agents that inhibit or induce CYP3A4. Refer to current drug interaction references and/or a pharmacist for additional information.

➔ *Conjugated and synthetic estrogen formulations cannot be measured through serum estradiol concentrations and are no longer recommended for gender-affirming hormone therapy.*

➔ *Synthetic estrogens, especially ethinyl estradiol, have been shown to have a higher risk of thromboembolism and should be avoided. Patients entering the BOP on synthetic estrogens should be transitioned to a more appropriate formulation.*

MONITORING

Gender-affirming hormone therapy may have risks up to and equivalent of those associated with hormone replacement therapy in biological females. Appropriate monitoring is crucial.

- Weight, blood pressure, physical exams, risk factors, medications, complete blood counts, renal and liver function, and lipid and glucose metabolism should be monitored for all TG individuals receiving gender-affirming hormone therapy.
- In addition, individuals undergoing feminizing hormone treatment should be monitored for development of feminine characteristics, target blood levels, and any adverse effects of the medication.

➔ *Refer to Appendix 4. Monitoring During Feminizing Hormone Therapy for additional guidance regarding monitoring.*

12. MASCULINIZING HORMONE THERAPY

The goal of masculinizing hormone therapy is the development of male secondary sex characteristics and suppression/minimization of female sex characteristics; this is usually done by the administration of a testosterone formulation.

EXPECTATIONS OF MASCULINIZING HORMONE THERAPY

Prior to beginning treatment, patients should receive education on realistic expectations of the treatment results, as well as the timeline of when to expect them. Every case is different, and slow change can lead to frustration.

- Effects developing within the first 6 months of treatment (onset within the first 3 months) include body fat redistribution, an increase in libido, an increase in skin oiliness and acne, clitoral enlargement, vaginal atrophy, cessation of menses, and infertility. Maximum effect usually occurs in 1–2 years but may take up to 5 years in some cases.
- Effects developing in the 6–12 month time frame include increased facial and body hair, scalp hair loss, increased muscle mass and strength, and deepening of the voice. Maximum effect often occurring in 1–2 years.
- Uterine bleeding should cease within a few months of high-dose testosterone therapy, but treatments such as GnRH agonists, medroxyprogesterone, and endometrial ablation may be used to stop menses prior to starting testosterone therapy or to decrease estrogen levels, if not responding to standard treatment.
- Most effects are reversible upon cessation of treatment, but changes in hair, voice depth, and infertility may be irreversible.
- Refer to *Figure 2* below for a general timeline of listed effects.

FIGURE 2. MASCULINIZING EFFECTS IN TRANSGENDER MALES

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	—[a]
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	—[b]
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

[a]Prevention and treatment as recommended for biological men.

[b]Menorrhagia requires diagnosis and treatment by a gynecologist.

Note: Adapted from Table 12. Masculinizing Effects in Transgender Males reprinted from Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline by W.C. Hembree, P.T. Cohen-Kettenis, L Gooren, S. E. Hannema, W. J. Meyer, M. H. Muran, S. M. Rosenthal, J.D. Safer, V. Tangpricha, G. G. T'Sjoen, 2017, The Journal of Clinical Endocrinology & Metabolism 102(11):1-35.

Serum Hormone Levels for Masculinizing Hormone Therapy

Goal Levels for Masculinizing Hormone Therapy: Serum Estradiol <50 pg/ml and Serum Total Testosterone 320–1000 ng/dl

Goal treatment levels are serum estradiol <50 pg/ml and serum total testosterone 320–1000 ng/dl (male physiologic range; some sources quote a normal reference range of 400–800 ng/dl). If a peak total testosterone level is drawn for injectable testosterone, the level should not exceed 1,000 ng/ml. If total testosterone levels exceed this range, refer to a transgender clinical care team physician or pharmacist for guidance in adjusting therapy.

➔ *Free testosterone level monitoring is rarely required during gender affirming treatment. Dose adjustments are based on Serum Total Testosterone levels.*

Masculinizing Hormone Therapy During Pregnancy

➔ *Gender-affirming hormone therapy is contraindicated during pregnancy.*

- While therapy may lead to potentially irreversible infertility, it does not function as contraception, and pregnancy is still possible during treatment. Precautions should be taken to avoid pregnancy during treatment.
- A pregnancy test is obtained prior to starting treatment for all individuals with childbearing potential.

Titration of Masculinizing Hormone Therapy

Titration of hormone therapy doses should be driven by patient goals and clinical response per individual, including hormone level and safety monitoring.

- Clinical response is measured objectively by the presence of amenorrhea by month 6 of therapy.
- Lab references for testosterone levels vary (e.g., 320–1000 ng/dl). However, TG men with levels on the lower end of the range may express concerns about slow progress in gender affirmation or may experience low energy, libido, or mood—and thus warrant increased doses.
- Titration of testosterone should be done slowly with close monitoring for adverse events. Evidence remains unclear on whether increased doses will have positive effects once testosterone levels are greater than the midpoint of the reference range.
- Daily testosterone levels in TG men do not fluctuate as they do in natal males; however, they may vary over the laboratory monitoring intervals.

MASCULINIZING MEDICATIONS

➔ *See the Summary Charts for MASCULINIZING Hormone Therapy in Appendix 3 for a full list of the different formulations of testosterone—including summarized information on dosing, adverse effects, contraindications, and interactions.*

➔ *Monitoring is covered in Appendix 5. Monitoring During Masculinizing Hormone Therapy*

TESTOSTERONE

Androgen supplementation is used to induce male sex characteristics, including cessation of menses, voice changes, increased facial/body hair growth, increased muscle mass, hairline recession/baldness, changes in sweat and odor patterns, and clitoral enlargement. Other effects include increased libido and energy. Vaginal dryness will also likely occur. Higher doses of testosterone may be needed for TG men than for natal males who are being treated for low testosterone.

- Several formulations are available, ranging from IM injections to transdermal patches and gels. Due to the classification of all testosterone preparations as DEA-controlled substances and their associated risk of potential abuse and/or diversion, in the correctional environment, injectable formulations are the preferred method of administration.
- The IM injections release slowly from the muscle but may induce cyclical adverse effects that coincide with varying plasma concentrations. This can be mitigated by using a lower dose of IM testosterone given one to twice weekly (rather than every two or more weeks).
- While oral formulations are available, they are not used, due to extensive liver metabolism and the associated potential for hepatic complications.
- Androgen use should be individualized and adjusted based on serum total testosterone levels, tolerance, efficacy, and patient goals. Dosing should start low and be titrated up to an appropriate level while keeping the dose as low as possible to minimize adverse reactions.
- Ovulation may still be possible even when undergoing long-term testosterone therapy. Therefore, it is possible for a transgender man to become pregnant.

PROGESTINS AND GNRH AGONISTS

Medroxyprogesterone and GnRH agonists are not routinely used but may be treatment options in individuals wishing to cease menstruation and decrease estrogen levels prior to testosterone treatment. These medications may also have a use in individuals receiving high-dose testosterone therapy who still experience uterine bleeding after the first few months of treatment.

Drug Risks

Table 3 lists conditions that can be exacerbated by gender-affirming testosterone therapy.

Table 3. Medical Conditions Requiring Increased Monitoring With Testosterone Therapy

Contraindications	
• Pregnancy • Breastfeeding • Trans Men with carcinoma of the breast	
Precautions	
• Severe liver dysfunction (transaminases >3x upper limit of normal) • Breast or uterine cancer • Erythrocytosis (hematocrit >50%) • Androgen-sensitive epilepsy • Migraines • Sleep apnea • Depression or significant history of violent behavior	• Epilepsy • Renal failure • Severe hypertension susceptible to salt retention and fluid overload • Coronary artery disease (CAD) or risk factors for CAD • Bleeding disorders (for injected testosterone)

Monitoring

Masculinizing hormone therapy has the same risks associated with hormone replacement therapy in biological males. Appropriate monitoring is crucial.

The Endocrine Society recommends monitoring of hormone levels every 3 months, especially when titrating treatment regimens or altering therapy before stabilization of dosages has been achieved. Once stabilization of dosages has been achieved, hormone levels are typically done every 6-12 months or as clinically indicated.

- Weight, blood pressure, physical exams, risk factors, medications, complete blood counts, renal and liver function, and lipid and glucose metabolism should be monitored for all TG individuals receiving gender-affirming hormone therapy.
- In addition, individuals undergoing masculinizing hormone treatment should be monitored for development of masculine characteristics, target blood levels, and any adverse effects of the medication. Some of the adverse effects experienced with chronic testosterone therapy are erythrocytosis, liver dysfunction, hypertension, excessive weight gain, salt retention, lipid changes, excessive or cystic acne, and adverse psychological changes.

➔ *Refer to Appendix 5. Monitoring During Masculinizing Hormone Therapy for additional guidance.*

13. PREVENTIVE HEALTH SCREENINGS

Regardless of the patient's identified gender or gender-confirming procedures, if the patient has a particular body part or organ, they must continue to have preventative health screening of that organ per recommended guidelines. Additionally, TG patients who are currently on or have previously been on gender affirming hormone treatment are at increased risk for some medical conditions which may require more frequent preventative health screenings. It is important to obtain a thorough medication and surgical history to fully ascertain the individual's screening needs. *Table 4* provides and overview of preventive screening needs of TG patients.

TABLE 4. PREVENTATIVE HEALTH SCREENING FOR TG PATIENTS

Health Screening	Transgender Women	Transgender Men
Breast cancer	• Screen patients age >50 years based on established clinical guidance.	• Intact breasts: Routine screening as for natal females. • Postmastectomy: Yearly chest wall and axillary exams.
Cardiovascular Disease	• Recommended periodically in accordance with established guidance. Parameters should include weight, BMI, blood pressure, lipids, and blood sugar/A1C.	
Cervical cancer	• Vaginoplasty: no screening.	• Cervix intact: Routine screening as for natal females. • Absent cervix: No screening
Colon cancer	• Recommended in accordance with established guidance.	
Diabetes Mellitus	• Recommended periodically in accordance with established guidance. • If on estrogen: increased risk and frequency of screening may be increased.	• Recommended periodically in accordance with established guidance.
Hyperlipidemia	• Recommended periodically in accordance with established guidance. • If on estrogen: annual lipid screening.	• Recommended periodically in accordance with established guidance • If on testosterone: annual lipid screening
Osteoporosis	• Testes intact: Routine screening as for natal males. • Postorchiectomy: Screen all patients > 65 years. • Screen all patients age 50-65 years if off hormones for >5 years	• Screen all patients age >65 years • Screen patients age 50-65 if off hormones for >5 years
Prostate cancer	• Routine screening as for natal males.	• Not applicable
Testicular cancer	• Pre-orchiectomy with intact testes: Recommended periodically in accordance with established guidance.	• Not applicable
Refer to UpToDate *Primary Care of Transgender Individuals* and BOP *Clinical Guidance for Preventive Health Care* for additional information.		

14. MINIMALY INVASIVE AND NON-INVASIVE GENDER AFFIRMING TREATMENT MODALITIES

There are several minimally invasive and non-invasive gender-affirming treatment modalities available to TG patients such as voice and communication training, professional laser facial hair removal, and chondrolaryngoplasty (tracheal shaving). Lesser invasive or minor surgical procedures may be deemed medically necessary and considered on a case-by-case basis.

The purpose of these gender-affirming treatment modalities is to decrease or stabilize the gender dysphoria/incongruence experienced by the TG patient and improve the psychosocial functioning of the TG individual. The primary care treatment provider should use sub-specialty consultation requests in the electronic health record (EHR) to order these modalities. It is the responsibility of the medical provider to document the medical necessity, using accepted medical standards for gender-affirming treatment, for each of the requested lesser invasive and non-invasive interventions.

Requests for these treatment modalities (other than hormone treatment) such as voice and communication training, professional laser facial hair removal/electrolysis, will be reviewed in accordance with **Program Statement 6031 Patient Care**, section on Utilization Review; ***a subspecialty consult will be placed in BEMR and referred to the local Utilization Review committee for review. All procedures approved at the local URC meeting will require referral to the Regional Medical Director (RMD) for review and approval per PS 6031.***

Appendix 1. Transition Pathway for Transgender Patients lists the transition pathway for the affirmation treatment of the incarcerated TG individual from diagnosis to referral for major gender affirming surgery. These steps are not required to be fulfilled in chronological order before progressing to more invasive and non-reversible gender affirming treatment modalities but are an example of treatment modalities from least to most invasive.

VOICE AND COMMUNICATION TRAINING

Providers are encouraged to reach out to Regional Physical and Occupational Therapists, who can assist in finding appropriate resources. The American Speech-Language-Hearing Association (ASHA) has a provider directory for speech language pathologists who specialize in voice and communication therapy for transgender and gender diverse people.

FACIAL HAIR REMOVAL

Facial hair is often a source of distress and suffering for patients who identify as trans-female. Several noninvasive options are available to our incarcerated population. Patients can access the commissary to purchase extra razors, hygiene items such as hair removal creams and lotions, as well as foundation/coverage cremes/liquids to match the color of their skin; some of these products require special order purchases. Hair removal through waxing is a custody concern and is avoided in an incarcerated environment.

When commissary items fail to achieve desired results, and there is continued Gender Dysphoria, Health Services may provide over-the-counter laser hair removal devices as medically necessary. These are secured/maintained in Health Services and used by the patient under monitoring of staff.

Most laser hair removal devices marketed for at-home use are IPL (Intense Pulsed Light) devices. These devices cause a reduction in hair by emitting multiple wavelengths of light to the skin targeting melanin in the hair follicle, which then heats up the hair follicle causing it to weaken or be destroyed. IPL devices only work on hair that is in the growth phase and attached to the follicle therefore multiple treatments are often required. These devices work best on brown and black hair and typically do not provide results on white, grey, light blonde, or red hair. IPL devices work best on Fitzpatrick skin types I-IV which includes all skin tones except dark brown or black skin.

Another laser hair removal device marketed for at-home use is the diode laser. The diode laser works like the IPL devices, except instead of emitting multiple various wavelengths of light it emits a single wavelength of concentrated light. The diode devices are considered safer for all skin types as the IPL cannot be used on darker skin due to lower effectiveness and increased risk of skin burning. It is important to check what skin types the device can treat prior to obtaining the device.

Patients need to be educated on realistic expectations of these devices including: understanding that treatment often is not permanent; will require multiple treatments, often to the same areas; and different devices have varied effectiveness depending on skin and hair color, among other factors. Additionally, they are not without adverse reactions, sometimes causing skin irritation, pain, blistering or scarring. They should not be used on skin with large moles, birthmarks, or tattoos. All visible hair should be shaved in the area prior to use. Sun exposure, before and after treatments, should be avoided.

Prior to obtaining a laser hair removal device, institutions must check to see if the device is FDA cleared using the link: *https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm.* Search by device name and look for the designation of "Substantially Equivalent (SESE)" to determine if FDA cleared. In addition, institutions will need to consider the options for cleaning between patient use with each product.

If these measures fail to remove the facial hair or are contraindicated (e.g., documented allergy or repeated infections) and patient has persistent unresolved Gender Dysphoria/incongruence, a referral consultation for professional laser facial hair removal or electrolysis may be submitted to the local Utilization Review Committee for consideration.

15. INVASIVE AND COMPLEX GENDER-CONFIRMING SURGERIES

➔ *Gender-Confirming surgery has also been referred to as sex reassignment surgery. It is important to note terminology changes often and the latter term is falling out of use.*

TG patients who have been compliant with all aspects of gender affirming care may desire further gender affirming treatment by requesting consideration for invasive and complex gender-confirmation surgery.

Gender confirming surgery may be medically necessary and is considered on a case-by-case basis. The BOP strives to provide community standard medical and surgical care within the confines its systems.

Surgical confirmation for trans individuals in BOP custody may be the final stage in their transition process. While many individuals may not require any surgery, for some it is medically necessary to complete more than a single procedure to alleviate their gender dysphoria/incongruence. See *Table 5* for different examples of surgical procedures.

TABLE 5. GENDER CONFIRMING PROCEDURES

Feminizing Surgical Procedures	
• Breast Augmentation	• Enlarging the breasts using breast implants
• Clitoroplasty	• Surgical creation of a clitoris
• Labiaplasty	• Creation or reshaping of the labia around the vagina
• Penectomy	• Removal of all or part of the penis
• Orchiectomy	• Removal of one or both testicles
Masculinizing Surgical Procedures	
• Bilateral Mastectomy	• Removal of both breasts
• Male Chest Contouring	• Contouring the chest into a masculine shape
• Hysterectomy	• Removal of the uterus
• Ovariectomy/Salpingo-oophorectomy	• Removal of ovaries/removal of ovaries and fallopian tubes
• Penile Prosthesis	• An erectile prosthetic device is placed to allow for an erection
• Phalloplasty	• Construction of a penis which may involve multiple surgeries
• Scrotoplasty	• Creation of a scrotum
• Metoidioplasty	• A surgical procedure that works with existing genital tissue to form a phallus, or new penis.
• Permanent Hair Removal	• When clinically required in preparation for bottom surgery

In accordance with ***Program Statement 5200.08 Transgender Offender Manual*****,** the TEC reviews all general administrative criteria for major gender affirming surgery and reviews additional correctional/custody considerations. The request for invasive and complex gender confirming surgery requires executive level administrative approval (by TEC), and approval from the Medical Director.

The **Clinical Director's (or designee's) role** at the referral institution is to support and treat the trans patient according to this guidance and document it accordingly. In general, clinical criteria for gender confirming consideration in the Bureau include the following:

- The patient has received ongoing gender affirming treatment by assigned medical and mental health providers, and there is persistent well-documented GD.
- There is clinical documentation of patient-centered discussions and documented ongoing follow-up regarding the specific therapeutic and surgical needs.
- The patient has been deemed capable to make fully informed decisions.
- Any significant medical and mental health conditions are reasonably well controlled.
- There have been 12 continuous months of hormone therapy as appropriate to the patient's individual goals (unless medically contraindicated).
  - ► Hormone therapy in trans-males is NOT a prerequisite for mastectomy and male chest contouring.
  - ► Hormone therapy in trans-females will maximize breast growth when continued for at least 2-3 years. Some surgeons will only perform the breast augmentation surgery after this period of time has elapsed. While this may be ideal, there will be times when Gender Dysphoria symptoms may warrant breast augmentation surgery after a minimum of one year of gender-affirming hormone treatment.
  - ► Patients should undergo masculinizing hormone therapy for at least 12-24 months prior to clitoral enlargement.

- There have been 12 continuous months of living in a gender role that is congruent with their gender identity. This experience provides ample opportunity for patients to experience and socially adjust to their desired gender role before undergoing irreversible surgery.
- Per ***Program Statement 5200.08 Transgender Offender Manual***,, the Warden submits a referral request to the TEC who will complete an administrative readiness review for gender-confirming surgery.
- When the TEC administratively approves a patient for surgical consideration, a referral is made to the Medical Director who remains the final authority in approving or disapproving a patient for gender confirming procedures. At the direction of the Medical Director, all pertinent clinical information will be reviewed by the Transgender Utilization Review Advisory Group to establish medical appropriateness for the procedure according to community standards.

TRANSGENDER UTILIZATION REVIEW ADVISORY GROUP REVIEW

The Transgender Utilization Review Advisory Group is made up of members of the Transgender Clinical Care Team. Each utilization medical review meeting will require one pharmacist, one psychiatrist, a primary care physician and one social worker from the Transgender Clinical Care Team.

All clinical information in the surgical referral packet submitted by the patient's treatment providers is reviewed. The Transgender Utilization Review Advisory Group may need to interview the patient and/or contact members of the treatment team at the referring institution for additional clinical information (EKG, Pulmonary Function Testing, etc). A targeted utilization review is conducted to assure the proposed procedure(s) are medically needed and appropriate according to community standard prior to making their recommendation to the Medical Director. The Medical Director has the final clinical authority, according to BOP Policy, for approving/disapproving patients for referral for Gender Confirming Surgery.

CLINICAL CONTENTS OF THE GENDER CONFIRMING SURGICAL REFERRAL PACKET

The **SURGICAL REFERRAL PACKET** should include the following items:

MENTAL HEALTH EVALUATION: the mental health professional (typically a Psychologist familiar with the patient) will document the patient's personal mental health and gender non-conformity history, progress, and suitability for surgery based on the stability of co-existing mental illness, and consolidation of one's identity. Recommended content of the mental health provider's referral for surgery include:

- The presenting general identifying characteristics.
- A list of all active mental health diagnoses.
- A review of history of suicidality, homicidality, history of violence, any psychiatric hospitalizations, and residential treatment for mental health or substance use.
- Any current and past substance use including nicotine.
- The duration of the mental health professional's relationship with the client, including the type of evaluation(s) and therapy or counseling to date.
- If and how long the patient has been living in the identified gender.
- An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery.

- Formal evaluation and documentation of capacity to give consent.
- Any issues regarding communication (e.g., English fluency, hearing impairments, an autism spectrum disorder, literacy level, learning differences, etc.)

MEDICAL EVALUATION: the objective of the medical evaluation of a pre-surgical candidate for gender-confirmation surgery is to establish medical suitability for the upcoming procedure. The medical evaluation will address both gender non-binary consolidation medical needs according to *WPATH*, as well as a general pre-surgical evaluation according to community standard. Recommended content for the medical evaluation for referral for surgery should include documentation on:

- Presence of persistent gender dysphoria/incongruence.
- Type of surgery patient is requesting.
- General statement about patient's ability to understand the irreversible aspects of the procedure.
- General patient discussion regarding risks for surgery which will be dependent on what type of surgery is being done. Some general risks to discuss with the patient include but are not limited to:
  - Significant pain.
  - Suboptimal appearance.
  - Risk related to general anesthesia to include death.
  - Excessive blood loss and need for transfusion.
  - Blood clots.
  - Damage to surrounding structures.
  - Nerve damage and loss of sensation.
  - Hematomas.
  - Infection or abscess potentially resulting in necrosis.
  - Excessive scarring.
  - Patient should also be informed that any detailed surgical technique information, risks of the procedure, and complication rates will be discussed with the surgeon, who is responsible for obtaining surgical consent.
- Documentation that the patient understands expected aftercare plan, what is to be expected during the healing process, and how the plan may change based on surgical results and recommendations from the surgeon.
- Patient History
  - History of present illness
    - Current medical and mental health status.
    - Medical and mental health conditions are reasonably well controlled.
  - Past medical history
  - Allergies

  - Medications
    - All active medications.
    - Dose and frequency.
    - Duration of hormone therapy (if applicable).
  - Review of systems
  - Family history
  - Social history
  - Surgical history
  - Sexual reproductive history and wishes
- Physical Exam (complete)
  - Including HEENT, cardiac, pulmonary, abdominal, extremities and neurologic
  - Special attention to signs of conditions that would be absolute/relative contraindications to surgery
- Laboratory Studies
  - Complete blood count with differential, comprehensive metabolic panel with liver function tests
  - Applicable hormone levels
- Pre-Surgical Work-Up- this may be at the preference of the surgeon and may include:
  - Recent EKG/Chest x-ray
  - Stress test
  - Nutritional assessment

PSYCHOSOCIAL EVALUATION: The social work psychosocial assessment for gender affirming surgery is utilized to gain a comprehensive understanding of the patient within their environment, both while incarcerated and upon release. It is completed by the social worker in the EHR. The assessment addresses the following areas:

- Family relationships, past and current
- Education, work/vocation, military history
- Religious/spiritual and/or cultural needs
- Financial resources
- Mental health, substance use, and medical history
- Sexual orientation and gender identity history
- Expectations or concerns regarding surgery
- Psychosocial functioning, support, and aftercare

16. TRANSITIONS OF CARE

Quality care and treatment includes planning for what will happen when a patient leaves the institution and BOP custody. Consultation with Transitional Care Team (TCT) should be pursued to assist with release planning efforts for transgender individuals, especially as it pertains to medical needs and gender affirming hormone therapy. The TCT can coordinate with relevant stakeholders and connect patients transitioning into the community with appropriate services and resources to ensure continuity of care. Aftercare planning for transgender individuals should include the following considerations:

NOTE: *If the institution is without a staff social worker, regional social workers are available to assist with aftercare planning.*

- A *Consent for Release of Medical Information* should be obtained from the inmate patient, in accordance with BOP policy, so that the inmate patient's treatment plan can be discussed with the community health care provider.
- An adequate supply of medications should be provided to the inmate prior to release or during community placement, in accordance with BOP policy.
- Patients transferring to Residential Re-entry Centers (RRC) or Home Confinement (HC) will be referred to BOP Health Systems Specialists (HSS) and Community Treatment Specialists (CTS) for continuity of care while in the RRC or on HC.
- If a patient is receiving gender affirming hormone therapy and is not transferring to RRC or HC, an aftercare plan should be established to ensure continuity of care.

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KEY TO ABBREVIATIONS

Below is a list of abbreviations used throughout this guidance.

➔ *See Section 2. Definitions for explanation of the terms marked with an asterisk (*).*

AEs	Adverse events
ARB	Angiotensin II receptor blocker
BMD	Bone mineral density
BMP	Basic metabolic panel, including glucose, calcium, sodium, potassium, CO2, chloride, blood urea nitrogen, and serum creatinine
CAD	Coronary artery disease
CBC	Complete blood count
CCARE	BOP Care Coordination and Reentry Team
CMA	Case Management Activity (codes)
CV	Cardiovascular
DM	Diabetes mellitus
FSH	Follicle-stimulating hormone
GD*	Gender dysphoria
GnRH	Gonadotropin-releasing hormone
hCG	Human chorionic gonadotropin
IM	Intramuscular
LFT	Liver function test
LH	Luteinizing hormone
N/V	Nausea and vomiting
PCOS	Polycystic ovarian syndrome
PREA	Prison Rape Elimination Act (see *Section 3*)
q	"Every" (example: q2wk = every 2 weeks)
SHBG	Sex hormone-binding globulin
SQ	Subcutaneous
TCCT*	BOP Transgender Clinical Care Team
TEC*	BOP Transgender Executive Council
TICC	Trauma-Informed Correctional Care in the BOP
TG*	Transgender
VTE	Venous thromboembolism

APPENDIX 1. TRANSITION PATHWAY FOR TRANSGENDER PATIENTS

1	**Patient self-identifies as TG or gender nonbinary to BOP staff member. Referral is made to a mental health professional or medical provider.**	
2	The mental health professional completes an assessment and documents gender non-conformity and/or gender dysphoria as indicated. (*Section 7*) Initiate gender-affirming live experiences within the prison system.	
3	Referral to medical provider for evaluation if patient has indicated an interest in initiating gender affirming hormone treatment (*Section 8*). Hormone treatment can be initiated prior to mental health evaluation, when/if patient presents to medical provider first and meets treatment criteria.	
4	Initiation of gender affirming hormone treatment after appropriate counseling completed on expected risks, outcomes, and complications. If needed, case can be discussed with BOP TCCT prior to initiation, though not required. Obtain informed consent (*Section 9*).	
5	***FEMINIZING THERAPY***	***MASCULINIZING THERAPY***
	Begin hormonal therapy with anti-androgen (spironolactone first, unless contraindicated) and estradiol Start low and titrate (no more than every few weeks) to appropriate level while using lowest effective dose. ➔ *See Section 11. Feminizing Hormone Therapy*	Begin hormonal therapy with testosterone Start low and titrate (no more than every few weeks) to appropriate level while using lowest effective dose. ➔ *See Section 12. Masculinizing Hormone Therapy*
	If treatment has reached maximum estradiol dose without desired effects after appropriate amount of time, consider adding another anti-androgen such as finasteride, a **GnRH** agonist, or medroxyprogesterone. Consult **BOP TCCT** if needed.	If still experiencing uterine bleeding after 6 months of high-dose testosterone therapy, consider adding medroxyprogesterone or a **GnRH** agonist to suppress menstruation. Consult **BOP TCCT** if needed.
6	After initiation and compliance with continuous gender affirming hormone treatment, a patient may request further gender affirmation by living in agender affirming institution. e.g., trans-female desires to live in a female institution/ trans-male desires to live in a male institution. The warden at the respective institution will request an administrative review by the TEC	
7	If approved by the TEC, the patient will be designated to the gender affirming institution (aka institution of the identified gender)	
8	Institutions that house transgender or gender non-conforming patients should develop a multidisciplinary team[1] who meet and discuss the patient's needs and progress	

(table continues on next page)

Transition Pathway for Transgender Patients (Cont.)	
9	After 12 months of living in the identified gender at the gender-affirming institution **or** original institution if the TG patient does not request transfer, compliance with continuous gender affirming hormone treatment and with documentation of persistent gender incongruence, the patient may benefit from lesser/non-invasive gender affirming treatment modalities or invasive/complex gender confirmation surgery[2] For all lesser/non-invasive gender affirming treatment modalities (ex. voice and communication training, professional laser facial hair removal) the individual provider will place the appropriate consult in the EHR and refer to the local Utilization Review Committee for review. Referral to the RMD will be required. For invasive/complex gender confirmation surgery- the warden at the respective institution will first request an administrative review by the TEC.
10	The TEC determines whether general administrative criteria for gender confirming surgery is met and refers the case to the Medical Director for a medical review. • The Medical Director will request review by the Transgender Utilization Review Advisory Group who will clinically review the surgical referral packet submitted by the Clinical Director. If the patient meets the clinical criteria for surgery, a memo, with all accompanying clinical supporting materials will be sent to the Medical Director, who is the final authority in approving a patient for referral to the gender confirming surgeon.
11	Gender confirming surgical evaluation will be completed by the contracted community surgeon who is responsible to meet with the patient to confirm readiness and medical suitability for complex surgery. Informed consent surrounding all aspects of the surgery to include risks, complication rates, and expected outcomes is the responsibility of the surgeon.

[1] Treatment team should consist of the Clinical Director (or designee), psychiatrist (as needed), Primary Care APP, psychologist, social worker, and pharmacist. Other representative members may include unit team, captain, chaplain (or patient representative), and associate warden. The patient may be invited to attend to clearly articulate and establish his/her clinical needs.
[2] Individuals will desire to progress to different stages of the stepwise approach. Only a subset of all gender non-conforming patients will pursue a surgical intervention.

APPENDIX 2. SUMMARY TABLES FOR FEMINIZING HORMONE THERAPY

➔ *See **Section 11** for more discussion on the medications used in Feminizing Hormone Therapy.*

➔ *These charts are not all-inclusive and are meant to summarize major considerations for medications. Refer to current drug interaction references, manufacturer information, and/or a pharmacist for additional information regarding drug dosing (to include renal and hepatic dosing), interactions, adverse effects, and contraindications.*

Table 1A: Anti-Androgen Drugs for Feminizing Hormone Therapy

★ GOAL LEVELS FOR MTF: SERUM ESTRADIOL 100-200 PG/ML AND SERUM TESTOSTERONE <50 NG/DL ★				
DRUG	**DOSE**	**MECHANISM OF ACTION**	**RISK CONSIDERATION /CONTRAINDICATIONS**	**NOTES**
SPIRONOLACTONE	• **Starting:** 25mg QD or BID • **Typical:** 100-300mg/day in 2 divided doses • **Max:** 200 mg BID	• Potassium-sparing antihypertensive that directly inhibits testosterone secretion and androgen binding to the androgen receptor	• Renal insufficiency • Potassium >5.5 mmol/L (use with caution if patient has comorbid condition or medications known to increase potassium)	
FINASTERIDE	• **Low:** 1 mg daily (generally used to treat androgenetic alopecia if needed and desired **after** individualized target level of androgen blockade is achieved) • **High:** 5 mg daily (generally used in those who cannot tolerate spironolactone or as an adjunct to spironolactone)	• 5α reductase inhibitor that blocks the conversion of testosterone to the more active 5α dihydrotestosterone (DHT)	• None pertinent	• Predicted to have little utility if the testosterone levels are suppressed and there is no substrate to generate DHT. • WPATH recommends against routine use in patients where testosterone and dihydrotestosterone levels have already been lowered with estrogen and an antiandrogen. Note, this includes for the use of androgenetic alopecia. • Use in combo with spironolactone for rare individuals not achieving desired effects. • May be used after orchiectomy if hirsutism or male pattern baldness are present. • When compared to placebo, 5-alpha-reductase inhibitors have been associated with an increase in the incidence of high-grade prostate cancers.
APPENDIX 1, TABLE 1A, PAGE 1 OF 2 *(see Key to Abbreviations in section preceding Appendices)*				

★ GOAL LEVELS FOR MTF: SERUM ESTRADIOL 100-200 PG/ML AND SERUM TESTOSTERONE <50 NG/DL ★				
DRUG	**DOSE**	**MECHANISM OF ACTION**	**RISK CONSIDERATION/ CONTRAINDICATIONS**	**NOTES**
GNRH AGONISTS: **GOSERELIN** **LEUPROLIDE**	• Goserelin: 3.6 mg SQ implant q4 weeks • Leuprolide: 3.75–7.5 mg SQ/IM monthly or 11.25mg SQ/IM q3 months ○ Lupron Depot® is administered IM ○ Eligard® is administered SQ	• Blocks the GnRH receptor, thus degreasing levels of FSH & LH resulting in highly effective gonadal blockade	• None pertinent	• Primary utilization is for patients who experience intolerable hyperkalemia, increased frequency of urination, and/or a reduction in blood pressure with spironolactone. • In cases of persistent elevations of testosterone despite maximized antiandrogen dosing, adherence must be thoroughly evaluated prior to consideration of GnRH Antagonist use. Directly observed therapy should be considered. If complete adherence is determined to exist, autonomous endogenous production (i.e., tumor) should be considered and appropriate evaluation should be conducted. • High cost should be considered in patients with proximal release dates. • Use can result in osteoporosis if doses of estrogen given concurrently are insufficient.
PROGESTIGENS: **MEDROXYPROGESTERONE**	• **Starting:** 2.5 mg daily • **Typical:** 5–10 mg daily • **Max:** 10 mg daily	• Inhibits secretions of pituitary gonadotropins	• Similar to estrogen. See ***CHART 1B*** below.	• No well-designed studies documenting efficacy. • Use in standard care generally lack formal recommendation for use. • If a patient is to be placed on a progestin, goals of use should be clearly documented and periodically evaluated. If goals are not achieved, medication should be discontinued. • Antidotal reports improved breast development, mood, and libido. However, evidence of benefit is unlikely to outweigh risk, which includes VTE
APPENDIX 1, TABLE 1A, PAGE 2 OF 2 *(see Key to Abbreviations in section preceding Appendices)*				

TABLE 1B: ESTROGEN FOR FEMINIZATION

★ GOAL LEVELS FOR MTF: SERUM ESTRADIOL <200 PG/ML AND SERUM TESTOSTERONE <50 NG/DL ★				
DRUG	**DOSE**	**MECHANISM OF ACTION**	**RISK CONSIDERATION/ CONTRAINDICATIONS**	**NOTES**
ESTRADIOL	• Typical: 2-6 mg daily • Occasionally higher doses are used as clinically indicated (literature recommends maximum does of 6-8mg depending on source) • If greater than 2 mg/day, recommend divided twice-daily dosing.	• Estrogens modulate the pituitary secretion of gonadotropins, LH, and FSH through a negative feedback system	**Absolute:** • Estrogen-dependent cancer **Precautions:** • History of thromboembolic disease (e.g., stoke, MI, DVT, PE) • Coronary artery disease • Hepatic dysfunction • Hyperlipidemia • Diabetes mellitus • Cigarette smoking • Migraine • Epilepsy • Retinal vascular thrombosis • Hypoparathyroidism • Porpyria • Diseases exacerbated by fluid retention	• Transdermal formulations are preferred for persons > 40 years old or those with risk factors for thromboembolic disease • Inform treatment team prior to surgery of hormone therapy. Individual risk assessment to determine adjustments to therapy perioperatively. • Individuals who enter the BOP on conjugated estrogen should be switched to a different form of estrogen due to inability to monitor estrogen levels with this preparation • IM injections cause greater peaks and troughs in estrogen levels making oral and transdermal preparations preferable
ESTRADIOL VALERATE IM (DELESTROGEN)	• **Typical:** 5-30 mg IM q2wk • *May divide dose into weekly injections for cyclical symptoms.*			
ESTRADIOL CYPIONATE IM (DEPO-ESTRADIOL)	• **Typical:** 2–10 mg IM q1wk			
ESTRADIOL PATCH (CLIMARA, ESTRADERM, ALORA, VIVELLE-DOT)	• **Typical:** 0.025 mg – 0.2 mg/day • *Max single patch dose available is 0.1 mg per 24 hours. More than one patch can be applied at a time* • *Frequency of patch change is brand/product dependent.*	*Same as above.*		

APPENDIX 1, TABLE 1B, PAGE 1 OF 1 *(see Key to Abbreviations in section preceding Appendices)*

APPENDIX 3. SUMMARY TABLE FOR MASCULINIZING HORMONE THERAPY

➔ ***See Section 12 for more discussion on the medications used in Masculinizing Hormone Therapy.***

➔ *These charts are not all-inclusive and are meant to summarize major considerations for medications. Refer to current drug interaction references, manufacturer information, and/or a pharmacist for additional information regarding drug dosing (to include renal and hepatic dosing), interactions, adverse effects, and contraindications.*

★ GOAL LEVELS FOR FTM: SERUM ESTRADIOL <50 PG/ML AND SERUM TESTOSTERONE 320–1000 NG/DL ★				
DRUG	**DOSE**	**MECHANISM OF ACTION**	**RISK CONSIDERATION/ CONTRAINDICATIONS**	**NOTES**
TESTOSTERONE CYPIONATE (in cottonseed oil) **TESTOSTERONE ENANTHATE (in sesame oil)**	• **Typical:** 50-100mg IM/SQ once weekly or 100-200mg IM every 2 weeks • **Max:** 200 mg q2wk or 100 mg/wk	• Maintains secondary sex characteristics in androgen-deficient patients	**Absolute:** • Pregnancy • Breast cancer (testosterone may have anti-proliferative effects on most, but not all, breast cancers) • Breastfeeding **Precautions:** • Erythrocytosis • Cardiac, hepatic, renal, or vascular disease with edema or risk of edema • Sleep apnea or high risk of sleep apnea due to obesity or chronic lung disease • Dyslipidemia • Migraines • Epilepsy • Depression, significant history of violent behavior	• Causes drop in blood glucose in DM individuals • May notice cyclic variation in mood with IM dosing Q 2–4 weeks. Use a lower, more frequent dose, or transdermal • Transdermal reaches same levels as IM, but in longer timeframe. • Menses typically stop in early months of treatment but may persist when using transdermals. • Testosterone is a DEA controlled substance. • For the first 3 to 9 months of treatment, total testosterone levels may be elevated with free testosterone levels remaining in the biological female range due to high sex hormone binding globulin levels in some biological women. • 15% of patients on testosterone will experience transient elevations in liver enzymes. If increase > 3x D/C and seek consultation. • Cypionate and enanthate formulations cannot be used interchangeably due to differences in duration of action.
TESTOSTERONE PATCH **Available strengths: 2 mg, 2.5 mg, 4 mg, 5 mg**	• **Typical:** 2.5-7.5 mg/day q PM • **Max:** 8 mg/day q PM			
TESTOSTERONE GEL (TESTIM 1%, ANDROGEL 1%)	• **Typical:**50-100mg/day			
TESTOSTERONE GEL (ANDROGEL 1.62%)	No published or anecdotal experience with these preparations			
TESTOSTERONE SOLUTION (AXIRON axillary solution)				
MEDROXYPROGESTERONE AND GNRH AGONISTS	Not routinely used. Refer to current drug references for dosing, mechanism of action, and contraindications/precautions.			• Use is recommended in patients who desire but have not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding
APPENDIX 2, PAGE 1 OF 1 *(see Key to Abbreviations in section preceding Appendices)*				

APPENDIX 4. MONITORING DURING FEMINIZING HORMONE THERAPY

Appropriate monitoring during gender-affirming hormone therapy is crucial to (1) ascertaining that target blood levels of hormones are being met and (2) assessing and maintaining the individual's health overall.

- **Clinical and laboratory monitoring** is appropriate every three months during the first year, and then as clinically indicated (typically once or twice yearly).
  - Monitor for development of feminine characteristics, for target blood levels, and for adverse effects of medication and other treatment.
- **Cardiovascular risk assessment** is recommended periodically for all patients treated with hormones in accordance with established guidelines and BOP guidance when available.
  - Specific parameters that should be monitored include weight and body mass index, blood pressure, lipids, and blood sugar and/or hemoglobin A1C levels, in accordance with established guidelines.
- **Serum ESTRADIOL and TESTOSTERONE levels** are obtained before starting those respective medications, and then every three months while on treatment.
  - **Target levels are <200 pg/ml for estradiol and <50 ng/dl for testosterone.** Higher levels of testosterone indicate inadequate suppression; higher levels of estradiol are associated with increased risks for thromboembolic disease, liver dysfunction, and development of hypertension.
- **Serum electrolytes, most importantly potassium, and renal function** are obtained prior to starting **SPIRONOLACTONE**, every three months during the first year of treatment, periodically thereafter, or more frequently with increases in dosage or as clinically indicated.
  - Dose adjustment or discontinuation of spironolactone is recommended for elevated potassium levels or serum creatinine >4 mg/dL.
- **Screening for colon and prostate cancer** is recommended in accordance with established guidelines and BOP guidance when available.
- **Breast cancer screening** guidelines for women are followed for transgender women treated with hormone therapy.
- **Screening for osteoporosis** with a DEXA scan may be appropriate in some cases. In addition, monitoring of hormone levels to ensure suppressed gonadotropin levels may serve as a surrogate marker to indicate adequate sex hormone levels in maintaining bone density in these patients.
  - In the absence of sufficient data to formulate evidence-based guidelines, it is considered appropriate to screen those who are at least five years post-gonadectomy, those who are 50 to 65 years old and have risk factors for osteoporosis, and all those who are 65 years or older.
  - Bone density measurements for transgender women are compared with standards for biological females.

- **Baseline and periodic monitoring of liver enzymes and prolactin levels** may be appropriate in those treated with **ESTRADIOL**, but there is insufficient data available to make a specific recommendation.

The following table below summarizes the monitoring schedule for individuals undergoing FEMINIZING hormone therapy.

➔ *See Key to Abbreviations in section preceding Appendices.*

LABORATORY MONITORING DURING FEMINIZING HORMONE THERAPY

Lab Test	Comments	Baseline	3 Mos[1]	6 Mos[1]	12 Mos[1]	Yearly	PRN
BMP	For individuals on spironolactone	X	X	X	X	X	
Lipids	As clinically indicated	X					X
A1C/Glucose	As clinically indicated	X					X
Estradiol	Range: generally, 100–200 pg/mL, but should not exceed 200 pg/ml	X	X	X	X	X	
Total Testosterone[2]	Range: < 50 ng/dL		X	X	X	X	
Prolactin	Only if symptoms of prolactinemia						X
LFTs	After baseline, optional if on estrogen, progesterone, or medroxyprogesterone	X				X	

[1] In the first year of therapy only

[2] Every 3 months in the first year then 1-2 times per year thereafter.

APPENDIX 5. MONITORING DURING MASCULINIZING HORMONE THERAPY

Appropriate monitoring during gender-affirming hormone therapy is crucial to (1) ascertaining that target blood levels of hormones are being met and (2) assessing and maintaining the individual's health overall.

- *A pregnancy test is obtained prior to starting treatment for all persons assigned as female at birth and have child-bearing potential.*

- **Clinical and laboratory monitoring** is appropriate every three months during the first year, and then as clinically indicated (typically once or twice yearly).
  - *Monitor for development of masculine characteristics, for target blood levels, and for adverse of effects of medication and other treatments.*
- Cardiovascular risk assessment is recommended periodically for all patients treated with hormones, in accordance with established guidelines and BOP guidance when available.
  - Specific parameters that should be monitored include weight and body mass index, blood pressure, lipids, and blood sugar and/or hemoglobin A1c levels.
- Serum testosterone levels are obtained before starting treatment with testosterone, and then every three months while on treatment.
  - Timing of the testosterone level is determined by the route of administration.
    - Testosterone enanthate/cypionate injections, testosterone levels should be obtained midway between injections. The target testosterone level is 400-700ng/dL.
    - Transdermal testosterone levels can be done any time after one week of therapy.
- Serum estradiol levels are obtained before starting hormone therapy, and then every three months while on treatment until estradiol levels are < 50 pg/ml and cessation of menses has been six months.
- A complete blood count (**CBC**) and liver panel are obtained prior to starting hormone therapy, every three months during the first year of treatment, once or twice yearly thereafter, or more frequently as clinically indicated.
  - Dose adjustment or discontinuation of testosterone is indicated if the hematocrit is > 54%.
- Screening for colon cancer is recommended in accordance with established guidelines and BOP guidance when available.
- Breast cancer screening guidelines for women are followed for **TG** individuals treated with hormone therapy and who have not had mastectomies.
- Cervical cancer screening is performed annually in those who are treated with hormone therapy and have cervical tissue (i.e., no hysterectomy).
- Screening for osteoporosis with a DEXA scan may be appropriate in some cases.
  - In the absence of sufficient data to formulate evidence-based guidelines, it is considered appropriate to assess bone mineral density prior to starting treatment in those with risk factors for osteoporosis, those who are at least five years status post-gonadectomy, and all those who are 60 to 65 years or older.

- Bone density measurements for transgender men are compared with standards for biological males.

The following table below summarizes the monitoring schedule for individuals undergoing hormone masculinizing therapy.

➜ *See Key to Abbreviations in section preceding Appendices.*

LABORATORY MONITORING OF MASCULINIZING HORMONE THERAPY

Lab Test	Comments	Baseline	3 Mos[1]	6 Mos[1]	12 Mos[1]	Yearly	PRN
CBC (Hgb & Hct)		X	X	X	X	X	
hCG (if child-bearing potential)		X					
Lipids	As clinically indicated	X					X
A1C/Glucose	As clinically indicated	X					X
LFTs		X		X	X	X	
Estradiol	Range: <50pg/mL		X				X
Total Testosterone[2]		X	X	X	X	X	X

[1] In the first year of therapy only

[2] If IM/SQ – check midway between injections (target level is 400-700ng/dL). Alternatively measure peak and trough levels to ensure levels remain in the normal male range. If patch – check after 1 week. Monitor levels every 3 months until levels are at goal.

APPENDIX 6. FEMINIZING GENDER-AFFIRMING HORMONE THERAPY – CONSENT AND COUNSELING FORM

FEMINIZING GENDER-AFFIRMING HORMONE THERAPY FOR TRANSGENDER PATIENTS

CONSENT AND COUNSELING FORM

INSTITUTION NAME: _____

PATIENT NAME: _____ **ID #:** _____

You want to take estrogen and other medications to feminize your body. Once you start these medications, some of them will need to be taken for the rest of your life to maintain their effects. Before using these medications, you need to know more about how they might affect you, including possible benefits, side effects, risks, and warning signs. We have listed them here for you. It's important that you understand all this information before you start. Please notify your health care provider should you have any questions.

WHAT ARE THE DIFFERENT MEDICATIONS THAT CAN HELP TO FEMINIZE YOU?

ESTROGEN is the female gender-affirming hormone. There are also medications—called **ANDROGEN ANTAGONISTS** (or **ANTI-ANDROGENS** or **ANDROGEN BLOCKERS**)—that stop the production of male hormones and can help you appear less like a man.

WARNING — WHO SHOULD NOT TAKE ESTROGEN?

It should NOT be used by anyone who has a current diagnosis of:

- An estrogen-dependent cancer
- Blood clots that could or did travel to the lungs

It should be used WITH CAUTION, and only after a full discussion of risks, by anyone who:

- Has a personal or strong family history of breast cancer or other cancers that grow faster when estrogens are present
- History of previous clots and currently not on blood thinners
- Has diabetes
- Has eye problems such as retinopathy
- Has heart disease, heart valve problems, or a tendency to have easily clotted blood
- Has hepatitis
- Has high cholesterol
- Has kidney or liver disease
- Has migraines or seizures
- Is obese
- Smokes cigarettes

Please review and **initial each statement** to show you understand the benefits, risks, and changes that may occur from taking these medications. At the end of the document, **indicate your preference regarding hormone therapy, then sign and date it.**

FEMINIZING EFFECTS OF ESTROGEN AND ANTI-ANDROGENS:

_____ I know that estrogen or anti-androgens—or both—may be prescribed to help me appear less like a man and more like a woman.

_____ I know that it can take several months to years for the effects to become noticeable. I know that no one can predict how fast—or how much—change will happen.

_____ I know that if I am taking estrogen, I will probably develop breasts.

- I know it can take several years for breasts to get to their full size.
- I know the breasts will remain, even if I stop taking estrogen.
- I know I should examine my breasts for irregularities as soon as they start growing. I should also have a clinician examine them every year.
- I know I might have a milky discharge from my nipples (galactorrhea). If I do, I know I should have it evaluated by my clinician because it could be caused by the estrogen or by other medications or medical conditions. I know that no one knows if taking estrogen increases the risk of breast cancer.

_____ I know that the following changes are usually not permanent—they are likely to go away if I stop taking the medicines:

- I know my body hair will become less noticeable and will grow more slowly, but it won't stop completely, even if I take the medicines for years.
- I know I will probably have less fat on my abdomen and more on my buttocks, hips, and thighs. It will be redistributed to a more female shape, changing from an "apple" shape to more of a "pear" shape.
- I know that if I already have male pattern baldness, it may slow down, but will probably not stop completely. It is also unlikely that hair that has been lost will grow back.
- I know I may lose muscle and strength in my upper body.
- I know my skin may become softer.

_____ I know that my body will make less testosterone. Upon release, this may affect my sex life in different ways and my future ability to cause a pregnancy:

- I know this treatment may (but is not assured to) make me permanently unable to make a woman pregnant.
- I know my sperm may no longer reach maturity. This could make me less able to cause a pregnancy. I also know I might never produce mature sperm again, but I know that it's also possible that my sperm could still mature. So, I know that I might get someone pregnant if we have vaginal intercourse, and we don't use birth control.
- I know this treatment may cause permanent infertility, and I will not be able to preserve or donate my sperm while incarcerated.

- I know my testicles may shrink down to half their size. Even so, I know that I will need regular checkups for them.
- I know it is likely that my penis won't be hard in the morning as often as it has been before. It is also likely that I will have fewer spontaneous erections.
- I know I may lose the ability to obtain an erection for intercourse.
- I know I may have less sex drive.
- I know that sex between inmates, or between inmates and staff, is not permitted within the BOP.

_____ I know that some parts of my body will not change much by using these medicines.

- I know the hair of my beard and moustache may grow more slowly than before. It may become less noticeable, but it will not go away.
- I know the pitch of my voice will not rise, and my speech patterns will not become more like a woman's.
- I know my Adam's apple will not shrink.
- Although these medicines can't make these changes happen, there are other treatments that may be helpful.

RISKS OF TAKING FEMINIZING MEDICATIONS (ESTROGEN AND ANTI-ANDROGENS):

_____ I know that the side effects and safety of these medicines are not completely known. There may be long-term risks that are not yet known.

_____ I know that I should not take more medicine than I am prescribed. I know it increases health risks. I know that taking more than I am prescribed won't make changes happen more quickly or more significantly. I know my body can convert extra estrogen into testosterone which can slow down or stop my appearing more womanly.

_____ I know these medicines may damage the liver and may lead to liver disease. I know I should be checked for possible liver damage as long as I take them.

_____ I know these medicines cause changes that other people will notice. Some transgender people have experienced harassment, discrimination, and violence because of this. Others have lost the support of loved ones. I know I can reach out to psychology services to help me find support resources. I also know that the BOP does not tolerate harassment, discrimination, and violence in any circumstances. If I feel I am the recipient of any of these actions, I will notify a BOP staff member.

RISKS OF TAKING ESTROGEN:

_____ I know that taking estrogen increases the risk of blood clots that can result in:

- Chronic problems with veins in the legs
- Heart attack
- Pulmonary embolism (blood clot to the lungs), which may cause permanent lung damage or death
- Stroke, which may cause permanent brain damage or death

_____ I know that the risk of blood clots is much worse if I smoke cigarettes, especially if I am over 40. I know the danger is so high that I should stop smoking completely if I start taking estrogen and that I should not start to smoke again when I am released from a BOP institution.

_____ I know that taking estrogen can increase the deposits of fat around my internal organs. This can increase my risk for diabetes and heart disease.

_____ I know that taking estrogen can raise my blood pressure. I know that if my blood pressure goes up, my clinician can work with me to try to control it with diet, lifestyle changes, and/or medication.

_____ I know that taking estrogen increases my risk of getting gallstones. I know that I should talk with my clinician if I get severe or long-lasting pain in my abdomen.

_____ I know that estrogen can cause nausea and vomiting. I know that I should talk with my clinician if I have long-lasting nausea or vomiting.

_____ I know that estrogen can cause headaches or migraines. I know I should talk with my clinician if I have headaches or migraines often, or if the pain is unusually severe.

_____ I know that it is not yet known if taking estrogen increases the risk of prolactinomas. These are non-cancerous tumors of the pituitary gland. I know they are not usually life-threatening, but they can damage vision and cause headaches. I know this possibility needs to be checked periodically by a clinician for at least three years after I start taking estrogen.

_____ I know that I am more likely to have dangerous side effects if:

- I smoke.
- I am overweight.
- I am over 40 years old.
- I have a history of blood clots.
- I have a history of high blood pressure.
- My family has a history of breast cancer.

RISKS OF TAKING ANDROGEN ANTAGONISTS:

_____ I know that spironolactone affects the balance of water and salts in the kidneys, which may:

- Increase the amount of urine I produce, making it necessary to urinate more frequently.
- Increase thirst.
- Reduce blood pressure.
- Cause (although rarely) high levels of potassium in the blood, possibly leading to changes in heart rhythms that may be life-threatening.

_____ I know that some androgen antagonists make it more difficult to evaluate test results for cancer of the prostate. I know that if I am over 50, I should have my prostate evaluated every year with a prostate-specific antigen test, as applicable.

PREVENTION OF MEDICAL COMPLICATIONS:

_____ I agree to take feminizing medications as prescribed, and I agree to tell my clinician if I have any problems or if I am unhappy with the treatment.

_____ I know that the dose and type of medication that is prescribed for me may not be the same as for someone else.

_____ I know that I need periodic physical exams and blood tests to check for any side effects.

_____ I know that feminization medications can interact with other drugs and medicines—including alcohol, diet supplements, herbs, other hormones, and street drugs—causing complications. I know that I need to prevent complications because they can be life-threatening. That's why I need to be honest with my clinician about whatever else I take or use. I also know that this will not interfere with my getting medical care; I will continue to get medical care here no matter what information I share about what I take.

_____ I know that it can be risky for anyone with certain conditions to take feminizing medicines. I agree to be evaluated if my clinician thinks I may have such a condition. Then, we will decide if it's a good idea for me to start or continue using these medications.

_____ I know that there may be a risk for blood clots after surgery, especially if I will not be mobile for an extended period. I will need to talk with the surgeon and my doctor to decide if I need to stop taking estrogen before and/or after the surgery or immobilizing event.

_____ I know that using these medicines to appear more womanly is an "off-label" use. I know that this means that using these medicines for this purpose is not approved by the Food and Drug Administration (FDA). I know that the medicine and dose that is recommended for me is based on the judgment and experience of the clinician.

_____ I know that I can choose to stop taking these medicines at any time. I know that if I decide to do that, I should do it with the help of my clinician. This will help me make sure there are no negative reactions. I also know that my clinician may suggest that I cut the dose or stop taking it altogether if certain conditions develop. This may happen if the side effects are severe or if there are health risks that cannot be controlled.

MY SIGNATURE BELOW CONFIRMS THAT:

- My clinician has talked with me about:
  - The benefits and risks of taking feminizing medication.
  - The possible or likely consequences of hormone therapy.
  - Potential alternative treatments.

_____
_____
_____
_____
_____

- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects or risks.
- I have had enough opportunity to discuss treatment options with my clinician.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to take, refuse, or postpone therapy with feminizing medications.
- I am 18 years old or older.

BASED ON ALL THIS INFORMATION:

_____ I understand the risks, and consent to taking estrogen.

_____ I understand the risks, and decided I do not consent to taking estrogen

_____ I understand the risks, and consent to taking androgen antagonists (e.g., spironolactone).

_____ I understand the risks, and decided I do not consent to taking androgen antagonists (e.g., spironolactone).

_____ _____
Patient's Signature *Date*

_____ _____
Prescribing Physician's Signature *Date*

Your health is important to us. If you have any questions or concerns, please come to sick call and an appointment with your provider will be made.

APPENDIX 7. MASCULINIZING GENDER-AFFIRMING HORMONE THERAPY – CONSENT AND COUNSELING FORM

MASCULINIZING GENDER-AFFIRMING HORMONE THERAPY FOR TRANSGENDER PATIENTS

CONSENT AND COUNSELING FORM

INSTITUTION NAME: _____

PATIENT NAME: _____ **ID #:** _____

You have expressed a desire to take testosterone to masculinize your body. Before beginning treatment, there are several details about treatment that you need to be familiar with, including the possible advantages, disadvantages, risks, warnings, and alternatives. These topics are covered below. It is important that you understand all this information before initiating treatment. Please notify your health care provider should you have any questions.

WHAT IS TESTOSTERONE?

Testosterone is the hormone responsible for male features. It builds muscle, causes the development of facial hair, and is responsible for the deepening of a person's voice during puberty. Testosterone also may increase sex-drive.

HOW IS TESTOSTERONE TAKEN?

Testosterone is usually injected every one to four weeks. It is not used as a pill because the body may not absorb it properly, and it can cause liver problems. Some people use skin creams and patches, but these are not used in the correctional environment.

The doses used for injections differ from product to product, and from patient to patient. Doses may range from 100 mg to 400 mg. The injections are administered into a large muscle to slow the release of the hormone. There can be unwanted swings in hormone levels. This can be controlled by changing how often the dose is given, how much of a dose is given, or by changing formulations.

WARNING — WHO SHOULD NOT TAKE TESTOSTERONE?

Testosterone should ***not*** be used by anyone who is pregnant or has uncontrolled coronary artery disease.

It should be used ***with caution and only after a full discussion of risks*** by anyone who has: acne, family history of heart disease or breast cancer, blood clot history, high levels of cholesterol, liver disease, or high red-blood-cell count. Caution should also be used in obese patients and persons who smoke.

MONITORING:

Periodic blood tests to check on the effects of the hormone will be required for treatment. Routine breast exams and pelvic exams with pap tests should be continued, when applicable.

BENEFITS AND RISKS OF TESTOSTERONE TREATMENT:

Benefits	Risks
• Appearing more like a man: • Larger clitoris***** • Coarser skin • Deeper voice***** • Increased body hair***** • Increased facial hair***** • Increased muscle mass • Increased strength • Elimination of menstrual periods • Increased physical energy • Protection against bone thinning (osteoporosis) *****_These are permanent changes._	• Acne (may permanently scar) • Blood clots (thrombophlebitis) • Emotional changes • Headache • High blood pressure (hypertension) • Increased red-blood-cell count • Infertility • Inflamed liver • Interaction with drugs for diabetes and blood thinning, e.g., Coumadin and Warfarin • Male pattern baldness • Increased abdominal fat • Increased risk of heart disease • Swelling of hands, feet, and legs • Weight gain

Please review and **initial each statement** to show that you understand the benefits, risks, and changes that may occur from taking these medications. At the end of the document, **indicate your preference regarding hormone therapy, then sign and date it.**

MASCULINIZING EFFECTS OF TESTOSTERONE:

_____ I know that testosterone may be prescribed to make me appear less like a woman and more like a man.

_____ I know that it can take several months or longer for the effects to become noticeable.

_____ I know that no one can predict how fast or how much change will take place.

_____ ***I know that the changes may not be complete for two to five years after starting testosterone.***

_____ ***I know the following changes are likely to be permanent, even if I stop taking testosterone:***

- Bigger clitoris — typically about half an inch to a little more than an inch
- Deeper voice
- Growth of facial hair (moustache and beard)
- Hair loss at the temples and crown of the head and the possibility of becoming completely bald
- More, thicker, and coarser hairs on abdomen, arms, back, chest, and legs

_____ ***I know that the following changes are usually NOT permanent and will likely go away if I stop taking testosterone:***

- Acne (however, acne scars will be permanent)
- Elimination of menstrual periods (typically stop one to six months after starting testosterone)
- Increased abdominal fat (redistribution of fat to a more masculine shape)
- Decreased fat on buttocks, hips, and thighs
- More muscle mass and strength

- Vaginal dryness

_____ I know that the effects of testosterone on fertility are unknown and may cause permanent infertility. I have been told that I may or may not be able to get pregnant even if I stop taking testosterone. I know I might still get pregnant even after testosterone stops my menstrual periods. I know I cannot take testosterone if I am pregnant. By continuing treatment, I accept that I may never be able to biologically parent a child. I know this treatment may cause permanent infertility, and I will not be able to preserve or donate my eggs while incarcerated

_____ I know that some aspects of my body will not be changed:

- Losing some fat may make my breasts appear slightly smaller, but they will not shrink very much.
- Although my voice may deepen, other aspects of the way I speak will not change.

_____ I know that there are other treatments that may be helpful to make my breasts smaller or my speech manlier. If I have concerns, I can discuss treatment options with my clinician.

RISKS OF TESTOSTERONE:

_____ I know that the medical effects and safety of testosterone are not completely known. There may be long-term risks that are not yet known.

_____ I know not to take more testosterone than prescribed. I know this would be a risk to my health. I know that taking more testosterone than I am prescribed will not make changes happen more quickly or more significantly. I know that my body can convert extra testosterone into estrogen, which can slow down or reverse the progress of my transition.

_____ I know that testosterone can cause changes that increase my risk of heart disease. I know these changes include:

- Less good cholesterol (HDL), which is needed to protect against heart disease, and more bad cholesterol (LDL), which may increase the risk of heart disease
- Higher blood pressure
- Increased deposits of fat around my internal organs

_____ I know that my risk of heart disease is higher if people in my family have had heart disease, if I am overweight, or if I smoke.

_____ I know that I should have periodic heart-health checkups for as long as I take testosterone. I know I must watch my weight and cholesterol levels and have them checked by my clinician.

_____ I know that testosterone can damage the liver and possibly lead to liver disease. I know I should be checked periodically for possible liver damage for as long as I take testosterone.

_____ I know that testosterone can increase my red blood cell count and hemoglobin. I know the increase is usually only to the level that is normal for a man. I know normal levels would have no health risks; however, higher increases can cause problems that can be life-threatening. These problems include stroke and heart attack. As such, I know I need to have periodic blood checks for as long as I take testosterone.

_____ I know that taking testosterone can increase my risk for diabetes. It may decrease my body's response to insulin, cause weight gain, and increase deposits of fat around my internal organs. I know I should have periodic checks of my blood glucose for as long as I take testosterone.

_____ I know that my body can turn testosterone into estrogen. I know that no one knows if this could increase the risk of cancers of the breast, ovaries, or uterus.

_____ I know that taking testosterone can thin the tissue of my cervix and the walls of my vagina. This can lead to tears or abrasions during vaginal intercourse. I know it does not matter if my partner is a woman or a man. This raises my risk of getting a sexually transmitted infection, including HIV. I know I should speak frankly with my provider regarding the best ways to prevent and check for infections.

_____ I am aware that sex between inmates, or between inmates and staff, is not permitted.

_____ I know that testosterone can give me headaches or migraines. I know it is best to talk with my clinician if I get them frequently or if the pain is unusually severe.

_____ I know that testosterone can cause emotional changes. For example, I could become more irritable, frustrated, or angry. I know my provider can help me find resources to explore and cope with these changes.

_____ I know that testosterone causes changes that other people will notice. Some transgender people have experienced harassment, discrimination, and violence because of this. Others have lost the support of loved ones. I know I can reach out to psychology services to help me find support resources. I also know that in the BOP, harassment, discrimination, and violence are not tolerated under any circumstances. If I feel I am the recipient of any of these actions, I will notify a BOP staff member.

PREVENTION OF MEDICAL COMPLICATIONS:

_____ I agree to take testosterone as prescribed, and I agree to tell my clinician if I have any problems or am unhappy with the treatment.

_____ I know that the dose and type of medication prescribed for me may not be the same as it is for someone else.

_____ I know that I need periodic physical exams and blood tests to check for any side effects.

_____ I know that testosterone can interact with other drugs and medicines, including alcohol, diet supplements, herbs, other hormones, and street drugs. This kind of interaction can cause complications. I know that I need to prevent complications because they can be life-threatening. I need to be honest with my clinician about other items I am taking. I also know that this will not interfere with my getting medical care; I will continue to get medical care here no matter what information I share about what I take.

_____ I know that it can be risky for anyone with certain conditions to take testosterone. I agree to be evaluated if my clinician thinks I may have one of these conditions. Then, we will decide if it is a good idea to start or continue using testosterone.

_____ I know that using testosterone to appear more masculine is an "off-label" use. I know this means it is not approved by the Food and Drug Administration (FDA) for this purpose. I know the medicine and dose recommended for me is based on the judgment and experience of the clinician.

_____ I know that I can choose to stop taking testosterone at any time. I know if I decide to stop, I should discontinue with the help of my clinician to ensure there are no negative reactions. I know my clinician may suggest I cut the dose or stop taking it altogether if certain medical conditions develop. This may happen if the side effects are severe or if there are health risks that cannot be controlled.

MY SIGNATURE BELOW CONFIRMS THAT:

- My clinician has talked with me about:
  - The benefits and risks of taking testosterone.
  - The possible or likely consequences of hormone therapy.
  - Potential alternative treatments.
  - _____
    _____
    _____
    _____
- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects or risks.
- I have had enough opportunity to discuss treatment options with my clinician.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to take, refuse, or postpone testosterone therapy.
- I am 18 years old or older.

BASED ON ALL THIS INFORMATION:

_____ I understand the risks, and consent to taking testosterone.

_____ I understand the risks, and decided I do not consent to taking testosterone at this time.

_____ _____
Patient's Signature *Date*

_____ _____
Prescribing Physician's Signature *Date*

Your health is important to us. If you have any questions or concerns, please come to sick call and an appointment with your provider will be made.

SUPPLEMENTAL APPENDIX B

Declaration of Dr. Dan H. Karasic in Support of Plaintiffs' Motion for a Preliminary Injunction,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. Mar. 17, 2025)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiff, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691

DECLARATION OF DR. DAN H. KARASIC IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Dan H. Karasic, M.D., hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

4. I am a Professor Emeritus of Psychiatry at University of California – San Francisco (UCSF). I have been on faculty at UCSF since 1991. I have also had a telepsychiatry private practice since 2020.

5. I received my Doctor of Medicine (M.D.) degree from the Yale Medical School in 1987. In 1991, I completed my residency in psychiatry at the University of California – Los Angeles (UCLA) Neuropsychiatric Institute, and from 1990 to 1991, I was a postdoctoral fellow in a training program in mental health services for persons living with AIDS at UCLA.

6. For over 30 years, I have worked with patients with gender dysphoria. I am a Distinguished Life Fellow of the American Psychiatric Association and have been the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, as well as the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

7. Over the past 30 years, I have provided care for thousands of transgender patients.

8. I previously sat on the Board of Directors of the World Professional Association for Transgender Health (WPATH) and am a co-author of WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7, and the lead author on the Mental Health chapter of Version 8. The WPATH Standards of Care are the internationally accepted guidelines designed to promote the health and welfare of transgender, transsexual, and gender variant persons. I remain active in the work of WPATH.

9. As a member of the WPATH Global Education Initiative, I helped develop a specialty certification program in transgender health and helped train over 2,000 health providers.

10. At UCSF, I developed protocols and outcome measures for the Transgender Surgery Program at the UCSF Medical Center. I also served on the Medical Advisory Board for the UCSF Center of Excellence for Transgender Care and co-wrote the mental health section of the original Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People and the revision in 2016.

11. I have worked with the San Francisco Department of Public Health, helping to develop and implement their program for the care of transgender patients and conducting mental health assessments for gender-affirming surgery. I served on the City and County of San

Francisco Human Rights Commission's LGBT Advisory Committee, and I have been an expert consultant for California state agencies and on multiple occasions for the United Nations Development Programme on international issues in transgender care.

12. I have held numerous clinical positions concurrent to my clinical professorship at UCSF. Among these, I served as an attending psychiatrist for San Francisco General Hospital's consultation-liaison service for AIDS care, as an outpatient psychiatrist for HIV-AIDS patients at UCSF, as a psychiatrist for the Transgender Life Care Program and the Dimensions Clinic at Castro Mission Health Center, and the founder and co-lead of the UCSF Alliance Health Project's Transgender Team. In these clinical roles, I specialized in the evaluation and treatment of transgender, gender dysphoric, and HIV-positive patients.

13. I also regularly provide consultation on challenging cases to psychologists and other psychotherapists working with transgender and gender dysphoric patients. I have been a consultant in transgender care to the California Department of State Hospitals, which treats patients held by forensic commitment and psychiatric patients from the state prisons, and have been a consultant for the California Department of Corrections and Rehabilitation on the care of incarcerated transgender people. I am currently a consultant in transgender mental health to the Alameda County Jails. In my 29 years working with transgender patients in San Francisco public health clinics, I worked with many formerly incarcerated people, including those who spoke of their experiences being denied care while incarcerated.

14. As part of my psychiatric practice treating individuals diagnosed with gender dysphoria and who receive other medical and surgical treatment for that condition, as well as a co-author of the WPATH Standards of Care and UCSF's Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, I am and must be familiar with

additional aspects of medical care for the diagnosis of gender dysphoria, beyond mental health treatment, assessment, and diagnosis.

15. In addition to this work, I have done research on the treatment of depression.

16. I have authored many articles and book chapters on the diagnosis and treatment of gender dysphoria and edited the book Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation.

17. Since 2018, I have performed over 130 independent medical reviews for the State of California to determine the medical necessity of transgender care in appeals of denial of insurance coverage.

18. My professional background, experiences, publications inclusive of those authored in the past ten years, and presentations are detailed in my curriculum vitae ("CV"). A true and correct copy of my most up-to-date CV is attached as Exhibit A.

B. Compensation

19. I am being compensated for my work on this matter at a rate of $400.00 per hour for preparation of declarations and expert reports. I will be compensated $3,200.00 per day for any deposition testimony or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I may provide.

C. Previous Testimony

20. Over the past four years, I have given expert testimony by deposition or trial in the following cases: *L.B. v. Premera Blue Cross*, No. 3:20-cv-06145-RJB (W.D. Wash.); *Misanin v. Wilson*, No. 2:24-cv-04734-BHH (D.S.C.); *Voe v. Mansfield*, No. 1:23-CV-864-LCB-LPA (M.D.N.C.); *Boe v. Marshall*, No. 2:22-cv-184-LCB (N.D. Ala.); *Doe v. Ladapo*, No. 4:23-cv-00114 (N.D. Fla.); *Dekker v. Weida*, No. 4:22-cv-00325 (N.D. Fla.); *K.C. v. The Individual Members of the Medical Licensing Board of Indiana*, No. 1:23-cv-00595 (S.D. Ind.); *Brandt v.*

Rutledge, No. 4:21-cv-00450 (E.D. Ark.); *C.P. v. Blue Cross Blue Shield of Illinois*, No. 3:20-cv-06145 (W.D. Wash.); *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C.); and *Fain v. Crouch*, No. 3:20-cv-00740 (S.D. W. Va.). To the best of my recollection, I have not given expert testimony at a trial or at a deposition in any other case during this period.

II. BASIS FOR OPINIONS

21. In preparing this report, I have relied on my training and my decades clinical experience as a psychiatrist treating patients with gender dysphoria, as well as my experience conducting research, as set out in my curriculum vitae (attached hereto as Exhibit A).

22. I have also relied on my knowledge of the peer-reviewed research regarding the treatment of gender dysphoria, which reflects advancements in the field of transgender health. I have reviewed the materials listed in the bibliography attached hereto as Exhibit B. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as supportive examples in particular sections of this report.

23. I have also relied on my knowledge of the clinical practice guidelines for the treatment of gender dysphoria, including my work as a contributing author of the WPATH Standards of Care, Versions 7 and 8, and the UCSF Guidelines.

24. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I reserve the right to revise and supplement the opinions expressed in this report or the bases for them if any new information becomes available in the future, including as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

25. Additionally, I have reviewed Executive Order 14168, titled "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to The Federal Government,"

issued on January 20, 2025 ("EO 14168").

III. SUMMARY OF EXPERT OPINIONS

26. Gender dysphoria is a serious condition which, if left untreated, can impair a person's ability to function and cause significant depression, anxiety, self-harm and suicidality.

27. EO 14168, by prohibiting "any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the "opposite sex," with "sex" being defined as immutable from the time of conception, prohibits treatments that are part of widely accepted protocols for the treatment of gender dysphoria that are supported by every major medical association in the country—social transition and gender-affirming medical care.

28. Decades of scientific research and clinical experience have demonstrated that social transition and gender-affirming medical care can significantly relieve the distress of gender dysphoria and are medically necessary for many people with this condition. I have seen first-hand, countless times over decades of practice, the many benefits of social transition and gender-affirming medical care.

29. For individuals for whom gender-affirming medical care is indicated, there are no alternative evidence-based treatments for gender dysphoria.

30. Prohibiting people with gender dysphoria from socially transitioning and withdrawing or denying gender-affirming medical care to those for whom it is indicated would put them at risk of significant harm to their health and well-being, including heightened risk of self-harm and suicidality.

31. When incarcerated people are unable to receive gender-affirming medical care to treat their gender dysphoria, some have resorted to self-castration or other self-harm to get relief, or have attempted to end their lives.

IV. EXPERT OPINIONS

A. Sex and Gender Identity

32. At birth, infants are assigned a sex, either male or female, based on the appearance of their external genitalia.

33. While the terms "male sex" and "female sex" are sometimes used in reference to a person's genitals, chromosomes, and hormones, the reality is that sex is complicated and multifactorial. Aside from external genital characteristics, chromosomes, and endogenous hormones, other factors related to sex include gonads, gender identity, and variations in brain structure and function.

34. EO 14168 defines "sex" as "an individual's immutable biological classification as either male or female," that "does not include the concept of 'gender identity.'" EO 14168 § 2(a). It further defines "Female" as "a person belonging, at conception, to the sex that produces the large reproductive cell," and "[m]ale" as "a person belonging, at conception, to the sex that produces the small reproductive cell." EO 14168 §§ 2(d), (e).

35. EO 14168's definition of "sex" is not consistent with how it is commonly understood in medicine. According to the American Medical Association, sex is made up of many diverse components. (AMA, 2023). Similarly, the Endocrine Society notes that because a person's sex characteristics "may not [always] be in line with each other …, the terms biological sex and biological male or female are imprecise and should be avoided." (Hembree, et al., 2017).

36. Gender identity is "a person's deeply felt, inherent sense of being a girl, woman, or female; a man, or male; a blend of male or female; or an alternative gender" (American Psychological Association, 2015, at 834).

37. Gender identity does not always align with sex assigned at birth.

38. Gender identity, which has biological bases (Fischer and Cocchetti, 2020), is not merely a product of external influence, nor is it subject to voluntary change.

39. As documented by multiple leading medical authorities, efforts to change a person's gender identity are ineffective, can cause harm, and are unethical. (American Psychological Association, 2021, Byne, et al., 2018, Coleman, et al., 2012).

40. EO 14168 defines "gender identity" as "a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex." EO 14168 § 2(g).

41. EO 14168's definition of "gender identity" differs from how this term is commonly understood and used in medicine and science. Gender identity does provide a meaningful basis for identification and has been a basis for identification federally as well as in most states, and in many other countries, for years.

42. For most people, their sex assigned at birth, or assigned sex, matches their gender identity. For transgender people, their assigned sex does not align with their gender identity.

43. Based on data from the Williams Institute, approximately 0.6% of the United States population age 13 or older, or about 1.6 million people, identify as transgender. (Herman, et al., 2022).

44. Being transgender is widely accepted as a normal variation in human development. Simply being transgender or gender nonconforming is not a medical condition to be treated and is not considered a mental illness. People who are transgender have no impairment in their ability to be productive, contributing members of society simply because of their transgender status.

45. In the replacement of Gender Identity Disorder in DSM-IV with Gender Dysphoria in DSM-5, the American Psychiatric Association recognized that the clinically significant distress and social/occupational impairment of gender dysphoria is the disorder, not transgender identity. DSM-5 notes that diagnosis and treatment are "focus[ed] on dysphoria as the clinical problem, not identity per se." (DSM-5, at 451). The World Health Organization, in placing Gender Incongruence outside the chapter of mental health conditions, states, "trans-related and gender diverse identities are not conditions of mental ill-health." (World Health Organization, Gender Incongruence).

46. Similarly, WPATH's Standards of Care, Version 8 states: "The expression of gender characteristics, including identities, that are not stereotypically associated with one's sex assigned at birth is a common and a culturally diverse human phenomenon that should not be seen as inherently negative or pathological. … It should be recognized gender diversity is common to all human beings and is not pathological. However, gender incongruence that causes clinically significant distress and impairment often requires medically necessary clinical interventions." (Coleman, et al. 2022).

B. Gender Dysphoria

47. The term "gender dysphoria" is distress related to the incongruence between one's gender identity and attributes related to one's sex assigned at birth.

48. The diagnosis of Gender Dysphoria (capitalized) is a serious medical condition, and it is codified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The current version, known as the *Fifth Edition, Text Revision* (DSM-5-TR), was released in 2022.

49. The DSM's diagnosis of Gender Dysphoria in Adolescents and Adults involves two major diagnostic criteria:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following (one of which must be Criterion A1):

1. A marked incongruence between one's experienced/expressed gender and primary or secondary sex characteristics.
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

50. Gender dysphoria is a condition that is highly amenable to treatment, and the prevailing treatment for it is highly effective.

51. When untreated, gender dysphoria can cause significant distress including increased risk of depression, anxiety, self-harm and suicidality. It can also impair individuals' ability to function in all aspects of life, including school or work, and in family and other personal relationships. These risks decline when transgender individuals are supported and live according to their gender identity.

52. With access to medically-indicated care, transgender people can experience significant and potentially complete relief from their symptoms of gender dysphoria. Not only is this documented in scientific literature and published data, but I have witnessed this in thousands of patients over three decades.

C. Evidence-Based Guidelines for Treatment of Gender Dysphoria

53. The World Professional Association of Transgender Health (WPATH) has issued *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* ("WPATH SOC") since 1979. The current version, published in 2022, is WPATH SOC 8. The SOC 8 provides guidelines for multidisciplinary care of transgender individuals and describes criteria for medical interventions to treat gender dysphoria, including hormone treatment and surgery when medically indicated.

54. The SOC 8 utilized a rigorous evidence-based approach to developing the guidelines. (Coleman, et al., 2022). The process of developing the SOC 8 was a multistep, several years long effort that started in 2017. This process is outlined in great detail in Appendix A to SOC 8.

55. This "process for development of the SOC-8 incorporated recommendations on clinical practice guideline development from the National Academies of Medicine and the World Health Organization that addressed transparency, the conflict-of-interest policy, committee composition and group process." (Coleman, et al., 2022, at S247 (citing Institute of Medicine Committee on Standards for Developing Trustworthy Clinical Practice, 2011; World Health Organization, 2019)). And "[t]he SOC-8 revision committee was multidisciplinary and consisted of subject matter experts, health care professionals, researchers and stakeholders with diverse perspectives and geographic representation." (Coleman, et al., 2022, at S247).

56. WPATH SOC 8's evidence-based recommendations were drafted "based on the results of the systematic, and background literature reviews plus consensus-based expert opinions." (Coleman, et al., 2022, at S250). The recommendations were developed and are based on available evidence supporting interventions, a discussion of risks and harms, as well as feasibility and acceptability within different contexts and country settings. A consensus of the

final recommendations was attained using the Delphi process that included all members of the Standards of Care Revision committee, and supportive and explanatory text of the evidence for the statements was written.

57. The Delphi process is a procedure by which a panel of experts are asked for their opinion on a relevant issue, summarizing and presenting their collective responses and repeating this process for a certain number of rounds. (Shang, 2023; Hsu and Sanford, 2019). It is "a well-established approach to answering a research question through the identification of a consensus view across subject experts." (Barrett and Healey, 2020).

58. The recommendations submitted to a vote under the Delphi process required approval of 75% of the authors of SOC 8 as a whole. More specifically, for a recommendation to be approved, a minimum of 75% of the voters had to approve the statement. (Coleman, et al., 2022, at S250). With regards to SOC 8, every member of the SOC revision committee voted for each statement. Following the aforementioned process, recommendations contained in SOC 8, as published in 2022, were approved by 75% or more of the revision committee.

59. A clinical practice guideline from the Endocrine Society (the Endocrine Society Guideline) provides similar guidelines for clinicians to provide safe and effective treatment for gender dysphoria. (Hembree, et al., 2017).

60. Each of these guidelines are evidence-based and supported by scientific research and literature, as well as extensive clinical experience.

61. The evidence base supporting the recommendations in these guidelines is comparable to the evidence base supporting treatment for other conditions.

62. The protocols and policies set forth by the WPATH Standards of Care and the Endocrine Society Guideline are endorsed and cited as authoritative by the major professional

medical and mental health associations in the United States, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the American College of Obstetrics and Gynecology, the American College of Physicians, and the World Medical Association, among others. They are also relied upon by clinicians treating patients with gender dysphoria.

D. Treatment of Gender Dysphoria

63. Under the WPATH SOC and the Endocrine Society Guideline, the overarching goal of treatment is to eliminate the distress of gender dysphoria by helping the patient live consistently with their gender identity by aligning their presentation and body with their gender identity.

64. Social transition is an integral part of addressing gender dysphoria for transgender people. Social transition involves changing appearance (e.g. garments, hair, make-up) and social role, with change of signifiers of gender, including name and pronouns, and public presentation in the identified gender.

65. In earlier versions of the Standards of Care, social transition was required before medical interventions were considered. While the current WPATH SOC 8 recognizes the necessity for individualized paths for transition, social transition remains central to addressing gender dysphoria for many transgender people.

66. While social transition alone can adequately address gender dysphoria for some people, many individuals with gender dysphoria cannot obtain relief without also receiving medical interventions to align the body with their gender identity. In accordance with the WPATH SOC and the Endocrine Society Guidelines, medical interventions to treat adults with gender dysphoria may include hormone therapy and surgeries, based on a patient's individual needs.

67. For assessing an adult for gender-affirming medical care, WPATH SOC 8 states that the health professional should be licensed and trained in identifying gender dysphoria as well as co-existing mental health and psychosocial concerns, and that medical or surgical treatment should only be recommended when "gender incongruence is marked and sustained," when there is capacity for consent, when other conditions that might affect outcomes have been assessed, and when diagnostic criteria for Gender Dysphoria of DSM 5-TR (in the US) or Gender Incongruence of ICD-11(outside the US) are met.

68. If a patient is assessed to have a medical need for hormone therapy, gender-affirming hormone therapy involves administering testosterone for transgender men and estrogen and testosterone suppression for transgender women. The purpose of this treatment is to attain the appropriate masculinization or feminization of the transgender person that matches as closely as possible to their gender identity. Gender-affirming hormone therapy is a partially reversible treatment.

69. Some transgender individuals need surgical interventions to help bring their phenotype into alignment with their gender. Surgical interventions may include, inter alia, vaginoplasty and orchiectomy for transgender female individuals, and chest reconstruction and hysterectomy for transgender male individuals.

70. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective.

71. The treatment protocols for gender dysphoria are comparable to those for other mental health and medical conditions. Indeed, these or similar procedures are provided for cisgender people with other diagnoses. For example, breast reduction surgery is much more commonly performed on cisgender males who have unwanted excess breast tissue

(gynecomastia), than on transgender males. Dai, et al. (2024) recently found that of the adolescents who had these surgeries, 97% were cisgender males and only 3% were transgender males. Testosterone treatment for transgender males, like for cisgender males with testosterone insufficiency (hypogonadism), involves administering testosterone to bring blood levels up to the normal male range.

E. Social Transition Has Been Shown to Help Alleviate Gender Dysphoria.

72. Social transition has been shown to positively affect mental health (Hughto, et al 2020). Bringing one's presentation into alignment with gender identity can help one see oneself and be recognized and treated by others consistent with one's gender identity. Recognition of chosen name with social transition has been associated with decreases in depression and suicidality. (Russell, et al 2018). In my work with thousands of transgender patients, social transition has been a critical step towards improved mental health. In patients who have been forced to socially detransition, while incarcerated or due to family or career, mental health impacts have been severe to my patients, with increased gender dysphoria, depression, anxiety and in some patients, suicidality and self-harm.

F. Gender-Affirming Medical Care Has Been Shown To Be Safe and Effective Treatment for Gender Dysphoria.

73. There is a substantial body of research and clinical evidence that gender-affirming medical care is effective in treating gender dysphoria. This evidence includes scientific studies assessing mental health outcomes for transgender people who are treated with these interventions, and decades of clinical experience, including my own.

74. The research and studies supporting the necessity, safety, and effectiveness of medical care for gender dysphoria are the same type of evidence that the medical community routinely relies upon when treating other medical conditions.

75. Medical treatment for gender dysphoria has been studied for over half a century, and there is substantial evidence that it improves quality of life and measures of mental health.[1] There is also substantial evidence that the risks of these treatments are low and manageable, and comparable to the type of risks that exist in the same treatments when given to cisgender patients and in many other medical treatments. For example, the cardiovascular risks associated with estrogen apply whether the person is receiving treatment for gender dysphoria, menopause, or other conditions. Regret rates for gender-affirming surgeries are very low, often much lower than for similar surgeries in cisgender patients. (Thornton, et al 2024).

76. The studies on gender-affirming medical care for treatment of dysphoria are consistent with decades of clinical experience of mental health providers across the U.S. and around the world. At professional conferences and other settings in which I interact with colleagues, clinicians report that gender-affirming medical care, for those for whom it is indicated, provides great clinical benefit. In my over 30 years of clinical experience treating gender dysphoric patients, I have seen the benefits of gender-affirming medical care on my patients' health and well-being. I have seen many patients show improvements in mental health, as well as in performance in school and work, in social functioning with peers, and in family relationships when they experience relief from gender dysphoria with gender-affirming medical care.

77. As part of the treatment process for gender dysphoria, patients provide informed consent to their care. In addition, a treating doctor will not offer gender-affirming medical

[1] *See, e.g.*, Dopp, et al., 2024; Shelemy, et al., 2024; Ascha, et al., 2022; Aldridge, et al., 2021; Almazan, et al., 2021; Baker, et al., 2021; Murad, et al., 2010; Nobili, et al., 2018; Pfafflin & Junge, 1998; T'Sjoen et al. 2019; Turan, et al., 2018; van de Grift et al., 2018; Olson-Kennedy, et al., 2018; Cornell, What We Know, 2018; Nguyen, et al., 2018; Oda, et al.,2017; White, Hughto and Reisner, 2016; Fisher, et al., 2016; Keo-Meier, et al., 2015; Wierckx et al., 2014; Colizzi, et al., 2014; Colizzi, et al., 2013.

treatments unless they have concluded after weighing the risks and benefits of care that treatment is appropriate. The risks and benefits of care are discussed with the transgender patient, who must consent.

78. Gender-affirming medical interventions provided in accordance with the WPATH SOC 8 and Endocrine Society Guidelines are widely recognized in the medical community as safe, effective, and medically necessary for many people with gender dysphoria. (*See, e.g.*, the American Psychological Association, 2024 and 2021; American Academy of Pediatrics, 2018 (reaffirmed in 2023); the American Medical Association, 2021; the Pediatric Endocrine Society, 2021; the American College of Obstetricians and Gynecologists, 2021; the Endocrine Society, 2020; the American Academy of Family Physicians, 2020; the American Psychiatric Association, 2018; and WPATH, 2022).

79. For all the reasons above, I am aware of no basis in medicine or science for categorically prohibiting gender-affirming medical care.

G. Harms of a Blanket Prohibition Against Social Transition and Hormone Therapy[2]

80. The overarching goal of treatment is to eliminate the distress of gender dysphoria by aligning an individual patient's body and presentation with their internal sense of self. The denial of medically-indicated care to transgender people not only results in the prolonging of their gender dysphoria, but causes additional distress and poses other health risks, such as depression, post-traumatic stress disorder, and suicidality. In other words, lack of access to gender-affirming care directly contributes to poorer mental health outcomes for transgender people. (Owen-Smith, et al., 2018).

[2] Because the preliminary injunction motion does not seek relief related to gender-affirming surgeries, this portion of the declaration does not address surgery.

81. For patients for whom gender-affirming medical care is indicated, no alternative treatments have been demonstrated to be effective. To the extent one proposed alternative is psychotherapeutic treatment to encourage identification with a person's assigned sex at birth, the American Psychological Association has stated that such efforts provide no benefit and instead do harm. (APA, 2021). Or if an alternative approach is to treat the worsening dysphoria only with therapy, that has not shown to be effective in any research. (Dopp, et al., 2024). Psychotherapy is a critical treatment modality for many patients, but it does not address the underlying gender dysphoria, which when persistent can only be addressed by bringing a patient's body and sex characteristics into alignment with the patient's gender identity.

82. Denying patients with gender dysphoria the ability to socially transition or obtain gender-affirming medical care where indicated predictably will lead to significant deterioration in mental health.

83. I have had patients over the years who were unable to access gender-affirming medical care when it was clinically indicated, including in the years before this care was more widely available. In many of these patients, delayed or denied care resulted in increased depression, anxiety, suicidal ideation and self-harm, increased substance use, and a deterioration in school or work performance. Some patients attempted to self-castrate or remove breasts. For patients with severe distress due to their gender dysphoria, psychotherapeutic approaches did not alleviate this distress absent medical intervention. Some of my patients had years of intensive mental health interventions, including long-term psychotherapy, without relief of gender dysphoria until receiving medical intervention.

84. Research documents the harms to incarcerated individuals with gender dysphoria who have not been able to receive necessary treatment, including attempts at self-castration.

(Brown, 2010, Aldrich et al, 2023). I have provided care for transgender patients after incarceration who had suffered severe mental health consequences, including intolerable gender dysphoria, depression, anxiety, self-harm and suicidality, from denial of the ability to socially and medically transition.

85. A blanket policy withdrawing hormone therapy and the ability to socially transition from individuals with gender dysphoria currently receiving that care would be expected to cause severe negative impact on patients' mental health. I have cared for or consulted on patients who were forced to socially and medically detransition and I've seen the suffering that it caused. For example, I consulted on a patient who, while in the long-term custody of a forensic psychiatry unit, was forced to detransition—both medically and socially. He severely decompensated and attempted suicide. After obtaining legal representation to request that the institution bring in an expert in the treatment of gender dysphoria, he was able to resume gender-affirming hormone therapy and live consistently with his male identity, and his mental health greatly improved. Eventually he was able to have gender affirming surgery, and then be released, and he has flourished in his life and work after release.

V. CONCLUSION

86. Executive Order 14168, which categorically prohibits gender-affirming medical care and social transition for individuals with gender dysphoria who are in the custody of the Bureau of Prisons, regardless of their medical needs, is contrary to widely accepted evidence-based medical protocols for the treatment of gender dysphoria and puts these individuals at risk of significant harm, including heightened risk of depression, self-harm, and suicidality.

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

Executed this 14th day of March, 2025



Dan H. Karasic

EXHIBIT A

University of California, San Francisco

CURRICULUM VITAE

Name: Dan H. Karasic, MD

Position: Professor Emeritus
Psychiatry
School of Medicine

[redacted]

EDUCATION

1978 - 1982	Occidental College, Los Angeles	A.B.; Summa Cum Laude	Biology
1982 - 1987	Yale University School of Medicine	M.D.	Medicine
1987 - 1988	University of California, Los Angeles	Intern	Medicine, Psychiatry, and Neurology
1988 - 1991	University of California, Los Angeles; Neuropsychiatric Institute	Resident	Psychiatry
1990 - 1991	University of California, Los Angeles; Department of Sociology	Postdoctoral Fellow	Research Training Program in Mental Health Services for Persons with AIDS

LICENSES, CERTIFICATION

1990	Medical Licensure, California, License Number G65105
1990	Drug Enforcement Administration Registration Number BK1765354
1993	American Board of Psychiatry and Neurology, Board Certified in Psychiatry

PRINCIPAL POSITIONS HELD

1991 - 1993	University of California, San Francisco	Health Sciences Psychiatry Clincial Instructor
1993 - 1999	University of California, San Francisco	Health Sciences Psychiatry Assistant Clinical Professor

1999 - 2005	University of California, San Francisco	Health Sciences Psychiatry	Associate Clinical Professor
2005 - 2020	University of California, San Francisco	Health Sciences Psychiatry	Clinical Professor
2020-present	University of California, San Francisco	Professor Emeritus of Psychiatry	

OTHER POSITIONS HELD CONCURRENTLY

1980 - 1980	Associated Western Universities / U.S. Department of Energy	Honors Undergraduate Research Fellow	UCLA Medicine
1981 - 1981	University of California, Los Angeles; UCLA Medicine American Heart Association, California Affiliate	Summer Student Research Fellow	
1986 - 1987	Yale University School of Medicine; American Heart Association, Connecticut Affiliate	Medical Student Research Fellow	Psychiatry
1990 - 1991	University of California, Los Angeles	Postdoctoral	Sociology Fellow
1991 - 2001	SFGH Consultation-Liaison Service; AIDS Care	Attending Psychiatrist	Psychiatry
1991 - 2001	AIDS Consultation-Liaison Medical Student Elective	Course Director	Psychiatry
1991 - present	UCSF Positive Health Program at San Francisco General Hospital (Ward 86)	HIV/AIDS Outpatient Psychiatrist	Psychiatry
1991 - present	UCSF AHP (AIDS Health Project/Alliance Health Project)	HIV/AIDS Outpatient Psychiatrist	Psychiatry
1994 - 2002	St. Mary's Medical Center CARE Unit. The CARE Unit specializes in the care of patients with AIDS dementia.	Consultant	Psychiatry
2001 - 2010	Depression and Antiretroviral Adherence Study (The H.O.M.E. study: Health Outcomes of Mood Enhancement)	Clinical Director	Psychiatry and Medicine
2003 - 2020	Transgender Life Care Program and Clinic, Castro Mission Health	Psychiatrist Clinic	Dimensions Dimensions Center
2013 - 2020	UCSF Alliance Health Project, Co-lead, Transgender Team	Co-Lead and Psychiatrist	Psychiatry

HONORS AND AWARDS

1981	Phi Beta Kappa Honor Society	Phi Beta Kappa
1990	NIMH Postdoctoral Fellowship in Health Services for People with AIDS (1990-1991)	National Institute of Mental Health Mental
2001	Lesbian Gay Bisexual Transgender Leadership Award, LGBT Task Force of the Cultural Competence and Diversity Program	SFGH Department of Psychiatry
2006	Distinguished Fellow	American Psychiatric Association
2012	Chancellor's Award for Leadership in LGBT Health	UCSF
2023	Alumni Seal Award for Achievement	Occidental College Professional

MEMBERSHIPS

1992 - present Northern California Psychiatric Society

1992 - present American Psychiatric Association

2000 - 2019 Bay Area Gender Associates (an organization of psychotherapists working with transgendered clients)

2001 - present World Professional Association for Transgender Health

SERVICE TO PROFESSIONAL ORGANIZATIONS

1981 - 1982	The Occidental	News Editor
1984 - 1985	Yale University School of Medicine	Class President
1989 - 1991	Kaposi's Sarcoma Group, AIDS Project Los Angeles	Volunteer Facilitator
1992 - 1996	Early Career Psychiatrist Committee, Association of Gay Lesbian Psychiatrists	Chair and
1992 - 1996	Board of Directors, Association of Gay and Lesbian	Member Psychiatrists
1993 - 1993	Local Arrangements Committee, Association of Gay and Psychiatrists	Chair Lesbian
1994 - 1995	Educational Program, Association of Gay and Lesbian 1995 Annual Meeting	Director Psychiatrists,
1994 - 1998	Board of Directors, BAY Positives	Member
1994 - 2020	Committee on Lesbian, Gay, Bisexual and Transgender	Member

Issues, Northern California Psychiatric Society

1995 - 1997 Board of Directors, Bay Area Young Positives. BAY Positives is the nation's first community-based organization providing psychosocial and recreational services to HIV-positive youth — President

1995 - 1997 Executive Committee, Bay Area Young Positives. — Chair

1996 - 2004 Committee on Lesbian, Gay, Bisexual and Transgender Issues, Northern California Psychiatric Society — Chair

1998 - 2002 City of San Francisco Human Rights Commission, Lesbian, Gay Bisexual Transgender Advisory Committee — Member

2000 - 2004 Association of Gay and Lesbian Psychiatrists. the organization's educational programs — Vice President Responsible for

2004 - 2005 Association of Gay and Lesbian Psychiatrists — President-elect

2005 - 2007 Caucus of Lesbian, Gay, and Bisexual Psychiatrists of the American Psychiatric Association — Chair

2005 - 2007 Association of Gay and Lesbian Psychiatrists — President

2007 - 2009 Association of Gay and Lesbian Psychiatrists — Immediate Past President

2009 - 2010 Consensus Committee for Revision of the Sexual and Gender Identity Disorders for DSM-V, GID of Adults subcommittee. (Wrote WPATH recommendations as advisory body to the APA DSM V Committee for the Sexual and Gender Identity Disorders chapter revision.) — Member

2010 - 2011 Scientific Committee, 2011 WPATH Biennial Symposium, Atlanta — Member

2010 -2022 World Professional Association for Transgender Care Standards of Care Workgroup and Committee (writing seventh and eighth revisions of the WPATH Standards of Care, which is used internationally for transgender care.) — Member

2010 - 2018 ICD 11 Advisory Committee, World Professional Association for Transgender Health — Member

2012 - 2014 Psychiatry and Diagnosis Track Co-chair, Scientific Committee, 2014 WPATH Biennial Symposium, Bangkok — Member

2014 - 2016 Scientific Committee, 2016 WPATH Biennial Symposium, Amsterdam — Member

2014 - 2018 Board of Directors (elected to 4 year term), World Professional Association for Transgender Health — Member

2014 - 2018 Public Policy Committee, World Professional Association for Transgender Health — Chair

2014 - 2018 WPATH Global Education Initiative: Training providers and specialty certification in transgender health — Trainer and Steering

		Committee Member
2014 - 2016	American Psychiatric Association Workgroup on Gender Dysphoria	Member
2016 - present	American Psychiatric Association Workgroup on Gender Dysphoria	Chair
2016	USPATH: Inaugural WPATH U.S. Conference, Los Angeles, 2017	Conference Chair

SERVICE TO PROFESSIONAL PUBLICATIONS

2011 - present Journal of Sexual Medicine, reviewer

2014 - present International Journal of Transgenderism, reviewer

2016 - present LGBT Health, reviewer

INVITED PRESENTATIONS - INTERNATIONAL

2009	World Professional Association for Transgender Health, Oslo, Norway	Plenary Session Speaker
2009	World Professional Association for Transgender Health, Oslo, Norway	Symposium Speaker
2009	Karolinska Institutet, Stockholm Sweden	Invited Lecturer
2012	Cuban National Center for Sex Education (CENESEX), Havana, Cuba	Invited Speaker
2013	Swedish Gender Clinics Annual Meeting, Stockholm, Sweden	Keynote Speaker
2013	Conference on International Issues in Transgender care, United Nations Development Programme - The Lancet, Beijing, China	Expert Consultant
2014	World Professional Association for Transgender Health, Thailand	Track Chair Bangkok,
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2014	World Professional Association for Transgender Health, Bangkok, Thailand	Invited Speaker
2015	European Professional Association for Transgender Health, Ghent, Belgium	Invited Speaker
2015	European Professional Association for Transgender Health, Ghent, Belgium	Symposium Chair
2015	Israeli Center for Human Sexuality and Gender Identity, Tel Aviv	Invited Speaker
2016	World Professional Association for Transgender Health, Amsterdam	Symposium Chair
2016	World Professional Association for Transgender Health, Amsterdam	Invited Speaker

2016 World Professional Association for Transgender Health, Amsterdam 2017 Brazil Professional Association for Transgender Health, Sao Paulo — Invited Speaker

2017 Vietnam- United Nations Development Programme Asia Transgender Health Conference, Hanoi

2018 United Nations Development Programme Asia Conference on Transgender Health and Human Rights, Bangkok

2018 World Professional Association for Transgender Health, Invited Speaker Buenos Aires

2021 Manitoba Psychiatric Association, Keynote Speaker

2022 World Professional Association for Public Health, invited speaker, Montreal

INVITED PRESENTATIONS - NATIONAL

1990 Being Alive Medical Update, Century Cable Television — Televised Lecturer

1992 Institute on Hospital and Community Psychiatry, Toronto — Symposium Speaker

1992 Academy of Psychosomatic Medicine Annual Meeting, San Diego — Symposium Speaker

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia — Workshop Chair

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia — Workshop Speaker

1994 American Psychiatric Association 150th Annual Meeting, Philadelphia — Paper Session Co-chair

1995 Spring Meeting of the Association of Gay and Lesbian Psychiatrists, Miami Beach — Symposium Chair

1996 American Psychiatric Association 152nd Annual Meeting, New York — Workshop Speaker

1997 American Psychiatric Association Annual Meeting, San Diego — Workshop Speaker

1997 Gay and Lesbian Medical Association Annual — Invited Speaker Symposium

1998 American Psychiatric Association Annual Meeting, Toronto — Workshop Chair

1998 American Psychiatric Association Annual Meeting, Toronto — Workshop Chair

1998	American Psychiatric Association Annual Meeting, Toronto	Media Session Chair
1998	American Psychiatric Association Annual Meeting, Toronto	Media Session Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Chair
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Symposium Presenter
1999	American Psychiatric Association Annual Meeting, Washington, D.C.	Workshop Chair
2000	American Psychiatric Association Annual Meeting, Chicago	Workshop Chair
2000	National Youth Leadership Forum On Medicine, University of California, Berkeley	Invited Speaker
2001	American Psychiatric Association Annual Meeting, New Orleans	Workshop Chair
2001	American Psychiatric Association Annual Meeting, New Orleans	Media Program Chair
2001	Association of Gay and Lesbian Psychiatrists Chair Symposium, New Orleans	
2001	Harry Benjamin International Gender Dysphoria Association Biennial Meeting, Galveston, Texas	Invited Speaker
2002	American Psychiatric Association Annual Meeting, Philadelphia	Media Program Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2002	American Psychiatric Association Annual Meeting, Philadelphia	Workshop Chair
2003	Association of Gay and Lesbian Psychiatrists CME	Chair Conference
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Symposium Co-Chair
2003	American Psychiatric Association Annual Meeting, San Francisco	Workshop Chair
2003	American Public Health Association Annual Meeting, San Francisco	Invited Speaker
2004	Mission Mental Health Clinic Clinical Conference	Invited Speaker

2004	Association of Gay and Lesbian Psychiatrists Conference, New York	Co-Chair
2004	Mental Health Care Provider Education Program: Los Angeles. Sponsored by the American Psychiatric Association Office of HIV Psychiatry	Invited Speaker
2005	American Psychiatric Association Annual Meeting, Atlanta	Workshop Speaker
2005	Association of Gay and Lesbian Psychiatrists Saturday Symposium	Invited Speaker
2008	Society for the Study of Psychiatry and Culture, San Francisco	Invited Speaker
2009	American Psychiatric Association Annual Meeting, San Francisco	Symposium Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	National Transgender Health Summit, San Francisco	Invited Speaker
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Chair
2011	American Psychiatric Association Annual Meeting, Honolulu, HI	Symposium Speaker
2011	World Professional Association for Transgender Health Conference, Atlanta, GA	Invited Speaker Biennial
2011	World Professional Association for Transgender Health Conference, Atlanta, GA	Invited Speaker Biennial

		Invited Speaker
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA	
2011	Institute on Psychiatric Services, San Francisco	Invited Speaker
2012	Gay and Lesbian Medical Association Annual Meeting	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	National Transgender Health Summit, Oakland, CA	Invited Speaker
2013	American Psychiatric Association Annual Meeting, San Francisco	Invited Speaker
2013	Gay and Lesbian Medical Association, Denver, CO	Invited Speaker
2014	American Psychiatric Association Annual Meeting, New York	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Moderator
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2014	Institute on Psychiatric Services, San Francisco	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	National Transgender Health Summit, Oakland, CA	Invited Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Workshop Speaker
2015	American Psychiatric Association Annual Meeting, Toronto	Course Faculty
2016	American Psychiatric Association Annual Meeting	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Atlanta	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Springfield, MO	Course Faculty
2016	World Professional Association for Transgender Health Global Education Initiative, Fort Lauderdale, FL	Course Faculty
2017	World Professional Association for Transgender Health, GEI, Los Angeles Course Faculty	
	World Professional Association for Transgender Health	

Surgeon's Training, Irvine, CA Course Faculty

2017 American Urological Association Annual Meeting, San Francisco CA Invited Speaker

2018 World Professional Association for Transgender Health GEI, Portland OR, Course Faculty

2018 World Professional Association for Transgender Health GEI, Palm Springs, Course Faculty

2019 American Society for Adolescent Psychiatry Annual Meeting, San Francisco, Speaker

2019 American Psychiatric Association Annual Meeting, San Francisco, Session Chair

2020 Psychiatric Congress, Invited Speaker

2022 World Professional Association for Transgender Health, Montreal, invited speaker

2023 National Transgender Health Summit, San Francisco, invited speaker

2023 American Psychiatric Association Annual Meeting, San Francisco, invited speaker

2023` US Professional Association for Transgender Health, speaker

2024 World Professional Association for Transgender Health, Lisbon

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

1990 Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute Invited Lecturer

1991 Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine Symposium Speaker

1991 Joint Project of the Southern California AIDS Interfaith Council and UCLA School of Medicine Workshop Panelist

1992 Advanced Group Therapy Seminar, UCLA Neuropsychiatric Institute Invited Lecturer

1993 UCSF School of Nursing Invited Lecturer

1995 UCSF/SFGH Department of Medicine Clinical Care Conference Invited Speaker

1996 UCSF School of Nursing Invited Speaker

		Invited Speaker
1996	Psychopharmacology for the Primary Care AIDS/Clinician, series of four lectures, UCSF Department of Medicine	Invited Lecturer
1996	UCSF AIDS Health Project Psychotherapy Internship Training Program	
1996	UCSF/SFGH Department of Medicine AIDS Quarterly Update	Invited Speaker
1996	San Francisco General Hospital, Division of Addiction Medicine	Invited Speaker
1996	UCSF Langley Porter Psychiatric Hospital and Clinics	Invited Speaker Grand Rounds
1997	UCSF School of Nursing	Invited Speaker
1997	UCSF Department of Medicine AIDS Program	Invited Speaker
1997	Northern California Psychiatric Society Annual Meeting, Monterey	Workshop Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1997	Northern California Psychiatric Society LGBT Committee	Chair Fall Symposium
1997	Progress Foundation, San Francisco	Invited Speaker
1998	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
1999	Northern California Psychiatric Society Annual Meeting, Rosa	Invited Speaker Santa
1999	Northern California Psychiatric Society Annual Meeting, Rosa	Invited Speaker Santa
1999	University of California, Davis, Department of Psychiatry	Invited Speaker Grand Rounds
1999	California Pacific Medical Center Department of Grand Rounds	Invited Speaker Psychiatry
1999	San Francisco General Hospital Department of Psychiatry Departmental Case Conference	Discussant
2000	Langley Porter Psychiatric Hospital and Clinics Consultation Liaison Seminar	Invited Speaker
2000	San Francisco General Hospital, Psychopharmacology Seminar	Invited Speaker

2000	UCSF Transgender Health Conference, Laurel Heights Conference Center	Invited Speaker
2000	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2000	Community Consortium Treatment Update Symposium, California Pacific Medical Center, Davies Campus	Invited Speaker
2000	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker
2001	Psychiatry Course for UCSF Second Year Medical Students	Invited Lecturer
2003	Tom Waddell Health Center Inservice	Invited Speaker
2003	San Francisco Veterans Affairs Outpatient Clinic	Invited Speaker
2004	San Francisco General Hospital Psychiatric Emergency Service Clinical Conference	Invited Speaker
2004	South of Market Mental Health Clinic, San Francisco	Invited Speaker
2005	Northern Psychiatric Psychiatric Society Annual Meeting	Invited Speaker
2005	Equality and Parity: A Statewide Action for Transgender HIV Prevention and Care, San Francisco	Invited Speaker
2005	San Francisco General Hospital Department of Psychiatry Grand Rounds.	Invited Speaker
2006	SFGH/UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2007	UCSF Department of Medicine, HIV/AIDS Grand Rounds, Positive Health Program	Invited Speaker
2007	California Pacific Medical Center LGBT Health Symposium, San Francisco LGBT Community Center	Invited Speaker
2007	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2008	UCSF Department of Medicine, Positive Health Program, HIV/AIDS Grand Rounds	Invited Speaker
2008	San Francisco General Hospital Psychiatry Grand Rounds	Invited Speaker
2008	UCSF CME Conference, Medical Management of HIV/AIDS, Fairmont Hotel, San Francisco	Invited Speaker
2010	Northern California Psychiatric Society Annual Meeting, Monterey, CA	Invited Speaker
2011	Transgender Mental Health Care Across the Life Span, Stanford University	Invited Speaker
2011	San Francisco General Hospital Department of Psychiatry Grand Rounds	Invited Speaker

2012	UCSF AIDS Health Project Veterans Affairs Medical Center.	Invited Speaker 2012 San Francisco
2013	Association of Family and Conciliation Courts Conference, Los Angeles, CA	Invited Speaker
2014	UCSF Transgender Health elective	Invited Speaker
2014	UCSF Department of Psychiatry Grand Rounds	Invited Speaker
2014	California Pacific Medical Center Department of Psychaitry Grand Rounds	Invited Speaker
2014	UCLA Semel Institute Department of Psychiatry Grand Rounds	Invited Speaker
2015	UCSF Transgender Health elective	Invited Speaker
2015	Fenway Health Center Boston, MA (webinar)	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Invited Speaker
2015	Transgender Health Symposium, Palm Springs	Co-Chair
2015	Santa Clara Valley Medical Center Grand Rounds	Invited Speaker
2016	UCSF School of Medicine Transgender Health elective	Invited Speaker
2016	Langley Porter Psychiatric Institute APC Case Conference	Invited Speaker (2 session series)
2016	Zuckerberg San Francisco General Department of Psychiatry Grand Rounds	Invited Speaker
2016	UCSF Mini-Medical School Lectures to the Public	Invited Speaker
2021	Los Angeles County Department of Mental Health,	Invited Speaker
2023	Alameda County Department of Behavioral Health,	Invited Speaker

CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT ACTIVITIES

2005	Northern California Psychiatric Society
2005	Northern California Psychiatric Society Annual Meeting, Napa
2005	Association of Gay and Lesbian Psychiatrist Annual Conference
2006	Annual Meeting, American Psychiatric Association, Atlanta
2006	Annual Meeting, American Psychiatric Association, Toronto
2006	Institute on Psychiatric Services, New York
2007	Association of Gay and Lesbian Psychiatrists Annual Conference

2007	American Psychiatric Association Annual Meeting, San Diego
2007	The Medical Management of HIV/AIDS, a UCSF CME Conference
2008	Society for the Study of Psychiatry and Culture, San Francisco
2009	American Psychiatric Association, San Francisco
2009	World Professional Association for Transgender Health, Oslo, Norway
2010	Annual Meeting of the Northern California Psychiatric Society, Monterey, CA
2011	Transgender Mental Health Care Across the Life Span, Stanford University
2011	National Transgender Health Summit, San Francisco
2011	American Psychiatric Association Annual Meeting, Honolulu, HI
2011	World Professional Association for Transgender Health Biennial Conference, Atlanta, GA
2011	Institute on Psychiatric Services, San Francisco
2012	Gay and Lesbian Medical Association Annual Meeting, San Francisco
2013	National Transgender Health Summit, Oakland, CA
2013	American Psychiatric Association Annual Meeting, San Francisco
2013	Gay and Lesbian Medical Association, Denver, CO
2014	American Psychiatric Association Annual Meeting, New York
2014	Institute on Psychiatric Services, San Francisco
2015	European Professional Association for Transgender Health, Ghent, Belgium
2015	National Transgender Health Summit, Oakland
2015	American Psychiatric Association Annual Meeting, Toronto
2016	American Psychiatric Association Annual Meeting, Atlanta
2016	World Professional Association for Transgender Health, Amsterdam

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

1998 - 2002	City and County of San Francisco Human Rights Member Commission LGBT Advisory Committee

I am the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, which developed a CME course fort the 2015 and 2016 APA Annual Meetings, and has an larger educational mission to train American psychiatrists to better care for transgender patients. I have been leading education efforts in transgender health at APA meetings since 1998. On the APA Workgroup on Gender Dysphoria, I am a co-author of a paper of transgender issues that has been approved by the American Psychiatric Association as a resource document and is in press for the American Journal of Psychiatry. I am also the sole author of the chapter on transgender care in the American Psychiatric Press's Clinical Manual of Cultural Psychiatry, Second Edition.

I have been active internationally in transgender health through my work as a member of the Board of Directors of the World Professional Association for Transgender Health. I am an author of the WPATH Standards of Care, Version 7, and am Chapter Lead for the Mental Health Chapter of SOC 8.
I chaired of the WPATH Public Policy Committee and was a member of the Global Education Initiative, which developed a specialty certification program in transgender health. I helped plan the 2016 WPATH Amsterdam conference, and was on the scientific committee for the last four biennial international conferences. I was on the founding committee of USPATH, the national affiliate of WPATH, and I chaired the inaugural USPATH conference, in Los Angeles in 2017. As a member of the steering committee of the WPATH Global Educational Initiative, I helped train over 2000 health providers in transgender health, and helped develop a board certification program and examination in transgender health.

UNIVERSITY SERVICE UC SYSTEM AND MULTI-CAMPUS SERVICE

1991 – 2003 HIV/AIDS Task Force Member

1992 - 1993 HIV Research Group Member

1992 - 1997	Space Committee	Member
1992 - 2003	Gay, Lesbian and Bisexual Issues Task Force	Member
1994 - 1997	SFGH Residency Training Committee	Member
1996 - 1997	Domestic Partners Benefits Subcommittee.	Chair
1996 - 2000	Chancellor's Advisory Committee on Gay, Lesbian, and Transgender Issues.	Member Bisexual
1996 - 2003	HIV/AIDS Task Force	Co-Chair
1996 - 2003	Cultural Competence and Diversity Program	Member
2009 - present	Medical Advisory Board, UCSF Center of Excellence for Transgender Health	Member
2010 - 2013	Steering Committee, Child Adolescent Gender Center	Member
2011 – 2017	Mental Health Track, National Transgender Health Summit	Chair

DEPARTMENTAL SERVICE

1991 - 2003 San Francisco General Hospital, Department of Psychiatry, Member HIV/AIDS Task Force

1992 - 1993 San Francisco General Hospital, Department of Psychiatry, Member HIV Research Group

1992 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Space Committee

1992 - 2003 San Francisco General Hospital, Department of Psychiatry, Member GLBT Issues Task Force

1994 - 1997 San Francisco General Hospital, Department of Psychiatry, Member Residency Training Committee

1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Member Cultural Competence and Diversity Program

1996 - 2003 San Francisco General Hospital, Department of Psychiatry, Co-Chair HIV/AIDS Task Force

2012 - 2020 San Francisco Department of Public Health Gender Member Competence Trainings Committee

2013 - 2020 San Francisco Department of Public Health Transgender Member Health Implementation Task Force

2014 - 2020San Francisco General Hospital, Department of Psychiatry, Member Transgender Surgery Planning Workgroup

PEER REVIEWED PUBLICATIONS

1. Berliner JA, Frank HJL, **Karasic D**, Capdeville M. Lipoprotein-induced insulin resistance in aortic endothelium. Diabetes. 1984; 33:1039-44.
2. Bradberry CW, **Karasic DH**, Deutch AY, Roth RH. Regionally-specific alterations in mesotelencephalic dopamine synthesis in diabetic rats: association with precursor tyrosine. Journal of Neural Transmission. General Section, 1989; 78:221-9.
3. Targ EF, **Karasic DH**, Bystritsky A, Diefenbach PN, Anderson DA, Fawzy FI. Structured group therapy and fluoxetine to treat depression in HIV-positive persons. Psychosomatics. 1994; 35:132-7.
4. Karasic DH. Homophobia and self-destructive behaviors. The Northern California Psychiatric Physician. 1996; 37 Nov.-Dec. Reprinted by the Washington State Psychiatric Society and the Southern California Psychiatric Society newsletters.
5. Karasic D. Anxiety and anxiety disorders. Focus. 1996 Nov; 11(12):5-6. PMID: 12206111
6. Polansky JS, **Karasic DH**, Speier PL, Hastik KL, Haller E. Homophobia: Therapeutic and training considerations for psychiatry. Journal of the Gay and Lesbian Medical Association. 1997 1(1) 41-47.

7. Karasic DH. Progress in health care for transgendered people. Editorial. Journal of the Gay and Lesbian Medical Association, 4(4) 2000 157-8.

8. Perry S, **Karasic D**. Depression, adherence to HAART, and survival. Focus: A Guide to AIDS Research and Counseling. 2002 17(9) 5-6.

9. Fraser L, **Karasic DH**, Meyer WJ, Wylie, K. Recommendations for Revision of the DSM Diagnosis of Gender Identity Disorder in Adults. International Journal of Transgenderism. Volume 12, Issue 2. 2010, Pages 80-85.

10. Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., **Karasic D** and 22 others. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version. International Journal of Transgenderism, 13:165-232, 2011

11. Tsai AC, **Karasic DH**, et al. Directly Observed Antidepressant Medication Treatment and HIV Outcomes Among Homeless and Marginally Housed HIV-Positive Adults: A Randomized Controlled Trial. American Journal of Public Health. February 2013, Vol. 103, No. 2, pp. 308-315.

12. Tsai AC, Mimmiaga MJ, Dilley JW, Hammer GP, **Karasic DH**, Charlebois ED, Sorenson JL, Safren SA, Bangsberg DR. Does Effective Depression Treatment Alone Reduce Secondary HIV Transmission Risk? Equivocal Findings from a Randomized Controlled Trial. AIDS and Behavior, October 2013, Volume 17, Issue 8, pp 2765-2772.

13. **Karasic DH**. Protecting Transgender Rights Promotes Transgender Health. LGBT Health. 2016 Aug; 3(4):245-7. PMID: 27458863

14. Winter S, Diamond M, Green J, **Karasic D**, Reed T, Whittle S, Wylie K. Transgender people: health at the margins of society. Lancet. 2016 Jul 23;388(10042):390-400. doi: 10.1016/S0140-6736(16)00683-8. Review./> PMID: 27323925

15. Grelotti DJ, Hammer GP, Dilley JW, **Karasic DH**, Sorensen JL, Bangsberg DR, Tsai AC. Does substance use compromise depression treatment in persons with HIV? Findings from a randomized controlled trial. AIDS Care. 2016 Sep 2:1-7. [Epub ahead of print]/> PMID: 27590273

16. Strang JF, Meagher H, Kenworthy L, de Vries AL, Menvielle E, Leibowitz S, Janssen A, Cohen-Kettenis P, Shumer DE, Edwards-Leeper L, Pleak RR, Spack N, **Karasic DH**, Schreier H, Balleur A, Tishelman A, Ehrensaft D, Rodnan L, Kuschner ES, Mandel F, Caretto A, Lewis HC, Anthony LG.
Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. J Clin Child Adolesc Psychol. 2016 Oct 24:1-11. [Epub ahead of print]/> PMID: 27775428

17. Milrod C, **Karasic DH**. Age Is Just a Number: WPATH-Affiliated Surgeons' Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States. J Sex Med 2017;14:624–634.

18. William Byne, Dan H. Karasic, Eli Coleman, A. Evan Eyler, Jeremy D. Kidd, Heino F.L. Meyer-Bahlburg, Richard R. Pleak, and Jack Pula.Gender Dysphoria in Adults:

An Overview and Primer for Psychiatrists.Transgender Health.Dec 2018.57-A3.http://doi.org/10.1089/trgh.2017.0053

19. Identity recognition statement of the world professional association for transgender health (WPATH). International Journal of Transgenderism. 2018 Jul 3; 19(3):1-2. Knudson KG, Green GJ, Tangpricha TV, Ettner ER, Bouman BW, Adrian AT, Allen AL, De Cuypere DG, Fraser FL, Hansen HT, **Karasic KD**, Kreukels KB, Rachlin RK, Schechter SL, Winter WS, Committee and Board of Direct

20. **Karasic, DH** & Fraser, L Multidisciplinary Care and the Standards of Care for Transgender and Gender Non-conforming Individuals. Schechter, L & Safa, B. (Eds.) Gender Confirmation Surgery, Clinics in Plastic Surgery Special Issue, Vol 45, Issue 3, pp 295-299. 2018 Elsevier,Philadelphia**.** https://doi.org/10.1016/j.cps.2018.03.016

21. Milrod C, Monto M, **Karasic DH.** Recommending or Rejecting "the Dimple": WPATHAffiliated Medical Professionals' Experiences and Attitudes Toward GenderConfirming Vulvoplasty in Transgender Women. J Sex Med. 2019 Apr;16(4):586-595. doi: 10.1016/j.jsxm.2019.01.316. Epub 2019 Mar 2.

22. ICD-11 and gender incongruence of childhood: a rethink is needed. Lancet Child Adolesc Health. 2019 10; 3(10):671-673. Winter S, Ehrensaft D, Telfer M, T'Sjoen G, Koh J, Pickstone-Taylor S, Kruger A, Griffin L, Foigel M, De Cuypere G, **Karasic D**. PMID: 31439494.

23. Gender Dysphoria in Adults: An Overview and Primer for Psychiatrists. Focus (Am Psychiatr Publ). 2020 Jul; 18(3):336-350. Byne W, **Karasic DH**, Coleman E, Eyler AE, Kidd JD, Meyer-Bahlburg HFL, Pleak RR, Pula J. PMID: 33343244; PMCID: PMC7587914.

24. WPATH Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, **D. H. Karasic**… J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

BOOKS AND CHAPTERS

1. **Karasic DH**, Dilley JW. Anxiety and depression: Mood and HIV disease. In: The UCSF AIDS Health Project Guide to Counseling: Perspectives on Psychotherapy, Prevention, and Therapeutic Practice. Dilley JW and Marks R, eds. Jossey-Bass. San Francisco, 1998, pp.227-248.

2. **Karasic DH**, Dilley JW. Human immunodeficiency-associated psychiatric disorders. In: The AIDS Knowledge Base, Third Edition. Cohen PT, Sande MA, Volberding PA, eds. Lippincott-Williams &Wilkens, Philadelphia, 1999, pp. 577-584.

3. **Karasic DH** and Drescher J. eds. Sexual and Gender Diagnoses of the Diagnostic and Statistical Manual (DSM): A Reevaluation. 2005. Haworth Press, Binghamton, NY. (Book Co-Editor)
4. **Karasic DH**. Transgender and Gender Nonconforming Patients. In: Clinical Manual of Cultural Psychiatry, Second Edition. Lim RF ed. pp 397-410. American Psychiatric Publishing, Arlington VA. 2015.
5. **Karasic DH**. Mental Health Care of the Transgender Patient. In: Comprehensive Care of the Transgender Patient, Ferrando CA ed. pp. 8-11. Elsevier, 2019.
6. **Karasic DH.** The Mental Health Assessment for Surgery. In: Gender Confirmation Surgery – Principles and Techniques for an Emerging Field. Schechter L ed. Springer Nature, in press 2019.

OTHER PUBLICATIONS

1. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Treatment issues. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base. Waltham, MA: The Medical Publishing Group/ Massachusetts Medical Society. 1994. pp. 5.31-1-5.
2. **Karasic DH**, Dilley JW. HIV-associated psychiatric disorders: Clinical syndromes and diagnosis. In: Cohen P, Sande MA, Volberding P, eds., The AIDS Knowledge Base, Second Edition. Waltham, MA: The Medical Publishing Group/Massachusetts Medical Society. 1994 pp. 5.30-1-5.
3. **Karasic DH**. A primer on transgender care. In: Gender and sexuality. The Carlat Report Psychiatry. April 2012. Vol 10, Issue 4.
4. **Karasic D and Ehrensaft D.** We must put an end to gender conversion therapy for kids. Wired. 7/6/15.

EXPERT WITNESS AND CONSULTATION ON TRANSGENDER CARE AND RIGHTS

2008 Consultant, California Department of State Hospitals

2012 Dugan v. Lake, Logan UT

2012 XY v. Ontario http://www.canlii.org/en/on/onhrt/doc/2012/2012hrto726/2012hrto726.html

2014 Cabading v California Baptist University

2014 CF v. Alberta
http://www.canlii.org/en/ab/abqb/doc/2014/2014abqb237/2014abqb237.html

2017 United Nations Development Programme consultant, transgender health care and legal rights in the Republic of Vietnam; Hanoi.

2017- 2018 Forsberg v Saskatchewan; Saskatchewan Human Rights v Saskatchewan
https://canliiconnects.org/en/summaries/54130
https://canliiconnects.org/en/cases/2018skqb159

2018 United Nations Development Programme consultant, transgender legal rights in Southeast Asia; Bangkok.

2018 Consultant, California Department of State Hospitals

2019, 2021 Consultant/Expert, Disability Rights Washington

2019, 2021 Consultant/Expert, ACLU Washington

2021 Consultant, California Department of Corrections and Rehabilitation

2021 Expert, Kadel v. Folwell, 1:19-cv-00272 (M.D.N.C.).

2021 Expert, Drew Glass v. City of Forest Park - Case No. 1:20-cv-914 (Southern District Ohio)

2021-2022 Expert, Brandt et al v. Rutledge et al. 4:21-cv-00450 (E.D. Ark.)

2021-2022 Expert, Fain v. Crouch, 3:20-cv-00740 (S.D.W. Va.)

2022 Expert, C.P. v. Blue Cross Blue Shield of Illinois, No. 3:20-cv-06145-RJB (W.D. Wash.)

2022-3 Expert, Dekker, et al. v. Weida, et al., No. 4:22-cv-00325-RH-MAF

2019-2023 Expert, Disability Rights Washington v Washington State Department of Corrections

2023 Expert, K.C. et al. v Individual Members of the Indiana Licensing Board, et al- No. 1:23-CV-595

2023 Expert, Doe, et al v Ladapo -No. 4:23-cv-00114-RH-MAF

2023 Expert, Doe et al v Thornbury -No. 3:23-cv-00230-DJH

2024 Expert Voe v Mansfield, *No. 1:23-CV-864-LCB-LPA*

2024 Expert *Boe v. Marshall, No. 2:22-cv-184-LCB (N.D. Ala.)*

2024 Expert *.B. v. Premera Blue Cross, No. 3:20-cv-06145-RJB (W.D. Wash.)*

2024 Expert *Misanin v. Wilson, No. 2:24-cv-04734-BHH (D.S.C.)*

EXHIBIT B

BIBLIOGRAPHY

Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. *International journal of pediatric endocrinology*, *2020*, 8.

Aldrich, J. et al, Gender-Affirming Care, Incarceration, and the Eighth Amendment, AMA J Ethics. 2023;25(6):E407-413.

Aldridge, Z., Patel, S., Guo, B., Nixon, E., Bouman, W. P., Witcomb, G. L., & Arcelus, J. (2021). Long-term effect of gender-affirming hormone treatment on depression and anxiety symptoms in transgender people: A prospective cohort study. *Andrology*, 9(6), 1808-1816.

Allen, L. R., Watson, L. B., Egan, A. M., & Moser, C. N. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology, 7*(3), 302–311.

Almazan, A. N., & Keuroghlian, A. S. (2021). Association Between Gender-Affirming Surgeries and Mental Health Outcomes. *JAMA surgery*, 156(7), 611–618.

American Academy of Family Physicians (2020). Care for the Transgender and Nonbinary Patient, www.aafp.org/about/policies/all/transgender-nonbinary.html.

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SUPPLEMENTAL APPENDIX C

Second Declaration of Dr. Dan H. Karasic in Support of Plaintiffs' Motion for a Preliminary Injunction,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. Apr. 4, 2025)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiff, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691

SECOND DECLARATION OF DR. DAN H. KARASIC IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Dan H. Karasic, M.D., hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

4. I submitted an expert declaration in this case on March 14, 2025. My background and qualifications are discussed in that declaration.

5. I submit this declaration to respond to a few points made in defendants' opposition to Plaintiff's motion and to provide observations regarding the subsequently filed amici brief.

6. First, defendants' brief asserts that there is "ongoing scientific and medical debate over the necessity and efficacy of hormone medication as a treatment for gender dysphoria." *See, e.g.*, Defendants' brief, at 2; *see also id.* at 15 (suggesting treating for gender dysphoria is a "highly controversial area of medical practice"). This is simply untrue. While there is some

discussion within the field about how to best care for minors with gender dysphoria,[1] there is no serious debate or controversy within the medical and mental health fields about the necessity and efficacy of hormone therapy to treat adults with gender dysphoria. As I explained in my first declaration, decades of research and clinical experience have shown the benefits of hormone therapy to individuals with gender dysphoria.

7. Defendants' brief suggests that if BOP were to discontinue hormone therapy, there will be no harm because, it says, there are alternative treatments that could be provided. *See* Defendants' brief, at 10. That is untrue. As I discussed in my first declaration, while not everyone with gender dysphoria needs hormone therapy, for those for whom it is clinically indicated, there is no alternative treatment. There is no evidence-based psychotherapeutic treatment to treat gender dysphoria. Withdrawing hormone therapy from those who have a medical need for it would be expected to result in an exacerbation of their gender dysphoria, putting them at significant risk of depression, anxiety, self-harm and suicidality.

8. The declaration of the Bureau of Prisons' Assistant Director of the Health Services Division, Chris Bina, suggests that if incarcerated people are taken off of hormone therapy, there will be no harm because he says they would "receive treatment for any symptoms they may experience as clinically indicated." *See* Bina declaration, par. 15. But the symptom that people would experience if hormones are withdrawn is a rise in gender dysphoria, and, as discussed above, there are no alternative treatments for gender dysphoria for those who need gender-affirming medical interventions. Thus, withdrawing or withholding such care when

[1] *See, e.g.*, The Cass Review, Independent Review of Gender Identity Services for Children and Young People: Final Report at 195 (April 2024) (the "Cass review") (recommending that puberty blockers be provided within the context of clinical research trials and that hormone therapy be provided "with caution" for youth ages 16 and 17). I do not reference the Cass Review to suggest that I agree with it; indeed, it has been widely criticized. *See, e.g.*, British Medical Association, "BMA to undertake an evaluation of the Cass Review on gender identity services for children and youth people," July 31, 2024, available at https://www.bma.org.uk/bma-media-centre/bma-to-undertake-an-evaluation-of-the-cass-review-on-gender-identity-services-for-children-and-young-people.

indicated puts people at risk of significant harm to their mental health.

9. Defendants cite the Cass Review's finding that "while deaths by suicide in trans-identifying individuals are tragically above the national average, there is 'no evidence that gender-affirmative treatments reduce this.'" Defendants' brief, at 16. As an initial matter, suicide prevention is not the only reason for providing hormone therapy to individuals with gender dysphoria. This condition can cause other severe harms to mental health as I discussed in my first declaration. Moreover, the Cass Review and the cited passage are focused on minors. The cited passage that was excerpted in Defendants' brief specifically refers to "risk of death by suicide among gender diverse youth." Cass Review, at 94. It is difficult to get data on completed suicides for any population,[2] but there is substantial evidence that gender-affirming medical care reduces suicidal ideation and suicide attempts,[3] which are significant risk factors for suicide (*see* n. 2, *supra*), and it is a serious mental health concern in its own right when people think about ending their lives.

10. I'd like to address some confusion reflected in the Defendants' brief about the purpose of hormone therapy in the treatment of gender dysphoria. Defendants' brief states that "[t]he Court apparently assumed that all hormone medication provided to treat gender dysphoria is 'for the purpose of conforming an inmate's appearance to that of the opposite sex,' Exec.

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[2] Because completed suicides are so rare, it's difficult to get data. For example, in clinical trials of over 4400 youth receiving antidepressants, there were no suicides. Nevertheless, there's a black box warning about increased risk of suicidality when antidepressants are used for people under the age of 25, which is based on increased suicidal ideation and attempts. *See* https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/suicidality-children-and-adolescents-being-treated-antidepressant-medications

[3] *See, e.g* Kaltiala, R., Heino, E., Työläjärvi, M., & Suomalainen, L. (2019). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. Nordic Journal of Psychiatry, 74(3), 213–219. https://doi.org/10.1080/08039488.2019.1691260; Allen, et al 2019
Allen LR, Watson LB, Egan AM, Moser CN. Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones. Clinical Practice in Pediatric Psychology. 2019;7(3):302-311. doi:10.1037/cpp0000288
Turban et al 2022 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0261039
Tordoff et al 2022
doi:10.1001/jamanetworkopen.2022.0978

Order No. 14168, § 4(c), regardless of the inmate's individual medical condition.'" Defendants' brief, at 13. Hormone therapy alleviates gender dysphoria by conforming an individual's body to be consistent with their gender identity. Defendants appear to assert that medically necessary hormone treatment and hormone treatment "for the purpose of conforming an inmate's appearance to that of the opposite sex" are separate things. They are not. The use of hormones to change the patient's appearance is medically necessary for the treatment of gender dysphoria.

11. Defendants point to some statements suggesting that WPATH's guidelines are based on ideology, not science or "extensive clinical experience." *See* Defendants' brief at 17. This is not true. As I discussed in my first declaration, WPATH's guidelines were developed by experts in the field using a rigorous evidence-based approach. *See* Karasic initial declaration, pars. 53-62. The authors of the WPATH guidelines include university professors and individuals with extensive clinical experience in providing care for people with gender dysphoria. I myself have been involved in the development of the WPATH guidelines and have over 30 years of clinical experience treating individuals with gender dysphoria. Since the first WPATH guidelines in 1979, WPATH has drawn on the expertise of the most experienced clinicians. And these guidelines were developed using widely accepted methods recommended by the National Academy of Medicine that have been used to develop other medical guidelines such as all American Psychiatric Association's practice guidelines for various psychiatric illnesses, such as schizophrenia, eating disorders, and alcohol use disorder, since 2011.[4] The WPATH guidelines are recognized as authoritative by every major medical association in the United States, including the National Commission on Correctional Health Care.[5]

[4] *See* https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines/guideline-development-process.
[5] *See* National Commission on Correctional Health Care, Position Statement- Transgender and Gender Diverse Health Care in Correctional Settings, November, 2020, available at https://www.ncchc.org/position-statements/transgender-and-gender-diverse-health-care-in-correctional-settings-2020/.

12. Defendants' brief also attempts to discredit the WPATH guidelines by citing references in Judge Lagoa's concurring opinion in *Eknes-Tucker v. Governor of Alabama* in which she cites a publication entitled "The WPATH Files." The WPATH Files is a collection of select out-of-context excerpts of communications among WPATH members on a message board over a four-year period that was obtained and published by a journalist and activist opposed to gender-affirming medical care, along with a narrative she created based on those cherry-picked excerpts in an attempt to discredit WPATH. These select, out-of-context statements do not permit the conclusions about WPATH asserted by the author. Moreover, the author is not someone within the field of medicine or mental health nor experienced in the treatment of gender dysphoria, and this document is not published in a scientific journal. It is an activist's opinion piece based on a highly misleading presentation of excerpts of communications.

13. I have reviewed the amicus brief filed by several states in this case and have a few observations.

a. First, while the amicus brief claims that hormone therapy is a "controversial practice" and attempts to support that claim by citing three studies, none of those studies permit such a conclusion. The first study[6] did not evaluate the evidence because the authors set criteria for inclusion in their review that excluded all of the studies. *See id.* ("We could not appraise the quality of the evidence because no studies met our review's inclusion criteria."). The second study[7] found that hormone therapy was associated with increased quality of life, decreased depression, and decreased anxiety. That the authors were unable to

[6] Haupt et al, Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women, 11 Cochrane Database of Systematic Reviews, Art. No. CD013138, at 2, 11 (2020).
[7] Kellan E. Baker, et al., Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review, 5 J. Endocrine Soc. 1, 12–13 (2021).

draw conclusions about the impact on death by suicide is an ongoing challenge in research. *See supra*, par. 9. Finally, the state amici suggest that a third study[8] indicated that hormone therapy increased suicidality, but that study showed a "reduction in suicidality following gender-affirming treatment." Within the medical and mental health fields, hormone therapy has long been widely recognized as an effective treatment for gender dysphoria.

b. The states' amicus brief also suggests that that psychotherapy is "widely recognized" as an alternative treatment for gender dysphoria in lieu of gender-affirming medical care, citing Anderson et al., Gender Dysphoria and Its Non-Surgical and Surgical Treatments, 10 Health Psych. Rsch., at 4 (2022). But that study, which notes the benefits of psychotherapy for patients with gender dysphoria (e.g. providing support, help with coming out), does not suggest that psychotherapy is a substitute for gender-affirming medical interventions when indicated. Indeed, the study cites to the WPATH Standards of Care and a paper that discusses psychotherapy in the context of preparation for gender-affirming surgery. As discussed above, there is no evidence-based psychotherapeutic treatment to treat gender dysphoria in lieu of hormones.

c. In sum, the amici states make baseless assertions about treatment for gender dysphoria based on a highly misleading characterization of the sources they cite.[9]

[8] Daniel Jackson, Suicide-Related Outcomes Following Gender-Affirming Treatment: A Review, 15(3) Cureus 11–13 (2023).

[9] The states' amicus brief also offers a misleading presentation of the evidence on gender-affirming surgery, but since the motion before the court does not address surgery, I have not provided an analysis of that discussion.

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

Executed this 3rd day of March, 2025

Dan H. Karasic

SUPPLEMENTAL APPENDIX D

Expert Declaration of Dr. Dan H. Karasic in Support of Plaintiffs' Motion for an Updated Preliminary Injunction,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. Apr. 29, 2026)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiff, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691

EXPERT DECLARATION OF DR. DAN KARASIC IN SUPPORT OF PLAINTIFFS' MOTION FOR AN UPDATED PRELIMINARY INJUNCTION

I, Dan H. Karasic, M.D., hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

4. I submitted an expert declaration in this case on March 14, 2024 (my "Initial Declaration") and a second declaration on April 4, 2025 (my "Second Declaration"). I incorporate both declarations by reference.

5. My background and qualifications are discussed in my Initial Declaration, which also includes my CV.

6. Since my Initial Declaration, I have given expert testimony by deposition or trial in the following cases: Hein v. UNMC Physicians et al; Keohane v Dixon; *Bella Boe et al. v.*

Children's Hospital Colorado (2026CV30232).

7. Since my prior two declarations in this case, I have reviewed the following documents related to this case: the Bureau of Prison's ("BOP") Program Statement 5260.01, Management of Inmates with Gender Dysphoria (the "Program Statement"); the Memorandum on Program Statement 5260.01, Management of Inmates with Gender Dysphoria (Feb. 19, 2026) (the "Memorandum"); and the Declaration of Dr. Kristopher Kaliebe dated September 19, 2025 ("Kaliebe Declaration" or "Kaliebe Dec.").

8. I submit this declaration in support of Plaintiffs' Motion for an Updated Preliminary Injunction to address the Program Statement and respond to erroneous statements about gender dysphoria and its treatment contained in the Memorandum and the Kaliebe Declaration, upon which the Memorandum significantly relies.

II. SUMMARY OF EXPERT OPINIONS

9. The Program Statement—by prohibiting and withdrawing hormone therapy and social accommodations from individuals with gender dysphoria—puts these individuals at risk of significant harm to their health and well-being just as the Implementing Memoranda did. The provision for a tapering process for withdrawing hormone therapy does not prevent the predictable serious harms of denying this treatment to those who have a medical need for it.

10. The assertion in the Memorandum and Kaliebe Declaration that social transition and hormone therapy are "unproven" treatments for gender dysphoria is baseless. These interventions are supported by the same type of research that is routinely relied on in medicine, as well as decades of clinical experience.

11. Contrary to assertions made in the Memorandum and Kaliebe Declaration, social transition and hormone therapy for the treatment of adults with gender dysphoria are not the

subject of controversy or debate within the medical and mental health fields. They are widely accepted treatments. To the extent there is any controversy about these treatments in public discourse, it is limited to the context of pediatric patients with gender dysphoria.

12. Dr. Kaliebe's assertion that social transition for individuals with gender dysphoria falls outside of the concept of medically necessary care because it involves things like clothing and grooming has no basis in medicine; all sorts of medically necessary interventions can involve everyday items and activities as opposed to prescriptions or other therapies.

13. The fact that an individual with gender dysphoria is incarcerated does not erase their medical need to socially transition or be treated with hormone therapy and does not make these interventions ineffective.

14. The Program Statement prohibits well-established treatments for gender dysphoria and, instead, provides for psychotherapy and psychotropic medications despite the absence of any evidence that these interventions are effective treatments for this condition. There is no basis for Dr. Kaliebe's assertion that "psychotherapy is the preferred treatment for gender dysphoria" (Kaliebe Dec. p. 14), or the Memorandum's assertion that the Program Statement "is more aligned with the latest scientific information." (Memorandum at 3)

15. There is no basis for the assertion in the Memorandum and Kaliebe Declaration that making gender-affirming care available to those who need it would reward threats of self-harm and that prohibiting such care may reduce self-harm. To the contrary, prohibiting this care regardless of medical need would increase the risk of self-harm.

16. Dr. Kaliebe's report rests on a fundamental lack of understanding of gender dysphoria and its treatment under the prevailing protocols. He has a personal idiosyncratic view of gender dysphoria that is at odds with how this condition is understood within the field of

psychiatry. And his description of what he calls the "affirming model" of care bears no resemblance to the widely accepted protocols for treatment.

17. The Memorandum and Kaliebe Declaration's claims about the lack of integrity of WPATH and all of the major medical and mental health professional organizations that support gender-affirming care for gender dysphoria are baseless.

III. EXPERT OPINIONS

A. The Program Statement—by prohibiting and withdrawing hormone therapy and social accommodations from individuals with gender dysphoria—puts these individuals at the same risk of significant harm to their health and well-being as the Implementing Memoranda did.

18. The Program Statement, like the Implementing Memoranda, prohibits social accommodations and hormone therapy for individuals with gender dysphoria. The Program Statement provides that for those currently receiving hormone therapy to treat gender dysphoria, they should be withdrawn from such care pursuant to a "tapering plan" for each patient. Program Statement at 8. It recognizes that individuals who have been receiving hormones to address gender dysphoria for an extended period of time may "develop severe physiological and psychological withdrawal effects from tapering" and, thus, "it may not be appropriate in all cases for the initial tapering plan to include cessation of hormones," but such plans "should be reevaluated regularly with respect to cessation of hormones." Program Statement at 8.

19. By prohibiting and withdrawing social accommodations and hormone therapy from individuals with gender dysphoria, the Program Statement puts them at the same risk of significant harm to their health and well-being as the Implementing Memoranda did. The fact that hormone therapy is withdrawn through a tapering process rather than cold turkey does not prevent the predictable serious harms of denying hormone therapy to those who have a medical

need for it. All of the anticipated harms to patients I identified in my Initial Declaration, thus, apply equally to the Program Statement. As I explained in my Initial Declaration, gender dysphoria is a serious condition which, if untreated, can cause serious distress and result in depression, anxiety, self-harm and suicidality. Patients who are stripped of this medically necessary care would be expected to see a resumption of the distress and other symptoms they experienced from gender dysphoria prior to treatment.

20. It is disturbing to read the Program Statement, which appears to recognize that some people will be deliberately put through a process that BOP anticipates could cause a "severe physiological and psychological" impact. Dr. Kaliebe suggests that the only harm from discontinuing hormone therapy for individuals with gender dysphoria is the withdrawal effect, which he compares to the impact of withdrawing standard psychiatric medications. Kaliebe Dec. par. 115. Focusing solely on withdrawal effects disregards the harm from losing medical care the patients need. The more apt comparison would be the long-term harm experienced by patients on standard psychiatric medications who are withdrawn from those medications even though they still have a medical need for them.

21. Moreover, there is no evidence that withdrawing people from hormone therapy they have been receiving to treat gender dysphoria (with or without a tapering process) can be done safely without causing significant mental health distress. And there is no evidence that provision of psychotherapy would make this safe

22. In my clinical experience, patients who have needed to discontinue hormone therapy temporarily due to medical issues experienced great distress due to the development of secondary sex characteristics that did not accord with their gender identity and their mental health decompensated. Subjecting this group of individuals to the withdrawal of hormone

therapy in the absence of a medical need to do so and against their will constitutes medical experimentation without consent.

23. In sum, the Program Statement, just like the Implementing Memorandum, imposes a draconian denial of medically-necessary hormone therapy[1] and social transition accommodations and if implemented, BOP should anticipate a mental health crisis for many inmates with gender dysphoria.

B. Contrary to the Memorandum and Kaliebe Declaration's assertion that social transition and hormone therapy are "unproven" treatments for gender dysphoria, substantial evidence of the type routinely relied on in the medical field shows the efficacy of these treatments.

24. The assertion made in the Memorandum and Kaliebe Declaration that social transition and hormone therapy are "unproven" treatments for gender dysphoria is baseless. As discussed in my Initial Declaration, research and decades of clinical experience demonstrate that social transition and hormone therapy can effectively alleviate gender dysphoria and improve patient mental health and functioning. Hormone therapy has been researched and recognized as an effective treatment since the 1950's. (Pfafflin and Junge, 1998)

Hormone therpy

25. The Memorandum asserts that "there is little (if any) reliable evidence showing that hormones address gender dysphoria." Memorandum at 21. It relies on Dr. Kaliebe and various review articles noting that the evidence supporting this care is "low quality". Kaliebe Dec. pars. 83-84. The term "low quality" evidence in scientific research is a term of art that

[1] There are other medications apart estrogen and testosterone, that can be part of hormonal treatment for gender dysphoria. They include testosterone blockers such as spironolactone and finasteride (the latter of which is sometimes used to treat male pattern hair loss). Such medications are part of treatment to help align the patient's body and appearance with their gender identity and, thus, can also be medically necessary.

generally refers to research that uses methods other than randomized controlled trials, which are generally considered "high quality" and provide the strongest evidence, though even many randomized controlled trials do not provide "high quality" evidence. "Low quality" evidence does not have the colloquial meaning of "poor quality" and these methods are not considered "unreliable" as the Memorandum asserts. To the contrary, the research methods used in this body of research—largely cross-sectional and longitudinal observational studies—are widely relied on in the field of medicine. Many widely recommended medical treatments are supported by these kinds of studies rather than by randomized controlled clinical trials, which are not always feasible or ethical. In one large study of systematic reviews, only 5.6% of all medical interventions, and 0% of all endocrine interventions, had a high GRADE score—a scoring system used to rate the quality of scientific research; most had low or very low GRADE scores. (Howick, et al 2022). But banning all endocrine care has not been suggested.

26. The authors of the North American systematic reviews of research on gender affirming medical care for minors that discussed the low quality (also called "low certainty") evidence in this area—Guyatt et al—put out a statement expressing their concern about that being inappropriately used as a basis to ban care, stating:

> It is profoundly misguided to cast health care based on low-certainty evidence as bad care or as care driven by ideology, and low-certainty evidence as bad science. Many of the interventions we offer are based on low certainty evidence, and enlightened individuals often legitimately and wisely choose such interventions. Thus, forbidding delivery of gender-affirming care and limiting medical management options on the basis of low certainty evidence is a clear violation of the principles of evidence-based shared decision-making and is unconscionable.

https://hei.healthsci.mcmaster.ca/systematic-reviews-related-to-gender-affirming-care/.

27. The Memorandum's reliance on two systematic reviews—Haupt et al, "Antiandrogen or estradiol treatment or both during hormone therapy in transitioning

transgender women," 11 Cochrane Database of Systematic Reviews, Art. No. CD013138, (2020), and Baker, et al, "Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review, 5 J. Endocrine Soc. 1 (2021)—is misplaced. These reviews merely note that the research on the treatment of gender dysphoria is the type of "low quality" research discussed above that is not as strong as randomized controlled trials. They do not suggest in any way that the research is unreliable. The Baker review concluded that "gender-affirming hormone therapy is likely associated with improvements in [quality of life], depression and anxiety." Baker 2021 at 13. The Haupt review, which was a review of studies comparing the safety and efficacy of two different approaches to hormone therapy for transgender women, limited inclusion criteria to controlled studies and found a lack of such studies. The authors said they plan to "include non-controlled cohort studies in the next iteration of this review, as our review has shown that such studies provide the highest quality evidence currently available in this field." Haupt 2020 at 2.[2]

28. Dr. Kaliebe's claim that a study by Dhejne had "unfavorable" findings about the efficacy of hormone therapy for the treatment of gender dysphoria (Kaliebe Dec. par. 92) is baseless. Dhejne's study found 10 suicides by transgender people in Sweden from 1973-2003, compared to 5 in its general population matched controls, but no statistically significant difference in suicidality in those who transitioned in the second 15 years of the 30-year period.

[2] Dr. Kaliebe misleadingly cites Miroshneychenko 2025, saying "[t]he best available evidence reporting on the effects of GAHT [cross sex hormones] in individuals with [Gender Dysphoria] ranged from moderate to high certainty for cardiovascular events and low to very low certainty for the outcomes of [Gender Dysphoria], global function, depression, sexual dysfunction, BMD [bone mineral density] and death by suicide." (Kaliebe Dec. par 88). The studies referenced by Miroshneychenko found that the risk of cardiovascular events was exceedingly low (.04%) and that various mental health measures improved with treatment. The certainty of findings regarding the low-risk of cardiovascular events was greater than the certainty of the findings regarding the mental health benefits of treatment given the quality of the evidence.

The paper did not compare transgender people who received gender-affirming medical treatment to those who had not, only recording higher suicidality compared to the general population, especially for those transitioning in the 1970's and 1980's. Therefore, no conclusions can be drawn from the study about the efficacy of hormone therapy for the treatment of gender dysphoria. Indeed, the lead author has stated that the study has been misused to justify blocking the provision of gender affirming care as the study was not designed to evaluate the efficacy of such care., that gender affirming care is beneficial to mental health, and that elevated suicidality in transgender people in Sweden likely is a reflection of societal discrimination.[3]

29. Dr. Kaliebe's suggestion that hormone therapy could actually worsen mental health, citing a study by Glintborg, is baseless. (Kaliebe Dec. par. 86.) Glintborg showed nothing of the kind. The study explains that because a psychological assessment was required to initiate hormone treatment among the subjects of the study, the engagement with mental health professionals resulted in greater mental health diagnoses and treatment of transgender people recorded in this Danish registry study. (Glintborg 2023) It did not suggest that hormone therapy worsens mental health.

30. Dr. Kaliebe speculates that the benefits of hormone therapy found in the research could be the result of a placebo effect. (Kaliebe Dec. par. 90) He offers no basis for making such an assumption that this accounts for all or most of the benefits of treatment found in the research;

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[3] *See* https://www.reddit.com/r/science/comments/6q3e8v/science_ama_series_im_cecilia_dhejne_a_fellow_of/; https://www.transadvocate.com/fact-check-study-shows-transition-makes-trans-people-suicidal_n_15483.htm

Dr. Kaliebe also cites a comment by Anckarsater and Gillberg to support his assertion that the data on the effectiveness of medical transition is unfavorable. (Kaliebe Dec. par. 92) It does not. It was a letter to the editor critiquing the methodology of a study on gender-affirming surgery.

nor does he explain why the findings of an entire body of research should be discounted based on this hypothesis (and if so, why all research on mental health treatments shouldn't be disregarded on this basis).

Social transition

31. As for the Memorandum and Kaliebe Declaration's assertion that social transition is an "unproven" treatment for gender dysphoria, as discussed in my Initial Declaration, research shows that social transition positively affects the mental health of individuals with gender dysphoria. *See also* James, et al 2024 (finding that transgender adults who reported social transition more often reported they were "very to pretty happy" (71% vs. 52%), "thriving" (36% vs. 18%), and satisfied with their lives (43% vs. 24%) compared to those who have not socially transitioned). As discussed above, the lack of "high quality" evidence supporting this intervention is not unusual for widely-used treatments. Additionally, decades of clinical experience show the benefits of social transition in alleviating the distress of gender dysphoria.

C. In the medical and mental health fields, social transition and hormone therapy are not controversial or disputed treatments for gender dysphoria in adults.

32. Contrary to assertions made in the Memorandum, social transition and hormone therapy for the treatment of adults with gender dysphoria are not "controversial" or "medically disputed".

33. Gender-affirming care—including social transition and hormone therapy—is widely accepted in the medical community as effective treatment for gender dysphoria. This is recognized by every major medical and mental health professional organization in the United States including the American Medical Association, the American Psychological Association, the American Psychiatric Association, and the Endocrine Society.

34. While gender-affirming care for minors has been debated in public discourse, that is not the case regarding such care for adults. And there is no debate or controversy within the medical and mental health fields about the necessity and efficacy of social transition and hormone therapy for the treatment of adults with gender dysphoria. As I have explained, decades of research and clinical experience have shown the benefits of gender-affirming care—including social transition and hormone therapy—to individuals with gender dysphoria and there are no other treatments that have been shown to be effective.

35. The Memorandum asserts that other countries and organizations are "reevaluating their clinical guidance for patients suffering from gender dysphoria, in light of recent debate." (Memorandum at 2). While government entities in some countries have urged caution in providing gender-affirming care for *minors* with gender dysphoria, none of those countries have moved away from gender-affirming care for adults. The Memorandum suggests, without basis that UCSF's announcement of a forthcoming revision of their guidelines means they are shifting away from gender affirming care. The UCSF guidelines, which I helped develop, are over 10 years old and it is the norm to periodically update clinical practice guidelines as the field accumulates more knowledge, as was done with the Endocrine Society Guideline and the WPATH SOC. A revision does not indicate a retreat from recommended best practices. I am not aware of any clinical practice guidelines for gender dysphoria that are shifting away from or questioning the effectiveness of hormone therapy for adults with gender dysphoria.

D. The fact that social transition involves everyday items like clothing does not mean it is not medically necessary.

36. Dr. Kaliebe claims that social transition is not medically necessary because, he says, "as can be seen from the list of activities related to social transition [--such as altering

appearance and expression and changing one's name and pronouns]—none are related to healing medical illness or disease." (Kaliebe Dec. pars. 131, 132) He seems to be suggesting that when treatment is for a mental health condition, it can never be medically necessary. But there are medically necessary interventions for many mental health conditions. And medically necessary interventions—whether for physiological or mental health conditions—can include not only medications but also other interventions such as prosthetic devices, particular clothing, and behavioral interventions. For example, people with orthopedic issues may have a medical need to wear certain types of shoes even though a doctor's prescription isn't needed to purchase these items. Diabetics have a medical need to eat sugar when their blood glucose is low even though they don't need a doctor's prescription to get juice or candy. And medically necessary treatment for eating disorders may include lifestyle/behavioral interventions focused on changing how one eats. The fact that there is no medication prescription does not make an intervention any less medically necessary.

E. The fact that an individual with gender dysphoria is incarcerated does not remove their medical need to socially transition or be treated with hormone therapy and does not make such care ineffective.

37. The Memorandum and Kaliebe Declaration say there is a lack of evidence that social transition or hormone therapy are effective at treating gender dysphoria if the patient is incarcerated. The Memorandum states that "[e]ven if there is some reliable evidence that social accommodations address gender dysphoria when the individual is in society at large," that does not apply to the correctional environment. Memorandum at 13. Dr. Kaliebe asserts that there is a lack of studies in the carceral setting that would support hormone therapy for inmates with gender dysphoria. (Kaliebe Dec. par. 83). But there is no basis for the speculation that treatments that have been shown to be effective treatments for gender dysphoria would be

ineffective if the patient is incarcerated. Gender dysphoria is an internal sense of incongruity between assigned gender and experienced gender and the distress that comes from that. The prison environment does not change it.[4]

38. Dr. Kaliebe points to incarcerated people having "histories, characteristics, and vulnerabilities that differ substantially from community-dwelling people with Gender Dysphoria" (Kaliebe Dec. par. 141) and he says that the concept of socially transitioning through accommodations, hormones or surgery is "out of place in the correctional context because an inmate does not live in society at large but a security prison environment." (Kaliebe Dec. par. 142) But none of this explains why this treatment should be presumed to be ineffective for patients in prison. Nothing in Dr. Kaliebe's Declaration offers a medically-based explanation for denying this care to individuals because they are incarcerated.

39. My own experience with patients who are incarcerated is at odds with Dr. Kaliebe's speculation that gender-affirming care is not effective in the prison context. As a consultant for the California Department of Corrections and Rehabilitation, the California Department of State Hospitals (forensic psychiatric hospitals), and the Alameda County jails, I reviewed the medical files of many patients with gender dysphoria, most of whom were receiving hormone therapy and social transition accommodations. And as an expert witness in a cases in Colorado and Washington, I evaluated eight incarcerated people with gender dysphoria who were receiving those interventions. For these patients, as with people with gender dysphoria in the community, these treatments helped alleviate gender dysphoria and improve mental health.

[4] It is worth noting that it can be difficult to do studies in prison because of the ethical issues in obtaining consent in that context in which they may not have the free will to refuse consent without consequences. (Knight 2012) And there is no need to wait for studies on incarcerated people before a medical treatment is used in prisons.

40. While the Memorandum and Dr. Kaliebe assert that gender-affirming care for gender dysphoria is inappropriate in the prison environment, the National Commission on Correctional Health Care—the organization that develops nationally-recognized standards for health services in jails and prisons—supports hormone therapy and social transition accommodations for incarcerated people with gender dysphoria. *See* Position Statement: Transgender and Gender Diverse Health Care in Correctional Settings, National Commission on Correctional Health Care, available at https://www.ncchc.org/wp-content/uploads/Transgender-and-Gender-Diverse-Health-Care-in-Correctional-Settings-2020.pdf.

F. There is no evidence that psychotherapy or psychotropic medications are effective treatments for gender dysphoria.

41. The Program Statement prohibits well-established treatments for gender dysphoria and, instead, provides for psychotherapy and psychotropic medications despite the absence of any evidence that these interventions are effective treatments for gender dysphoria.

42. The Memorandum asserts that "[p]sychotherapy is a well-known and well-established treatment for gender dysphoria," Memorandum at 29, referencing Dr. Kaliebe's Declaration. But neither the Memorandum nor the Kaliebe Declaration provide any studies finding that psychotherapy effectively treats gender dysphoria as a substitute for medical intervention. That is because there are none.

43. For decades, psychotherapy was attempted to try to alleviate gender dysphoria without success. (Brown, 1960) No studies have shown it to be effective. Dopp, et al. 2024 found that psychotherapy aimed at trying to resolve gender incongruence was not effective and

associated only with harm.[5]

44. There are no established psychotherapeutic protocols for the treatment of gender dysphoria.

45. In my experience with patients in the years before medical transition was widely available, many patients with gender dysphoria underwent psychotherapy for years and did not experience relief until they were able to medically transition.

46. This is not to say that psychotherapy can't be helpful in other ways for individuals with gender dysphoria. It can be important to address comorbidities, to help the patient come to understand their gender identity, and to provide support. But it cannot alleviate distress due to gender incongruence.

47. To the extent the goal of psychotherapy is to encourage identification with a person's assigned sex at birth, the American Psychological Association has stated that such efforts are not effective and instead do harm. (APA, 2021).

48. Given that the Program Statement prohibits the evidence-based treatments that exist for gender dysphoria and replaces them with treatments for which there is no evidence of efficacy, there is no basis for Dr. Kaliebe's assertion that "psychotherapy is the preferred treatment for gender dysphoria," (Kaliebe Dec. p. 14), or the claim in the Memorandum that the Program Statement "is more aligned with the latest scientific information." (Memorandum at 3)[6]

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[5] For this reason, Dr. Kaliebe's speculation that the benefits seen in those being treated with hormone therapy could be due to psychosocial support patients may receive while being provided treatment (Kaliebe Dec. par. 91) is without basis. *See also* Kaltiala 2020 (patients who had already been receiving mental health care treatment prior to hormone therapy for suicidality, depression, and anxiety saw significant improvement in those symptoms after being treated with hormone therapy).

[6] Dr. Kaliebe also asserts without any basis that social transition "may undermine an individual's desire to participate in psychotherapy," which he says can provide relief of gender-related distress. (Kaliebe Dec. par 135) As I discussed, no psychotherapy protocol resolves gender

G. There is no basis for the assertion in the Memorandum and Kaliebe Declaration that making gender-affirming care available to those who need it would reward threats of self-harm and that prohibiting such care may reduce self-harm.

49. The Memorandum, relying on Dr. Kaliebe's Declaration, says that one of the reasons for prohibiting gender affirming care is that it "avoids rewarding threats of self-harm and may reduce overall self-harm." (Memorandum at 16; Kaliebe Dec. pars 148-50). This is one of the most bizarre justifications I've seen for denying care. Self-harm is one of the manifestations of the distress of gender dysphoria among some people who are unable to access treatment, including in prisons. Long-term incarceration with limited access to gender affirming care has been associated with a much elevated risk of suicide attempts. (Drakeford 2018) This is consistent with my clinical experience. One of my patients who was being held in a state psychiatric hospital after being convicted of a crime experienced such distress from the denial of gender-affirming care that he attempted to cut off his breasts. But there is no logical basis to conclude that if treatment *is available* to those who need it, people will engage in self-harm to access care. If care is being provided based on assessment of the patient's condition and need for treatment, there should be no reason patients would resort to self-harm as a plea for care. The notion that withholding care could reduce self-harm is, thus, nonsensical. Research and clinical experience make clear that the opposite is true.

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dysphoria, but therapy can be important for comorbidities. It is illogical to speculate that people who would otherwise seek psychotherapy to treat depression, anxiety or other comorbidities would not do so if permitted to socially transition. And this speculation is at odds with my experience as many of my patients are socially transitioned and also participating in psychotherapy.

H. Dr. Kaliebe's declaration demonstrates a lack of understanding of gender dysphoria and its treatment.

50. The Memorandum relies heavily on the Kaliebe Declaration to support its asserted justifications for the policy. But Dr. Kaliebe's declaration reflects a significant lack of understanding of gender dysphoria and its treatment.

51. First, Dr. Kaliebe's declaration reflects a personal idiosyncratic view of gender dysphoria that is at odds with how this condition is understood within the field of psychiatry. He claims that gender dysphoria is a "temporary" disorder that is not likely to be long-lasting if a patient is not provided gender affirming care (Kaliebe Dec. par. 38), which he claims can prolong gender dysphoria (Kaliebe Dec. par. 133). There is no basis for these assertions.

52. Dr. Kaliebe does not provide any support for his claim that "most" cases of gender dysphoria are not long-lasting and there is none, particularly with respect to adults. Some who oppose gender-affirming care for minors have argued that research shows that gender dysphoria in children tends to resolve on its own as they grow up. That is a misreading of that research, which does not actually look at children diagnosed with gender dysphoria, but rather, whether gender non-conforming children grow up to be transgender. But even if one accepted that reading, it has no bearing on adults. Dr. Kaliebe cites no evidence that gender incongruence in adults is likely to resolve on its own, and there is no such evidence. To the contrary, it is widely recognized that when gender incongruence persists past childhood and into adolescence and adulthood, it is highly unlikely to desist. (Zucker et al. 2010; van der Loos, et al 2022). Withholding gender-affirming care as Dr. Kaliebe suggests does not make gender incongruence go away. It only increases suffering by denying treatment that is known to alleviate the distress of gender dysphoria.

53. Dr. Kaliebe's claim that gender affirming care can prolong gender dysphoria in

adults is similarly based on a misreading of inapplicable research on children. He points to research he claims shows that "social transition appears to prolong transgender identification and continue Gender Dysphoria." (Kaliebe Dec. par. 133-134). The studies he cites found that most youth who socially transitioned continued to identify as transgender at follow up. But they did not demonstrate that social transition causes continued transgender identification. One of those studies, Steensma 2013, found that subjects with the most severe gender dysphoria were the ones who socially transitioned and also the ones who were more likely to continue to identify as transgender. In any case, however one interprets this research on children, as noted, gender incongruence in adults is highly unlikely to desist. Thus, withholding gender-affirming care will not promote a cisgender identification; it will cause unnecessary suffering.

54. Further reflecting what appears to be a lack of experience with gender dysphoria, Dr. Kaliebe speculates that because psychotherapy can be effective for body dysmorphic disorder and eating disorders, it could be effective for gender dysphoria. But as discussed, psychotherapy to resolve gender dysphoria was tried for decades and not found to be effective. Kaliebe's assertion that psychotherapy is helpful for other disorders does not change the fact that psychotherapy is ineffective in resolving gender dysphoria.

55. In addition to his lack of understanding of gender dysphoria, Dr. Kaliebe appears to have a profound misunderstanding of gender-affirming care as he offers a description of such care that bears no resemblance to the widely accepted protocols for treatment. He refers to the "affirmation model" of care, implying that what he describes is an accepted mode of treatment, but the model he describes is not what is recommended by the WPATH SOC 8 or the Endocrine Society Guideline or any other well-accepted guideline for treatment of gender dysphoria.

56. First, Dr. Kaliebe says the so-called "affirmation model" of care "promotes

affirmation of the transgender identity immediately and decisively." (Kaliebe Dec. par. 35) Neither WPATH nor the Endocrine Society suggest such treatment. As WPATH has explained: "Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them . . . . Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications." (Coleman, et al., 2012) Psychotherapy, therefore, should be respectful of the patient and allow them the space to explore or express their gender identity, without preconceptions imposed by the therapist: "[Mental health providers] working with transgender people should use active listening as a method to encourage exploration in individuals who are uncertain about their gender identity. Rather than impose their own narratives or preconceptions, MHPs should assist their clients in determining their own path." (Coleman, et al., 2022 p.S171) Contrary to Dr. Kaliebe's assertion, "questions about the patients' self-identification" are not "viewed as hostile and potentially harmful to the patient" (Kaliebe Dec. par. 37), if these questions are part of a respectful process of helping the patient explore their gender, as opposed to an effort by a therapist to suppress the patient's gender expression or to attempt to change their identity.

57. Next, contrary to what Dr. Kaliebe suggests, the prevailing treatment protocols do not ignore comorbidities or shun psychotherapy. (Kaliebe Dec. pars. 32-35) Addressing comorbidities is part of care. Psychotherapy is important to address comorbidities as well as to help patients better understand their gender identity. WPATH SOC 8 states that the health professional should be licensed and trained in identifying gender dysphoria as well as co-existing mental health and psychosocial concerns. (Coleman et al., 2022, at S32) As a psychiatrist working with transgender patients with co-occurring mental illness, treating co-morbidities in

transgender people has been my life's work.

58. Finally, the prevailing treatment protocols do not "minimize discussion of" potential risks. (Kaliebe Dec. par. 37). Hormone therapy is not provided without patients first being informed of the potential risks as part of the informed consent process and treating doctors will not offer such treatment unless they have concluded after weighing the risks and benefits of care that treatment is appropriate.

59. In sum, Dr. Kaliebe creates a straw man by providing a false description of care under the prevailing protocols and then attacks it. He either misunderstands the prevailing protocols or assumes, without basis, that clinicians providing care to patients with gender dysphoria disregard them.

I. The Memorandum and Kaliebe Declaration's attempt to attack the professional medical organizations' support for gender-affirming care is unsupported.

60. The Memorandum and Kaliebe Declaration attempt to cast doubt on the integrity of the major American medical organizations, all of which support gender-affirming care for the treatment of gender dysphoria. They do this this by making a range of allegations about WPATH and the SOC 8 and arguing that all of the other major medical groups' positions are tainted by WPATH. Even if there were such a conspiracy encompassing all of the major medical organizations in the country, that would not change the fact that decades of research and clinical experience demonstrate the effectiveness of gender-affirming care at alleviating gender dysphoria, and the absence of any other evidence-based treatments. But there is no basis for these allegations and I will address some of the key problems with these claims.

61. The Memorandum, relying largely on Dr. Kaliebe's Declaration, asserts that WPATH makes treatment recommendations based on ideology rather than science, suppresses

evidence, and used inappropriate methodology used in developing SOC 8. As I discussed in my Initial Declaration, WPATH's SOC 8 was developed by experts in the field using a well-accepted rigorous process. Kaliebe falsely states that WPATH Standards of Care 8 did not follow the Institute of Medicine's recommendations. They did, as I discussed in my initial declaration.

62. Dr. Kaliebe attempts to discredit the WPATH SOC by discussing cherry-picked excerpts of a document production from WPATH in the case *Boe v. Marshall* (M.D. Ala.) to make assertions about WPATH and its process for developing SOC 8. (Kaliebe Dec. pars. 62, 63) Dr. Kaliebe had access to the documents in the case, most of which remain under seal, because he served as an expert witness in the case. I also served as an expert witness in the case and had access to the same document production. His reliance on select out-of-context excerpts from a production containing thousands of pages of documents does not permit the conclusions that he draws. Nor do his conclusions gain validity by the fact that some opinion writers who have long opposed gender-affirming care and a non-scientific magazine (without an identified author) offered similar commentary about the WPATH document production. (Kaliebe Dec. par. 62)

63. Dr. Kaliebe also relies on a publication called "The WPATH Files," which similarly tries to cobble together a disparaging narrative of WPATH based on excerpts of communications among WPATH members on a clinical care message board. As I discussed in my Second Declaration, this misleading presentation was created by a journalist and activist opposed to gender-affirming medical care and published on an advocacy organization's website.

64. Dr. Kaliebe suggests that the involvement of members of other professional medical groups in the development of the WPATH SOC is a flaw that makes the other

professional groups' guidelines tainted by WPATH's SOC. (Kaliebe Dec. par. 74) This reflects a misunderstanding of WPATH as a multidisciplinary organization. WPATH enlists experts from the relevant fields, including endocrinology and psychology, to develop its clinical guidelines for patients with gender dysphoria. Contrary to Dr. Kaliebe's implication, WPATH is not dictating guidelines for other professional groups to follow; rather, WPATH's guidelines are developed based on the expertise of members of those fields. WPATH exists to coordinate educational and scientific sessions as well as to periodically release practice guidelines. WPATH's SOC is a reflection of the expertise and experience clinicians and academics who practice and study transgender health care around the world. It is therefore unsurprising that those groups' guidelines would agree with WPATH's recommendations.

65. The provision of gender-affirming care for adults around the world is not based solely on WPATH's guidelines; it has been practiced globally for decades, even preceding the first WPATH Standards of Care in 1979. This care has been provided and considered beneficial for over 70 years, and fabricated controversies about WPATH does not change this fact.

66. The Memorandum's reliance on the United States Department of Health and Human Services report "Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices," Nov. 19, 2025, to support its attack on the scientific integrity of WPATH and all of the major medical groups that support gender-affirming should not be given any credence. This publication was mandated by President Trump's Executive Order 14187, "Protecting Children from Chemical and Surgical Mutilation" ("EO 14187"). EO 14187 refers to gender-affirming medical care as "dangerous" treatment that is "maiming" and "mutilat[ing]" children, and directs HHS to take action to "end the chemical and surgical mutilation of children." In this same EO, the President directed HHS to "publish a review of the existing literature and best

practices for promoting the health of children who assert gender dysphoria . . . ." That the report comes out against gender-affirming medical care for minors is, thus, hardly surprising. Moreover, the authors selected by HHS had publicly been on record opposing such care or transgender rights more generally. And most do not have experience treating transgender people because they are not licensed clinicians.

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

Executed this 27th day of April, 2025



Dan H. Karasic

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SUPPLEMENTAL APPENDIX E

Expert Rebuttal Declaration of Dr. Dan H. Karasic in Support of Plaintiffs' Motion for an Updated Preliminary Injunction,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. May 21, 2026)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiff, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691

EXPERT REBUTTAL DECLARATION OF DR. DAN H. KARASIC IN SUPPORT OF PLAINTIFFS MOTION FOR AN UPDATED PRELIMINARY INJUNCTION

I, Dan H. Karasic, M.D., hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

4. I submit this declaration to respond to some of the statements made in the Declaration of Elizabete M. Stahl, Medical Director of the Federal Bureau of Prisons.

5. Dr. Stahl s declaration, which did not provide information about how gender affirming health-care affected patients with gender dysphoria in BOP s custody (apart from her own personal experience with what she characterized as a small number of patients), suggests that that it is not possible to ascertain this information because there is not a vetted, or validated clinical instrument that measures the success or failure of gender dysphoria treatment as there is for treatments for conditions like hypertension and hepatitis C. Stahl Decl. pars. 15, 16, see also *id.* ¶ 13. I am quite surprised that a doctor would make this assertion because clinicians

routinely assess the effectiveness of treatment without using validated measurement instruments. There are many conditions for which such instruments are not widely used. Dr. Stahl apparently is aware of this because she states that medical and mental health providers "rely on objective measures" of disease progression or control "[t]o the extent possible." *Id.* But even where we have instruments to measure symptoms like the Patient Health Questionnaire-9 (PHQ-9) for depression or the Generalized Anxiety Disorder-7 (GAD-7) for anxiety, those may be used to screen for these conditions and provide some information about symptomology, but they are not sufficient on their own to assess efficacy of treatment or make treatment decisions. A clinical exam—including the clinician's observations of the patient and information gathered from the patient—is needed to understand the patient's symptoms and response to treatment.

6. There are in fact some validated instruments for measuring gender dysphoria such as the Utrecht Gender Dysphoria Scale–Gender Spectrum (UGDS-GS) and the Gender Identity/Gender Dysphoria Questionnaire for Adults and Adolescents (GIDYQ-AA). And there are validated instruments to measure quality of life, e.g. the WHOQoL-BREF and the SF-36, that are widely used to assess patient response to all sorts of medical interventions, including treatments for gender dysphoria. These gender dysphoria and quality of life measuring instruments are typically used in research settings as opposed to clinical practice, but they could be used in that context if BOP medical staff truly felt that they were not able to evaluate their patients' response to gender affirming care using clinical exams.

7. Given doctors' routine reliance on clinical exams—without validated measurement instruments—to ascertain treatment effectiveness, it is hard to believe that BOP's medical staff is actually unaware of whether hormone therapy and/or social transition accommodations have been effective in alleviating any patients' gender dysphoria and improving

their mental health.

8. Dr. Stahl's declaration states that one factor that prompted BOP to question its previous position on gender affirming care was "the departure of medical societies and associations from WPATH's guidance." Stahl Decl. ¶ 30; see also *id.* ¶ 37. I am not aware of any major medical societies or associations in the United States that have moved away from gender-affirming care, including hormone therapy and social transition, as treatment for gender dysphoria in adults. The American Medical Association, the American Psychiatric Association, the American Psychological Association, the Endocrine Society, and many others continue to recognize that gender affirming care is appropriate and effective treatment for many patients with gender dysphoria. The only recent change in position regarding gender-affirming care that I am aware of from a major American medical group is that the American Society of Plastic Surgeons now recommends that surgeons delay gender-affirming surgery until a patient is at least 19 years old.

9. Relatedly, I'd also like to respond to the statement in Defendants' brief that "many European countries 'have distanced themselves' from gender affirming care and 'leading organizations in the United States are reevaluating their clinical guidance.'" Brief, at 7. While a few Western European countries have imposed some limits on access to gender affirming medical care for minors, none have moved away from such treatment for adults with gender dysphoria. And while medical organizations regularly update their clinical guidance in all areas of medicine, I am not aware of any major American medical group revising their clinical guidelines in a way that steps away from gender-affirming care as treatment for gender dysphoria.

10. Dr. Stahl suggests that because Dr. Cathy Thompson is a psychologist, she

would not be a reliable expert to opine on whether hormonal treatments are considered medically necessary for treatment of any mental health disorder because psychologists do not prescribe cross-sex hormones or any other medication. *Id.* par 18. This is false. Psychologists are especially well-equipped to assess a patient's need for gender-affirming hormone therapy because gender dysphoria is a mental health diagnosis and its symptoms are mental health symptoms. Indeed, evaluations for gender-affirming hormone therapy or surgeries are often done by psychologists.

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

Executed this 17 day of May, 2026

Dan H. Karasic

SUPPLEMENTAL APPENDIX E

Expert Rebuttal Declaration of Dr. Dan H. Karasic in Support of Plaintiffs' Motion for an Updated Preliminary Injunction,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. May 21, 2026)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiff, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691

EXPERT DECLARATION OF OLE-PETTER HAMNVIK, M.B. B.Ch. B.A.O., M.M.Sc., IN SUPPORT OF MOTION FOR UPDATED PRELIMINARY INJUNCTION

I, Ole-Petter Hamnvik, hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

4. This declaration is based on my own clinical, educational and research experience as a board-certified endocrinologist with experience in assessing and providing gender-affirming hormone therapy to people with gender dysphoria, as well as review of the relevant literature. It is also based on my clinical, educational and research experience with a wide range of medical conditions that are treated with the same medications that are used in gender-affirming hormone therapy for the treatment of gender dysphoria.

5. In preparing this declaration, I have reviewed the following case-specific material: the Bureau of Prisons' ("BOP") Program Statement 5260.01, Management of Inmates with Gender Dysphoria (the "Program Statement"); the Memorandum on Program Statement 5260.01, Management of Inmates with Gender Dysphoria (Feb. 19, 2026) (the "Memorandum"); and the expert declaration of Dr. Kristopher Kaliebe dated September 19, 2025 ("Kaliebe Declaration" or "Kaliebe Dec.").

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

6. I received my medical degree (M.B. B.Ch. B.A.O.) from the Royal College of Surgeons in Ireland (RCSI) in 2005 with First-Class Honors, and my Master of Medical Science (M.M.Sc.) from Harvard Medical School (HMS) in 2014.

7. I completed one year as an intern followed by one year as a Senior House Officer at Beaumont Hospital, Dublin, Ireland.

8. I completed 3 years of Internal Medicine Residency at Brigham and Women's Hospital (BWH) in Boston, MA in 2010, and also spent one additional year as a Chief Medical Resident (overseeing the training of the hospital's internal medicine residents). I remained at BWH for a 3-year Clinical/Research Fellowship in Endocrinology, Diabetes and Metabolism. During this time, I received training in clinical endocrinology as well as in the execution and interpretation of research.

9. I have been Board Certified by the American Board of Internal Medicine in Internal Medicine since 2010, and in Endocrinology, Diabetes and Metabolism since 2012.

10. I have been an Associate Physician in the Division of Endocrinology, Diabetes and Hypertension at BWH since completion of my training in 2014, where I currently see patients in an outpatient endocrinology clinic.

11. My clinical practice spans the full spectrum of adult endocrinology. This includes evaluation and management of patients with hormone excess (e.g., hyperthyroidism, hyperprolactinemia), hormone deficiency (e.g., hypothyroidism, type 1 diabetes), structural problems in endocrine glands (e.g., nodules of the thyroid, adrenal, or pituitary glands), and other conditions that do not fit this framework (polycystic ovary syndrome (PCOS), osteoporosis, gender dysphoria). Many of the conditions that I see are treated with androgens (primarily testosterone) or estrogens, for example estrogen-containing birth control pills in PCOS, testosterone for impaired testicular function in cisgender men, and hormone therapy for menopausal symptoms in cisgender women. Part of my clinical time is spent supervising the endocrinology fellows' clinic at BWH, where the fellows (physicians who are training to become endocrinologists) do a primary evaluation of patients under my supervision and teaching.

12. I have treated patients with gender dysphoria since I started my endocrinology fellowship in 2010. I played a leading role in establishing and expanding the multidisciplinary

Center for Transgender Health at BWH. Gender-affirming hormone therapy is now a significant part of my clinical practice. In the year from Oct 1, 2024, to Sept 30, 2025, I had a total of 692 separate clinic visits with patients with gender dysphoria (representing around half of my clinical volume).

13. I have advised multiple national and international institutions on gender-affirming hormone therapy, including the Oslo Municipal Health Center for Gender and Sexuality in Norway, Northwestern Memorial Hospital in Chicago, and Cambridge Health Alliance in Massachusetts. I served on the Norwegian Directorate for Health and Social Affairs' advisory committee for the development of national guidelines on care for persons with gender incongruence and gender dysphoria.

14. My academic work is primarily in medical education. I am an Associate Professor of Medicine at HMS where I have held faculty appointments since 2012. I am also a Lecturer with the Institute for Medical Engineering and Science at the Massachusetts Institute of Technology (MIT).

15. I direct the Fellowship Program in Endocrinology, Diabetes, and Metabolism at BWH and the Fellowship Program in Transgender Medicine at the same institution. I am also the Director of Education for the Brigham and Women's Center for Transgender Health, and Course Director for the Mass General Brigham Transgender Health Grand Rounds and for the Harvard Medical School course *Sex- and Gender-Informed Medicine: Research, Clinical Practice, and Population Health*.

16. I have authored or co-authored numerous peer-reviewed publications and presented invited lectures on a variety of endocrine topics. These include lectures on "Management of menopausal symptoms" for the Indian Health Service Remote Continuing Medical Education Program and "Diagnosis and management of male hypogonadism" to HCA Healthcare in Nashville, TN, as well as publications on "Management of vasomotor symptoms in cancer patients" published in the journal The Oncologist in 2025.

17. I have provided invited grand rounds and continuing medical education lectures on gender-affirming hormone therapy and transgender health at major academic institutions, including at HMS, Duke University, and Cedars-Sinai Medical Center. I have also spoken on this topic nationally and internationally, including at meetings of the World Professional Association

for Transgender Health (WPATH), the United States Professional Association for Transgender Health (USPATH), and the Endocrine Society.

18. I have been a member of the Endocrine Society since 2008. I was previously co-chair of its Transgender Medicine & Research Special Interest Group, and I am currently a member of its Clinical Guidelines Committee.

19. I have been a member of WPATH since 2017 and am currently co-lead of the WPATH Global Education Institute Curriculum Development Committee. I am certified in WPATH's Standards of Care 8 and have served as a mentor for clinicians seeking this certification for themselves.

20. I am also actively involved in research. This includes leading a multi-institutional effort across six leading academic medical centers in the United States to better define the most appropriate dose of injectable estradiol for patients with gender dysphoria, which led to two publications in leading endocrinology journals.

21. My professional background, experience, publications, and presentations are provided in detail in my curriculum vitae ("CV"), a true and correct copy of which is attached hereto as Exhibit A.

B. Compensation

22. I am being compensated for my work on this matter at a rate of $400/hr, $500/hr for deposition, and $2000/half-day for testimony work, plus expenses. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

C. Previous Testimony

23. Over the past four years, I have given expert testimony by deposition in one case—Keohane v. Dixon (N.D. Fla. No. 4:24-cv-434-AW).

II. SUMMARY OF EXPERT OPINIONS

24. Hormone therapy for the treatment of gender dysphoria is safe, and its risks are comparable to the risks of other well-accepted medical treatments.

25. Most of the risks associated with testosterone, estrogen, and anti-androgens are present regardless of whether these medications are being used to treat transgender people with gender dysphoria or cisgender people for other indications.

26. The risk of more serious adverse effects is very low and often consistent with the risk profiles of cisgender individuals: transgender men receiving testosterone therapy may see increases in some risks and decreases in others as their risk profile aligns more closely with cisgender men, and transgender women receiving estrogen therapy may see increases in some risks and decreases in others as their risk profile aligns more closely with cisgender women.

27. Most medical treatments carry risks, some severe. In medicine, patients and their doctors weigh the potential risks and benefits of a treatment and of foregoing the treatment to decide how to address a condition. This is part of the informed consent process. There is nothing unique about the potential risks of hormone therapy for gender dysphoria that warrants deviating from this approach or prohibiting such care.

28. The Program Statement, by prohibiting and withdrawing hormone therapy from patients receiving such treatment for gender dysphoria, would reverse most—but not all—of the physical changes from hormone therapy. In my experience with patients who had to discontinue hormone therapy because of loss of insurance, they experienced significant distress; in some cases, patients were not even able to function at work. For patients who have had gender-affirming surgeries to remove their testes or ovaries, the loss of hormone therapy would also expose them to the risks of sex hormone deficiency (hypogonadism), which includes bone fragility (osteoporosis), hot flashes, and increased risk of cardiovascular disease.

III. EXPERT OPINIONS

A. Hormone Therapy is Safe and the Risks are Comparable to Other Well-Accepted Medical Treatments.

1. Testosterone

29. Testosterone is a hormone that is primarily produced in the testes, and to a lesser extent the ovaries and the adrenal glands. As with all hormones, it exerts wide-ranging effects, with physiologic roles in both women and men.

30. Testosterone has been available for treatment of low testosterone in cisgender men since the 1930's-1940's (Nieschlag and Nieschlag, 2019). This includes use in conditions such as genetic disorders that lead to reduced testosterone; after medical treatments that damage the testes or the pituitary gland (such as chemotherapy, radiation, or surgery); or tumors that interfere with testosterone production. In addition, there is widespread use of testosterone in

cisgender men with low testosterone due to aging or obesity (Morden et al., 2019), and also increasing use in cisgender women for a variety of indications (Davis, 2025).

31. Testosterone has been regularly used to treat gender dysphoria in adults since the mid-20th century, and was recommended in the very first guidelines from WPATH (then called the Harry Benjamin International Gender Dysphoria Association) (Harry Benjamin International Gender Dysphoria Association, 1979). Its use to treat gender dysphoria is widely accepted in the medical community and is supported by every major medical organization in the United States, including the Endocrine Society, the American Medical Association, and the American College of Physicians (GLAAD, 2024).

32. When used in transgender men with gender dysphoria, the goal of testosterone is to induce physical changes to better align the body with the patient's gender identity. Hair growth on the face and body, deepening of the voice, redistribution of fat and muscle, and growth of the clitoris are some of the desired physical changes from testosterone therapy, in addition to cessation of menstruation.

33. Testosterone is administered to transgender men at similar doses to those used in cisgender men with low testosterone, and the dose is adjusted to achieve blood levels of testosterone that are in the reference range for cisgender men. This is standard-dose testosterone administration to achieve testosterone levels in the male physiologic range.

34. Like most medical treatments, testosterone therapy may carry some risks of adverse effects. The main serious risks that have been linked to therapeutic testosterone use for hypogonadism in cisgender men or for gender dysphoria in transgender men are an increased risk of cardiovascular risk factors and cardiovascular disease (heart attacks and stroke), and erythrocytosis (abnormally high red blood cell count).

35. Some cardiovascular risk factors could be affected by testosterone, including hypertension, dyslipidemia (adverse changes in blood cholesterol levels) and body weight. The most recent systematic review of studies of testosterone treatment of transgender men did not find any significant change in blood pressure, but found expected changes in weight and in cholesterol values (Rahman et al., 2024). An increase in weight is expected but is primarily due to an increase in muscle mass which is not thought to carry any increase in cardiovascular risk (Gois et al., 2025). As to the blood cholesterol levels in transgender men taking testosterone, these were noted to become more similar those of cisgender men, with higher LDL-cholesterol

and triglyceride levels and lower HDL-cholesterol levels. The changes in cholesterol were all modest, and patients are frequently monitored for these changes and appropriate lifestyle advice is provided to help limit cardiovascular risk.

36. Whether changes in cardiovascular risk factors translate into a change in the risk of actual cardiovascular events (heart attack, stroke, blood clots) has been studied. The most informative studies are those that compare cardiovascular risk in transgender men taking testosterone to two separate comparison groups: cisgender women and cisgender men. In these studies, the cardiovascular risk in transgender men taking testosterone is not significantly different from that seen in cisgender men (Getahun et al., 2018; Nota et al., 2019). In other words, the potential increase in cardiovascular risk is to the same risk level that is seen in cisgender men.

37. Thus, Dr. Kaliebe is correct that testosterone may increase risk of hypertension and atherosclerosis and cause a 1.5- to 2-fold increase in cardiovascular events in transgender men (Kaliebe Dec. par. 102) if the comparison group is cisgender women, because testosterone can raise the risk of these health issues to be comparable to the risk profile of cisgender men. But there is no evidence that testosterone therapy puts transgender men at a heightened risk of these adverse health issues compared to other men.

38. Another known risk of testosterone therapy is erythrocytosis, which refers to an increase in the amount of red cells in the blood (often measured using a test called hematocrit), and which can lead to increased blood viscosity, blood clots, and neurological symptoms (headaches, numbness, weakness) in severe cases. Erythrocytosis can be seen whether testosterone is taken by transgender men or cisgender men. Data shows that 0.5% of transgender men treated with testosterone have hematocrit greater than 54% on repeated measures (Madsen et al., 2021). A hematocrit greater than 54% is the threshold level for intervention in guidelines for cisgender men, above which interventions to lower it are recommended (Bhasin et al., 2018). Hematocrit is routinely monitored in anyone receiving testosterone treatment—whether a transgender man or cisgender man—to ensure that any additional contributing factors (e.g., smoking, lung disease) are addressed and testosterone therapy adjusted.

39. Testosterone therapy—whether for transgender or cisgender men—also increases the risk of acne and male pattern baldness, symptoms that are also commonly seen in individuals with high levels of endogenous testosterone. So, again, while these risks increase with taking

testosterone, transgender men receiving such treatment experience the same risk as cisgender men.

40. A risk of testosterone therapy that applies only to transgender men is thinning of the tissues of the genitourinary tract (genitourinary atrophy), primarily manifesting as vaginal dryness. This can be addressed with lubricants, vaginal moisturizers, and vaginal estrogen, the same way it is for post-menopausal women if they experience discomfort from this. Dr. Kaliebe discusses a study looking at pelvic floor dysfunction, including urinary incontinence, bowel dysfunction, sexual dysfunction and pelvic pain (Kaliebe Dec, par. 105). However, the study's methodology does not allow any causal inference to be made about testosterone's role in producing these symptoms. The study relied on an online survey distributed via social media, with 68 respondents. This study design is prone to significant selection bias when studying adverse effects of a medication and cannot be used to draw conclusions about the prevalence of adverse effects in the broader population of individuals taking the medication. Individuals experiencing symptoms are substantially more likely to self-select into survey participation than asymptomatic individuals, meaning the study is not one that can reliably estimate the prevalence of this condition in the population, and almost certainly overrepresents the prevalence of pelvic floor dysfunction (Andrade, 2020). Finally, the study cannot establish causation since there was no baseline assessment of symptoms prior to testosterone initiation, making it impossible to attribute any reported symptoms.

The causal link is further weakened by evidence that pelvic floor symptoms are prevalent in transgender men regardless of testosterone use (Abern et al., 2022).

In clinical practice, the most commonly encountered pelvic symptoms in transgender men are those due to genitourinary atrophy which are similar to those seen in postmenopausal women, such as vaginal dryness, painful intercourse and urinary changes. These typically resolve with topical estrogen or other local therapies for vaginal dryness.

41. Testosterone use in transgender men can potentially—but not necessarily—negatively impact fertility. Most patients taking testosterone will see cessation of menstrual periods, which in many cases is a marker that ovulation is no longer occurring. This means that the likelihood of getting pregnant while taking testosterone is lower. Since testosterone can cause birth defects if taken during pregnancy, and since some patients will still ovulate while taking testosterone, clinicians will still recommend use of other forms of contraception if patients are

engaging in sexual activities that put them at risk of pregnancy. However, should the patient wish to pursue fertility after taking testosterone, there are reassuring data suggesting that this may still be possible. This will typically involve discontinuing testosterone, after which menstrual periods resume within 3-6 months (Leung et al., 2019). This is also consistent with what is seen in cisgender women who stop taking birth control pills (Davis et al., 2008). Both testosterone and estrogen-containing birth control pills control periods in a similar way, by shutting down the body's own hormone production due to taking hormones as a medication, so it is not surprising that recovery of normal cycles is similar. Several studies have shown that pregnancy can be achieved, or that artificial reproduction technologies can be successfully used, after discontinuation of testosterone (Kinnear and Moravek, 2023). While larger and longer studies are needed, the data currently available show that there are transgender men having restoration of fertility after discontinuing testosterone therapy.

42. The potential impact of testosterone on fertility—including options for fertility preservation—is discussed with patients prior to starting hormone therapy and as part of the informed consent process. As with other medical treatments that can impair fertility, such as certain medications used in the treatment of lupus, or chemotherapy used in the treatment of cancer, the patient and prescriber weigh this risk against the potential benefits of treatment.

43. Dr. Kaliebe's comparison of testosterone therapy to the high levels of androgens from anabolic steroid use and certain tumors that produce androgens—which can cause psychiatric effects such as aggression and mania—is inappropriate (Kaliebe Dec. par. 99). The doses of androgens (testosterone-like hormones) used by those who abuse anabolic steroids are not comparable to the doses of testosterone used in gender-affirming testosterone therapy (or testosterone therapy for the other conditions mentioned above). In the study cited by Dr. Kaliebe to support his claim about the psychiatric effects of testosterone, the participants were taking anabolic steroids at doses ranging from 300 mg to >1000 mg per week (Hall et al., 2005). For comparison, typical doses of testosterone for transgender men are 50-100 mg per week (Hembree et al., 2017), and as discussed above, the dose is adjusted to achieve testosterone levels in the range seen in cisgender men.

44. Dr. Kaliebe misleadingly references results from the Food and Drug Administration's (FDA's) Adverse Event Reporting System (FAERS) (Gomez-Lumbreras and Villa-Zapata, 2024) to support his contention that there are "substantial health risks" from cross-

sex hormone therapy for transgender men (and transgender women) (Kaliebe Dec. pars. 97, 98). He does this by noting that among reports of adverse drug events from transgender men (a total of 82), a high percentage involved hormone therapy and were categorized as serious. However, there are substantial limitations to the FAERS data that are neither subtle nor obscure, and should be apparent to any clinician engaging with this literature (Chedid et al., 2017; Food and Drug Administration, 2025). Data from pharmacovigilance databases such as FAERS do not tell you whether hormone therapy is the actual cause of the reported adverse effects or provide any information about the prevalence of adverse effects from hormone therapy. FAERS is a passive system that logs reports from the public about adverse drug reactions. Anyone can make a report if they believe a drug was responsible for a symptom they experienced. There is no assurance that the reported event was in fact due to the drug. Furthermore, clinicians are more likely to report adverse effects that they expect to see, leading to potential bias in the reporting. Moreover, because the number of total individuals taking the drugs in question is not provided, these databases cannot be used to calculate risk. None of the percentages quoted by Dr. Kaliebe (e.g., 88% serious adverse events, 10.9% risk of neoplasm) refer to the risk of that adverse effect; instead, they refer simply to the percentage of the 82 reports that included that specific side effect. Using a conservative estimate of 500,000 transgender patients taking testosterone in the United States, a mere 82 reports to FAERS cannot be used to support a claim that these medications pose a substantial health risk.

2. Estrogen

45. Estrogen refers to a category of sex hormones that is primarily produced in the ovaries in cisgender women. In men and women, estradiol is also produced through a process called aromatization, where testosterone is converted to estrogen. The main form of estrogen in humans is called estradiol. Estrogen exerts wide-ranging effects, with physiologic roles in both women and men.

46. Estrogens have been used pharmacologically since the 1930's-1940's (Santen and Simpson, 2019). Currently, there are many types of estrogens that are in use pharmacologically. The most commonly prescribed estrogen is ethinyl estradiol, which is the form of estrogen that is present in most types of birth control tablets. Another estrogen-containing drug is conjugated equine estrogens, which is primarily used to treat symptoms of menopause. A third form of

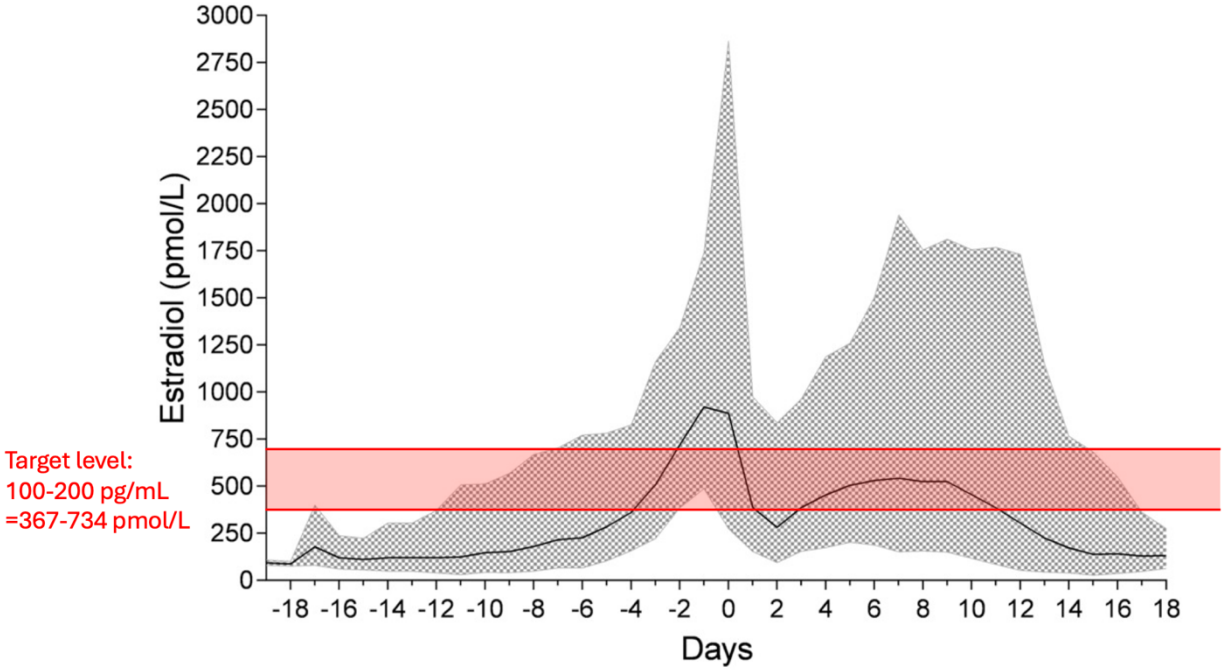
estrogen is estradiol, which is FDA-approved primarily for treatment of menopausal symptoms and for treating low estrogen from other causes (such as after medical treatments that damage the ovaries or in autoimmune conditions that destroy the ovaries) (DailyMed, 2024).

47. Similar to testosterone, estrogens have been used in adults with gender dysphoria since the middle of the 20th century and were also recommended in the very first standards of care from WPATH (Harry Benjamin International Gender Dysphoria Association, 1979). In transgender care, the estrogen that is prescribed is typically estradiol (which is identical to the predominant form of estrogen in humans). This form is recommended because of data showing that it has a lower risk of venous thromboembolism than the estrogen in birth control pills (Goldstein et al., 2019), and because estradiol levels can be readily measured with a blood test.

48. The use of estrogen to treat gender dysphoria is widely accepted in the medical community and supported by every major medical organization in the United States, including the Endocrine Society, the American Medical Association, and American College of Physicians (GLAAD, 2024).

49. When used in transgender women, the goal of estradiol is to induce physical changes to better align the body with the patient's gender identity. Growth of breast tissue, softening of the skin, and changes in fat deposition and muscle development are some of the desired female secondary sex characteristics.

50. In transgender women, the estradiol is dosed to bring the blood level of estradiol into the normal range for cisgender women to induce the desired physical changes and to suppress testosterone levels. Estradiol levels vary greatly in cisgender women throughout the menstrual cycle; the target range for estradiol levels in transgender women (100-200 pg/mL in US units, or 367-734 pmol/L in international units) is set to be around the mean estradiol level in premenopausal cisgender women. This is illustrated in the figure showing the daily mean estradiol concentration (black line) and reference interval (95% range, grey area) in 30 premenopausal women throughout one menstrual cycle, with the red shaded area showing the target range for estradiol in transgender women taking estradiol (Verdonk et al., 2019).



51. Like most medical treatments, estrogen therapy carries some risks of adverse health impacts. Estrogen treatment is associated with an increased risk of blood clots (venous thromboembolism), including blood clots to the lungs (pulmonary embolism), high blood pressure, and elevated triglycerides. These risks exist whether this medication is used to treat gender dysphoria in transgender women or to treat cisgender women with other conditions mentioned above. These risks are all low and can be managed by appropriate estradiol dosing with monitoring of blood levels and other relevant labs, and other interventions as needed.

52. Studies have shown that the risk of venous thromboembolism is increased approximately 2-fold in transgender women taking estradiol compared to people not taking estradiol (van Zijverden et al., 2024). While the risk is doubled, it remains very low - the risk has been estimated to be 2.3 cases of venous thromboembolism per year for every 1000 patients receiving estradiol (Khan et al., 2019). Secondly, the increased risk is lower than the risk of venous thromboembolism seen with cisgender women taking estrogen via oral birth control pill, where the risk is increased 3.8-fold (with variation depending on the exact type of birth control pill studied and patient risk factors), and similar to the 2.1-fold increased risk seen in cisgender women taking estrogen and progesterone as part of menopausal hormone therapy (Mullins and Mullins, 2024).

53. The effect of estradiol treatment on cardiovascular disease and risk factors in transgender women has been extensively studied, given that it is known that these risks exist for cisgender women treated with estrogen. Reassuringly, a recent systematic review of studies of transgender women taking estrogen did not find any significant changes in cardiovascular risk factors with the only significant finding being a small increase in triglyceride levels (Rahman et al., 2024) – just as seen in cisgender women receiving estrogen treatment (Godsland et al., 1990).

54. In most of the studies that have compared the risk of cardiovascular events in transgender women taking estrogen with the risk in cisgender women as well as with the risk in cisgender men, the cardiovascular risk is not significantly different from that seen in cisgender men (Alzahrani et al., 2019; Getahun et al., 2018; Nota et al., 2019). In other words, treatment with estradiol in transgender women does not seem to change the patients' cardiovascular risk; it remains at the cisgender male level. Dr. Kaliebe says that "limited data suggests a slight increase in stroke risk," for transgender women receiving estrogen treatment compared to cisgender men (Kaliebe Dec. par. 101). Presumably he is referring to Nota et al., 2019. He appropriately acknowledges that the "evidence is less conclusive" and in fact, this finding was not seen in another study (Getahun et al., 2018). In any case, patients are monitored for changes in cardiovascular risk factors and appropriate lifestyle advice is provided to help limit cardiovascular risk.

55. Dr. Kaliebe says that changes to the testes from estrogen therapy in transgender women may lead to an elevated risk of cancer (Kaliebe Dec. par. 109). This statement is not supported by current research. The changes in testicular microscopic findings represent the expected findings of testicular atrophy, but it does not lead to an increased risk of testicular cancer risk. One systematic review was only able to identify a single case of testicular cancer in the literature to date (Joint et al., 2018).

56. While Dr. Kaliebe does not mention a risk of breast cancer, BOP's Memorandum, in asserting that hormone therapy for gender dysphoria can cause substantial health risks, cites a study (Gurrala et al., 2023) that it describes as finding that "males who are treated with estrogen have twenty-two times the likelihood to develop breast cancer" (Memorandum at 22). In fact, the cited study did not show this – it was a study of the effect of *testosterone* treatment on breast cancer risk in *transgender men*, and did not include anyone treated with estrogen. This particular study found that the risk of breast cancer in transgender men treated with testosterone was only

about one-fifth of the breast cancer risk in cisgender women. It is true, however, that other studies have shown that breast cancer risk in transgender women taking estradiol is higher than the breast cancer risk in cisgender men. For example, the biggest study (de Blok et al., 2019) found that the risk of breast cancer was higher in transgender women who had received estrogen when compared to *cisgender men*. It is, however, important to note that the risk was only about one-third of that seen in *cisgender women*, and the actual risk was quite low (15 cases of breast cancer among 2260 transgender women). Even though transgender women taking estrogen are at lower risk than cisgender women, the recommendation for managing the breast cancer risk is similar to that for cisgender women, with breast cancer screening based on age and other risk factors (Brown et al., 2021).

57. Dr. Kaliebe asserts that there are potential cognitive risks, including memory loss and early-onset cognitive impairment, from estrogen therapy (Kaliebe Dec. par. 110). The paper cited (Schwartz et al., 2025) quotes the FDA label for estradiol which listed dementia as a potential risk (regardless of what indication it is used for). However, it is now recognized that there is no such risk from estrogen treatment, as shown in a recent meta-analysis (Melville et al., 2025). This recently led the FDA to remove this warning from its label (Food and Drug Administration, 2026). The other data quoted by Schwartz et al. show lower cognitive functioning in transgender women on estrogen compared to cisgender groups (van Heesewijk et al., 2025). However, the authors highlight that this difference can be largely explained by increased rates of mental health problems and adverse social circumstances.

58. Estrogen therapy can negatively impact fertility when used in transgender women. During estrogen treatment, there is a reduction in the number and quality of sperm cells in the semen; there is reduced semen volume; and there are a variety of microscopic changes in the testes indicating reduced sperm cell production (Rodriguez-Wallberg and Pfau, 2025). Sperm production may recover after interruption of estrogen therapy even after many years of estrogen treatment, although larger studies are needed to confirm this (Nie et al., 2023). The potential impact of estrogen on fertility—including options for fertility preservation—is discussed at length with patients prior to starting hormone therapy and as part of the informed consent process. As with other medical treatments that can impair fertility, the patient and doctor weigh this risk against the potential benefits of treatment.

59. Estrogen therapy can potentially affect sexual function in transgender women. Reduced interest in sex can be seen, but studies have shown this effect to be transient (Defreyne et al., 2020). Reduction in frequency of erections is common and may be persistent (Yaish et al., 2025). If this is a cause of concern, it can be treated with the same medications that are used in cisgender men who experience erectile dysfunction (e.g., Viagra, Cialis). Again, this is something that is discussed during the informed consent process. Of note, for many patients, a decrease in libido and spontaneous erections is a desired effect from hormones (Sandhu et al., 2024).

3. Antiandrogens

60. Antiandrogens are medications that are used in conjunction with estradiol in transgender women. While estradiol will suppress testosterone levels, it will typically not bring testosterone levels into the female range on its own. A second medication, often called an antiandrogen, is therefore often added to further suppress testosterone levels. The main antiandrogens used are spironolactone and GnRH agonists (leuprolide is the most commonly used medication in this class of medications).

61. Spironolactone is an antihypertensive that was approved by the FDA in 1960 and is used for a variety of medical conditions such as hypertension, heart failure, cirrhosis, polycystic ovarian syndrome (to reduce body and facial hair growth) and acne (DailyMed, 2025a). Leuprolide was approved in 1985, and is used for a variety of hormone-responsive conditions such as prostate cancer, breast cancer, endometriosis, and precocious puberty (DailyMed, 2025b).

62. These antiandrogens have been used as part of gender-affirming hormone therapy for transgender women since the 1980's.

63. These medications carry risks of certain adverse effects. The risks of spironolactone include a reduction in kidney function, abnormal electrolytes, low blood pressure, frequent urination, and dehydration. These risks exist whether the medication is used to treat transgender women with gender dysphoria or cisgender people with other conditions. However, severe side effects affecting kidney function or electrolytes are rare in transgender people, occurring in 2-2.5% of patients (Hayes et al., 2022). This is less frequent than the rate of these side effects in patients taking spironolactone for other conditions such as heart failure and

cirrhosis (Böhm et al., 2026), presumably because transgender patients often do not have co-existing medical conditions that further predispose them to these side effects, and therefore have intact other mechanisms to ensure maintained renal function and electrolytes.

64. The primary risks of GnRH agonists are due to the decrease in sex hormone levels, and include hot flashes and osteoporosis. These side effects are not typically seen when used to treat gender dysphoria since sex hormones are part of treatment, countering that risk.

* * *

65. In sum, most of the risks associated with testosterone, estrogen, and anti-androgens are present regardless of whether these medications are being used to treat transgender people with gender dysphoria or cisgender people with other conditions. The risk of serious adverse effects is low and often consistent with the risk profiles of cisgender individuals: transgender men receiving testosterone therapy may see increases in some risks and decreases in others as their risk profile aligns more closely with cisgender men, and transgender women receiving estrogen therapy may see increases in some risks and decreases in others as their risk profile aligns more closely with cisgender women.

66. Managing risks associated with medical treatments are common in medical practice. Many widely-used medical treatments have risks that are comparable or far more significant than medical treatments used for gender dysphoria. Like all medical treatments, the risks are evaluated for each individual patient and discussed as part of the informed consent process. The risks of hormone therapy for the treatment of gender dysphoria are the types of risks that doctors and patients routinely weigh in making treatment decisions. There is nothing about the risks of hormone therapy for gender dysphoria that warrants prohibiting the care.

B. The Impact of the Program Statement

67. The Program Statement prohibits the initiation of hormone therapy for individuals with gender dysphoria and mandates the withdrawal of this treatment for patients currently receiving it, providing for a tapering process depending on how long the patient has been receiving hormone therapy.

68. If the Program Statement is implemented and patients are withdrawn from hormone therapy, it will reverse most—but not all—of the physical changes that have occurred as a result of the treatment.

69. For transgender women, discontinuing hormone therapy will cause a resumption of facial and body hair growth, a redistribution of fat and muscle to a more typically male shape, and a coarsening of the skin. The one change that will not be affected by withdrawing care is breast development. These patients will experience a masculinization of their face and body but will retain their breasts.

70. For transgender men, discontinuing hormone therapy will cause a resumption of the menstrual period and a redistribution of fat and muscle to a more typically female shape. The deepened voice caused by testosterone therapy will remain, any changes in facial bone structure and prominence of the Adam's apple will remain, and facial and body hair will remain (although may grow slower and slightly thinner).

71. In my experience with patients who had to discontinue hormone therapy because of loss of insurance, they experienced significant distress as their bodies began to misalign with their gender identity; in some cases, this caused severe functional impairment where patients were no longer able to function at work.

72. For patients who have had gender-affirming surgeries to remove their testes or ovaries, apart from the psychological risks of discontinuing treatment, the loss of hormone therapy would leave them with no sex hormones (hypogonadism). The risks of hypogonadism are severe, and include hot flashes and night sweats that can severely impact quality of life (Blümel et al., 2026). Loss of sex hormones also leads to rapid loss of bone strength, causing osteoporosis which puts the patient at high risk of fractures. It is known that osteoporotic fractures of large bones such as the hip comes with a substantial risk of loss of function and excess mortality (LeBoff et al., 2022).

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

Executed this 26th day of April, 2026



Ole-Petter Hamnvik

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Hamnvik Declaration

Exhibit A

Harvard Medical School
Curriculum Vitae

Date Prepared: April 19, 2026

Name: Ole-Petter Riksfjord Hamnvik

Office Address: Division of Endocrinology, Diabetes, and Hypertension
Brigham and Women□s Hospital
221 Longwood Avenue, RFB-2
Boston, MA 02115

Education:

2005	M.B., B.Ch., B.A.O. (1st class honors)	Medicine	Royal College of Surgeons in Ireland (RCSI), Dublin, Ireland
2014	M.M.Sc.	Clinical and Translational Investigation	Harvard Medical School (HMS), Boston, MA

Postdoctoral Training:

07/05□06/07	Resident	Internal Medicine	Beaumont Hospital, Dublin, Ireland
06/07□06/10	Resident	Internal Medicine	Brigham and Women□s Hospital (BWH), Boston, MA
07/07□06/10	Clinical Fellow	Internal Medicine	HMS
07/09□09/09	Chief Resident	Medicine	Brigham and Women□s Faulkner Hospital (BWFH), Boston, MA
07/10□06/11	Clinical Fellow	Endocrinology, Diabetes and Metabolism	BWH
07/10□06/12	Clinical/Research Fellow	Medicine (Mentor: Dr. Christos Mantzoros)	HMS
07/11□06/12	Research/Clinical Fellow	Endocrinology, Diabetes and Metabolism (Mentor: Dr. Christos Mantzoros)	BWH
07/12□06/13	Chief Medical Resident	Internal Medicine	BWH

07/13□06/14	Research Fellow	Endocrinology, Diabetes and Metabolism (Mentor: Dr. Jonathan Williams)	BWH

Faculty Academic Appointments:

07/12□ 05/16	Instructor	Medicine	HMS
06/16□ 09/23	Assistant Professor	Medicine	HMS
10/23□	Associate Professor	Medicine	HMS
06/24□	Lecturer	Institute for Medical Engineering and Science	Massachusetts Institute of Technology

Appointments at Hospitals/Affiliated Institutions:

07/12□	Associate Physician	Medicine	BWFH
07/13□	Associate Physician	Endocrinology, Diabetes and Hypertension	BWH
05/15□	Physician	Adult Survivorship Program	Dana-Farber Cancer Institute (DFCI), Boston, MA
09/17□ 01/25	Associate Physician	Medical Communications	BWH
04/26□	Associate Physician	Endocrinology, Diabetes and Hypertension	Massachusetts General Hospital (MGH)

Other Professional Positions:

2015	Content Expert	HealthEquity Labs / healthiq.com, Plano, TX	
2015□2016	Endocrinology Specialist	Rubicon MD, New York, NY	
2016	Expert witness, providing report for plaintiff	Rydzy vs. McLean et al., No. NNH-CV-14-6047622S (Superior Court of Connecticut, Judicial District of New Haven)	8 hours over 2 months
2018	Consultant	Fusion Pharma, Hamilton, ON, Canada	

2020□2021	Clinical advisor for transgender hormone therapy	Northwestern Memorial Hospital Gender Pathways Program, Chicago, IL	
2020□	Clinical advisor for transgender hormone therapy	Oslo Municipal Health Center for Gender and Sexuality, Oslo, Norway	2 hours per month
2020	Expert witness for the defendant, providing pre-trial report	Plate et al. vs. Estate of Paul Weeks	10 hours over 3 months
2021	Clinical advisor for transgender hormone therapy	Cambridge Health Alliance-Malden, Malden, MA	
2025□2026	Expert witness for the plaintiffs, providing report, deposition, and trial testimony	Keohane et al. v. Dixon et al., No. 4:24-cv-434-AW-MAF (United States District Court for the Northern District of Florida, Tallahassee Division)	Total of 50 hours over 7 months
2025□2026	Expert witness, providing advice to defendant	Anzu v. Kaiser Foundation Health Plan of the Northwest et al., No. 24CV52050 (Circuit Court of the State of Oregon for the County of Multnomah)	Total of 4 hours over 2 months
2025□2026	Expert witness, providing advice to defendant	*Lovdahl v. Kaiser Foundation Hospitals*, No. STK-cv-UMM-2023-0006100 (Cal. Superior Ct., San Joaquin County)	

Major Administrative Leadership Positions:

Local

2006□2007	Associate Tutor, Intermediate Cycle 1	RCSI
2012□2019	Section Director for Endocrinology, Introduction to Clinical Medicine (IN710M.23)	Harvard-Massachusetts Institute of Technology (MIT) Health Sciences and Technology, Boston, MA
2013□	Course Director, Fundamentals of Clinical and Translational Research	Harvard Catalyst, Boston, MA
2014□2015	Course Co-Director, Endocrine Clinical Case Conference Continuing Medical Education (CME) course	BWH and HMS

2014□2017	Associate Program Director, Fellowship Program in Endocrinology, Diabetes and Hypertension	BWH
2014□2017	Assistant Program Director, Internal Medicine Residency Program	BWH
2014□	Course Director, Brigham Endocrinology Board Review Course	BWH
2014□	Lead Faculty for Medical Endocrinology, Reproductive Endocrinology and Infertility Fellowship Program	BWH
2014□2023	Core Faculty and Design Faculty, Homeostasis 2 (PWY131)	HMS
2014□	Residency Scheduling Consultant, Internal Medicine Residency Program	BWH
2015	Course Director, Harvard Current Trends in Endocrinology	HMS
2015□2016	Course Director, Fundamentals of Medical Education	Center for Faculty Development & Diversity (CFDD), BWH
2015□2017	Course Director, Leadership Strategies for the Researcher	Harvard Catalyst
2015□	Course Director, Endocrine Clinical Case Conference CME course	BWH and HMS
2016□2017	Clinical Navigator, □HMX Fundamentals: Biochemistry□	HMS
2016□	Course Director, Endocrinology and Metabolism (ME508M.23)	HMS
2017□	Program Director, Fellowship Program in Endocrinology, Diabetes & Metabolism	BWH
2021	Director, Learning Collaborative on Diabetes Prevention in LGBTQIA+ populations	Fenway Health
2022□	Course Planner, Brigham Center for Transgender Health Grand Round Series	BWH
2022□	Director of Education, Center for Transgender Health	BWH
2023□	Course Co-Director, Innovations and New Practices in Internal Medicine 2023	HMS

2024□	Core Faculty, Integrated Human Physiology III (PWY134)	HMS
2024□	Program Director, Fellowship Program in Transgender Medicine	BWH
2025□	Course Co-Director, Sex- and gender-informed medicine: Research, clinical practice, and population health (AISC626.0)	HMS
2025□	Course Director, MGB Transgender Health Grand Rounds	MGB
2025□	Co-director, Sexual and Gender Minority Health Frontiers in Healthcare Theme	HMS

International

2014	Co-Director, Diabetes management academy. Two-day CME course for Latin-American physicians.	Asociación Civil de Investigación y Desarrollo en Salud (ACINDES), Buenos Aires, Argentina
2014	Co-Director, Effectively communicating research. Two-day CME course for Latin-American physicians.	ACINDES
2014	Co-Director, Effectively communicating research. Three-hour subcomponent of a larger CME course for Latin-American physicians.	ACINDES
2017	Director, Update in endocrinology. Four-day CME course for Latin-American physicians	ACINDES

Committee Service:

Local

2007□2010	Housestaff Committee	Department of Medicine, BWH
2009	Intensive Care Unit Committee	BWFH
2009	Meditech Committee	BWFH
2009	Pharmacy and Therapeutics Committee	BWFH
2009	Ethics Committee	BWFH
2009□2010	Drug Safety Committee	BWH
2010, 2013, 2014, 2016	Housestaff Selection Committee	Department of Medicine, BWH

2014□2020	Internal Medicine Recruitment Subcommittee	Department of Medicine, BWH
2014□	The Academy at Harvard Medical School	HMS
2014□	Clinical Competency Committee	Division of Endocrinology, Diabetes and Hypertension, BWH Chair
2014□	Program Evaluation Committee	Division of Endocrinology, Diabetes and Hypertension, BWH Chair
2014□	Fellowship Selection Committee	Division of Endocrinology, Diabetes and Hypertension, BWH Chair
2015	Course Review Committee, HST.060	Harvard-Massachusetts Institute of Technology Division of Health Sciences and Technology, Boston, MA
2016	Committee for Internal Review of BWH Abdominal Diagnostic Radiology Fellowship Program	Partners Healthcare Office of Graduate Medical Education
2017	Endocrine Division Retreat Planning Committee	Division of Endocrinology, Diabetes and Hypertension, BWH
2017□2018	Clinical Process Working Group	Division of Endocrinology, Diabetes and Hypertension, BWH
2018□2020	Admissions Committee, Medical Degree Program	Harvard-Massachusetts Institute of Technology Program of Health Sciences and Technology (HST)
2019□2020	Scholarship Oversight Committee, Kate Millington	Boston Children□s Hospital
2020□2023	BWH Graduate Medical Education Committee	BWH
2023	Honors Examiner, Exam Committee, Casey Orozoco-Poore	HMS
2023	Mass General Brigham (MGB) Graduate Medical Education Special Review ad hoc committee	MGB
2023□	MGB Graduate Medical Education Committee	MGB

2025□	MGB Graduate Medical Education □ Executive subcommittee	MGB
2025	Member, Master of Medical Sciences in Clinical Investigation Thesis Committee, Ons Kaabia	HMS

National

2017□2019	Continuing Board Certification: Vision for the Future Commission	American Board of Medical Specialties
2019□2021	Remediation Task Force	American Board of Medical Specialties
2019□2021	Milestones 2.0 Working Group	Accreditation Council for Graduate Medical Education

International

2019	Advisory committee, Norwegian Guideline Committee for Healthcare for Persons with Gender Incongruence / Gender Dysphoria	Norwegian Directorate for Health and Social Affairs

Professional Societies:

1999□2005	Norwegian Medical Association	
2005□2007	Irish Medical Society	
2007□2010	American College of Physicians	
2007□2010	American Medical Association	
2007□	Royal College of Physicians in Ireland	Member of the Royal College of Physicians in Ireland (MRCPI)
2007□	Massachusetts Medical Society (MMS)	
	2018□2022 Member, Committee on Medical Education	
	2020□ Member, LGBTQ Health Disparities Grant Selection Committee	
	2022□2025 Vice-Chair, Committee on Medical Education	
	2025□ Chair, Committee on Medical Education	
2008□	Endocrine Society	
	2016□2021 Member, Clinical Endocrine Education Committee	
	2016□2021 Chair, Fellows Training Series (FTS) Steering Group	

	2018□	Member, Abstract Review Committee, Endocrine Society's Annual Meeting & Expo (ENDO)
	2019□2023	Member, Transgender Medicine & Research Special Interest Group Steering Committee
	2020, 2023	Judge, Presidential Poster Competition
	2022□2025	Member, Annual Meeting Steering Committee
	2022□2023	Member, Special Interest Group Advisory Panel
	2022□2024	Chair, Oncoendocrinology Special Interest Group
	2025□	Member, Clinical Guidelines Committee
2010□2014	American Association of Clinical Endocrinologists	
2011□2013	American Thyroid Association	
2014□2020	American Society of Clinical Oncology	
2014□	Association of Program Directors in Endocrinology and Metabolism (APDEM)	
	2019□2025	Member, Finance Committee
	2019□2024	Member, Transgender Curriculum Writing Group
	2021□2024	Member, Milestones 2.0 Implementation Committee
	2022□2025	Co-chair, Curriculum Committee
	2023□2025	Member, APDEM Council
	2025□	Secretary-treasurer
	2025□	Chair, Finance Committee
2016□2017	Association of Program Directors in Internal Medicine	
2016□	Association of Specialty Professors	
2017□	World Professional Association for Transgender Health (WPATH)	
	2022□2024	Member, Global Education Institute Faculty Development Committee
	2022□	Medical Co-Lead, Global Education Institute Curriculum Development Committee
	2022□	Member, Global Education Institute Steering Group
2018□	United States Professional Association for Transgender Health (USPATH)	
	2019□	Member, Abstract Review Committee, and lead for □Endocrinology / Hormone Therapy □ Adult□ category
	2021	Adult Clinical Care Co-Lead, USPATH 2021 Scientific Symposium Steering Committee

Grant Review Activities:

2012	Self-Initiated Research Funding	South African Medical Research Council
	2012	*Ad hoc* reviewer
2022	Education research grant	Physician Services Incorporated (PSI) Foundation, Ontario, Canada
	2022	*Ad hoc* reviewer

Editorial Activities:

***Ad hoc* Reviewer**

Accreditation Council for Continuing Medical Education Content Reviewer
American Association of Clinical Endocrinologists (AACE) Clinical Case Reports
Andrology & Gynecology: Current Research
BioMed Central (BMC) Endocrine Disorders
BMC Cardiovascular Disorders
CA: A Cancer Journal for Clinicians
Clinical Advances in Hematology & Oncology
Clinical Endocrinology
Endocrine Practice
Frontiers in Endocrinology
Frontiers in Reproductive Health
Hormone Research in Pediatrics
International Journal of Transgender Health
Irish Journal of Medical Science
JAMA Internal Medicine
Journal of Cancer Survivorship
Journal of Clinical Endocrinology & Metabolism
Journal of Clinical Investigation
Journal of Clinical Oncology □ Oncology Practice
Journal of the Endocrine Society
Journal of General Internal Medicine
Journal of Medical Education and Curricular Development
Journal of Medical Internet Research
Journal of Medical Internet Research - Dermatology
Journal of Sexual Medicine
Journal of the Endocrine Society
Metabolism
Nigerian Journal of Clinical Practice
Open Forum Infectious Diseases
PLoS One
Sexual Medicine Reviews
The Medical Letter on Drugs and Therapeutics
The Oncologist

Transgender Health

Editorial Roles

2011	Peer reviewer	American College of Physicians (ACP) Medicine
2014	Peer reviewer	First Aid for the United States Medical Licensing Exam (USMLE) Step 3
2016□	Education Editor This role involves editorial oversight of the educational products offered by NEJM Group, primarily NEJM Knowledge+ (≈72,000 separate users from 2016 until June 15, 2021), and NEJM Resident 360 (≈127,000 separate users from 2017 until Nov 17, 2021; ≈60,000 page views per week).	New England Journal of Medicine (NEJM) Group
2019, 2022	Peer reviewer	Alosa Health
2023	Peer reviewer	Merck Manual
2024	Guest editor, special print supplement to the New England Journal of Medicine	Clinical Endocrinology and Diabetes Update from NEJM Group
2025□	Editorial Board Member	*Endocrine Practice*
2025□	Associate Editor	*NEJM Clinician*

Honors and Prizes:

2000□2005	Medical School Prizes	RCSI	20 academic prizes. Examples include: - Norman Rae Gold Medal and First Prize in Biochemistry - Kane Medal and First Prize in Physiology
2002	Dr. H. H. Stewart Medical Scholarship in Biochemistry, Third Prize	National University of Ireland (NUI), Dublin, Ireland	Third place in Biochemistry based on the results of the final examination of all students in the NUI medical schools
2003	Dr. H. H. Stewart Medical Scholarship in Pathology, First Prize	NUI	First place in Pathology based on the results of the final examination of all students in the NUI medical schools

2003	Sheppard Memorial Medal in Pathology	Beaumont Hospital	Highest mark in a separate Pathology oral examination
2004	Dr. H. H. Stewart Medical Scholarship in General Practice, First Prize	NUI	First place in General Practice based on the results of the final examination of all students in the NUI medical schools
2005	Dr. Desmond Lyons Prize in Internal Medicine	Beaumont Hospital	Highest mark in the final year written Internal Medicine examination
2005	Reuben Harvey Prize	Royal College of Physicians in Ireland, Dublin, Ireland	Highest aggregate mark in Ireland in Medicine, Surgery, Obstetrics and Gynecology
2013 and 2015	Fellowship Teaching Award Endocrinology	BWH, Department of Medicine	Awarded by medical residents for compassion and dedication to teaching
2014□2015	Rabkin Fellowship in Medical Education	Beth Israel Deaconess Medical Center (BIDMC), Boston, MA	One-year competitive fellowship in Medical Education
2015	Certificate in Excellence in Tutoring	HMS	Awarded based on tutor evaluation by students
2016	Nominee, Harvard Medical School Donald O□Hara Faculty Prize for Excellence in Teaching (Years I & II)	HMS	Nominated by medical students for excellence in preclinical teaching
2017	Macy Program for Educators in Health Professions	Harvard Macy Institute	Professional Development Course in Medical Education
2019	Gail Backus Endocrinology Faculty Clinical Teaching Award	Division of Endocrinology, Diabetes and Hypertension, BWH	Selected by clinical endocrinology fellow for outstanding clinical teaching of endocrinology fellows and a significant positive impact on their clinical development
2019	Distinguished Service Award	American Board of Medical Specialties	Awarded to all the members of the Vision Commission of which I was a member
2019	Ambulatory Lecturing Attending Award	Department of Medicine, BWH	Awarded to the attending who best exemplifies excellence in ambulatory

			lecturing, as selected by the housestaff
2020	Above and Beyond Award	Division of Endocrinology, Diabetes and Hypertension, BWH	Awarded to a faculty member who has gone above and beyond in helping out their colleagues
2025	2025 Brigham and Women□s Hospital Education Award	BWH	The highest recognition from within BWH, honoring faculty educators who have made significant and lasting contributions to medical education, training, and research.
2025	LGBTQ Health Award	MMS	Awarded to an MMS member in recognition of outstanding contributions to LGBTQ health

Report of Funded and Unfunded Projects

Funding Information:

Past

2015□2019 Development and evaluation of a novel curriculum using web-based educational tools to improve internal medicine residents□ quality of care of patients with type 2 diabetes mellitus

Educational grant provided by Dr. Marshall Wolf

Principal investigator

The goal of this project was to develop new online learning modules for internal medicine residents to improve diabetes teaching and diabetes care.

2017 Applying the flipped classroom method to GME

BWH Department of Medicine Macy Scholarship

Principal investigator

This career development award allowed me to attend the Macy Program for Educators in the Health Professions to refine and execute the above project.

Report of Local Teaching and Training

Teaching of Students in Courses:

HMS/HSDM/DMS Courses

2009, 2012, 2013, 2014, 2016	Endocrinology Pathophysiology Course 2nd-year medical and dental students	2009/2014: 12 hours weekly for 5 weeks 2012/2013: Substitute tutor, total 3 hours per year 2016: Lecturer, total 7.5 hours

2011□2019	Introduction to Clinical Medicine (IN710M.23)	Harvard-MIT Health Sciences and Technology
	2nd-year medical students	One 2-hr session per year
2012□2013	Principal Clinical Experience (ME600M.23)	
	3rd-year medical students	One 1-hr session per month for 12 months
2012□2013	Medicine Core II Subinternship (ME550M.23)	
	4th-year medical students	One 1-hr session per month for 12 months
2013	Introduction to the Profession (IN555.0)	
	1st-year medical students	Two 3-hr sessions
2014	Patient-Doctor 2	
	2nd-year medical students	One 3-hr session
2015	Integration Week	
	2nd-year medical students	One 3-hr session
2016□	Core endocrinology faculty, Homeostasis 2 (PWY131)	HMS
	1st year medical students	16 1-hr lectures per week for 10 weeks per year
2017	Thyroid Exam, Practice of Medicine (POM100)	HMS
	1st year, medical students	One 2-hr lecture
2018□2019	Advanced Abdominal Exam, Practice of Medicine (POM100)	HMS
	2nd year medical students	One 3-hr session per year
2021□	Sex- and gender-informed medicine: Research, clinical practice, and population health (AISC626.0)	HMS
	3rd and 4th year Pathways medical students	One 3-hour workshop per year
2021□2024	Introduction to Clinical Medicine (HST.201)	HMS
	PhD students in HST program	1 hour per year

Formal Teaching of Residents, Clinical Fellows and Research Fellows (post-docs):

2009	BWFH morning reports	BWFH
	Internal Medicine residents	32 one-hour case-based morning reports
2009	Intern curriculum	BWFH
	Internal Medicine interns	10 one-hour lectures

2009	Morbidity and Mortality Conference	BWFH
	Internal Medicine faculty and residents	Two one-hour conferences
2009	Case conference	BWFH
	Internal Medicine residents	Instituted this one-hour resident-led case-based conference.
2012	Thyroid exam workshop	BWH
	Primary Care residents	Preceptor for physical exam
2012□2013	Cardiovascular endocrinology research group (CERG) meetings	BWH
	Members of CERG	Two two-hour research talks
2012□2013	BWH morning reports	BWH
	Internal Medicine residents	38 one-hour case-based morning reports
2012□2014	□Thyroid functions tests □ complex cases□	BWH
	Internal Medicine residents	Five one-hour lectures
2012□2016	□Novel antidiabetic therapies□	BWH and BWFH
	Internal Medicine residents	Four one-hour lectures
2013	□Adrenal insufficiency□	BWH
	Harvard Vanguard Medical Associated (HVMA) Primary Care residents	One-hour lecture
2013	□Outgoing chief panel□	Chief resident retreat, Partners Office of Resources to Trainees, Boston, MA
	Incoming chief residents	One-hour panel discussant
2013	□Case conference□ (discussant)	BWH
	HVMA Primary Care residents	One-hour lecture
2013	□Pheochromocytoma □ the basics□	BWH
	Internal Medicine residents	One-hour lecture
2013□2015	□Common endocrine referrals□	BWH and BWFH
	Internal Medicine residents	Four one-hour lectures
2013□	Discussant, morning report	BWH and BWFH
	Internal Medicine residents	Seven one-hour case-based morning reports annually
2014	□Hypothyroidism and the thyroid exam□	BWH
	Internal Medicine residents	Three 1.5-hour lectures

2015	□Incorporating medical education and teaching in your career□	BWH
	Fellows in Internal Medicine subspecialties	Two-hour panel discussion
2015	□MedForum: A patient with an obstructing multinodular goiter□	Department of Medicine, VA Boston Healthcare System
	Internal Medicine residents and faculty	One-hour case discussion
2015	□Management of cardiovascular risk factors in patient with diabetes mellitus□	BWH
	HVMA Primary Care residents	One-hour lecture
2015	□Advanced management of difficult-to-control diabetes in the ambulatory setting□	BWH
	Internal Medicine residents	Two one-hour lectures
2015, 2017	□Endocrine management of the transgender patient□	BWH
	Endocrinology fellows	One-hour lecture
2017	□Treatment of symptoms of the menopause□	BWH
	Endocrinology fellows	One-hour lecture
2017	□Culturally competent care for LGBT patients□ Professionalism and cross-cultural care curriculum	BWH
	Dermatology residents	One-hour small group session
2017□18	□Introduction to novel antidiabetic agents□	BWH
	Internal medicine residents	Five one-hour lectures
2017, 2019	□Gender dysphoria and medical management of the transgender patient□	BWH
	Internal medicine residents	One-hour lecture
2018	□Adrenal insufficiency□	BWH
	Internal medicine residents	One-hour lecture
2018, 2021, 2022	□Medical care for transgender patients□	BWH
	Internal medicine residents	One-hour lecture
2019	□Master clinician □ transgender□	BWH

	Internal medicine residents	One-hour lecture
2019	□Trans Health: Changing Paradigms in a Changing Society□	BWH
	Internal medicine residents	Five one-hour lectures
2019	□Trans Health: Changing Paradigms in a Changing Society□	BWH
	Maternal-fetal medicine fellows	One-hour lecture
2020□	□In-Training Exam Review□	BWH
	Endocrinology fellows	Annual one-hour lecture
2020	□Cases in oncoendocrinology□	New England chapter of the American Association of Clinical Endocrinologists
	Endocrinology fellows	One-hour lecture
2020	□Writing multiple choice questions in medical education: Do□s and don□t□s□	BWH
	Internal medicine residents	One-hour lecture
2021	□Medical care for transgender patients□	BWH
	HVMA Primary Care residents	One-hour case-based talk
2022	□Medical care for transgender patients□	Salem Hospital, Salem, MA
	Internal medicine residents	One-hour lecture
2022	□Endocrinopathies with immune checkpoint inhibitors□	BWH
	Internal medicine residents	One-hour lecture
2022□	□Introduction to endocrine care for transgender patients□	BWH
	Endocrinology fellows	Annual one-hour lecture
2022□	□Board review □ transgender endocrinology□	BWH
	Endocrinology fellows	Annual one-hour lecture
2024	□Board review □ calcium and bone disorders□	BWH
	Endocrinology fellows	One-hour lecture

Clinical Supervisory and Training Responsibilities:

2012□2017	Supervising attending for internal medicine interns and residents on the general medical service	BWH 50 hours per week for 2-10 weeks per year

2014□2017	Principal clinical experience student advisor for 2nd and 3rd year medical students	HMS Two hours per week for 30 weeks per year
2014□	Preceptor for endocrinology fellows on the inpatient consult service	BWH 40 hours per week for 2 weeks per year
2014□	Preceptor for the endocrinology fellows□ weekly general endocrinology continuity clinic	BWH One half-day session per week for 40 weeks per year
2018□2020	Specialty advisor for medical students applying for internal medicine residency	HMS 5 hours per year
2022□2025	Mentor, WPATH Global Education Institute Medical Mentorship Group. Served as formal mentor in the medical management of gender-diverse patients for 10 clinicians from the United States, the United Kingdom, and Mexico.	WPATH 2.5 hours per month for six months

Laboratory and Other Research Supervisory and Training Responsibilities

2015	Capstone project faculty advisor Participants in United Kingdom Clinical Scholars Research Training Program	HMS Office of Global Education 5 hours
2016	Capstone project faculty advisor Participants in Global Clinical Scholars Research Training Program	HMS Office of Global Education 15 hours

Formal Teaching of Peers (e.g., CME and other continuing education courses):

No presentations below were sponsored by outside entities

2013	□Pituitary disorders□	Single presentation
	Brigham Intensive Review of Internal Medicine	Boston, MA
2013□2014	□Diagnosis and management of male hypogonadism□	Single presentation
	Office Practice of Primary Care Medicine	Boston, MA
2014	□Endocrine emergencies□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2014	□Carcinoid and pancreatic neuroendocrine tumors□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2014	□Hirsutism and hyperandrogenism□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2015	□Thyroid and calcium disorders □ What a hospitalist needs to know□	Single presentation

	Update in Hospital Medicine	Boston, MA
2015	□Adrenal cases□	Single presentation
	Harvard Current Trends in Endocrinology	Boston, MA
2015	□Case presentation and panel discussion: long-term and late effects□	Single presentation
	Cancer Survivorship: Optimizing Care and Outcomes	Boston, MA
2016	□Case presentation and panel discussion: long-term and late effects□	Annual presentation
	Cancer Survivorship: Optimizing Care and Outcomes	Boston, MA
2016	□Endocrine and diabetes□	Single presentation
	Brigham Medicine Update and Maintenance of Certification Preparation	Boston, MA
2016	□Endocrine maintenance of certification□	Single presentation
	Brigham Medicine Update and Maintenance of Certification Preparation	Boston, MA
2016	□Prolactin and Growth Hormone Excess□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2016	□Management of Menopausal Symptoms□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2016	□Gender Dysphoria and Medical Management of the Transgender Patient□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2016□	□Testosterone replacement therapy□	Annual presentation
	Office Practice of Primary Care Medicine	Boston, MA
2017	□Understanding our differences: the role of hormonal therapy, surgery and reproductive treatment for transgender patients□	Single presentation
	Women□s Health Forum: Hormones: Do They Define Us?	Framingham, MA
2017□2019	□Gender-Affirming Hormonal Treatment of Transgender Individuals: Changing Paradigms in a Changing Society□	Annual presentation
	Clinical Endocrinology	Boston, MA
2018	□Thyroid Cases for the Boards□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2018	□Management of Menopausal Symptoms□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA

2018	□Gender Dysphoria and Medical Management of the Transgender Patient□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2018, 2019, 2021, 2023	□Incorporating e-learning to engage learners and enhance retention□	Single presentation
	Advanced Teaching Skills Course	Boston, MA
2019	□Gender identity in clinical care□	Single presentation
	Advancing Women□s Health: Care Across Multiple Disciplines	Boston, MA
2019	□Care of the LGBTQ Patient□	Single presentation
	Office Practice of Primary Care Medicine	Boston, MA
2019	□Focus on long-term metabolic effects of cancer treatments: Patient-tailored approaches to management□	Single workshop
	Diabetes & cancer: Novel links and treatments	Boston, MA
2019	□Focus on survivorship: Optimizing health after surviving cancer□	Single workshop
	Diabetes & cancer: Novel links and treatments	Boston, MA
2020	□Care of the transgender patient: Hormonal therapy and its consequences□	Single presentation
	Innovations and New Practices in Internal Medicine 2020	
2020	□Thyroid Cases for the Boards□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2020	□Management of Menopausal Symptoms□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2020	□Hormonal Treatment of Transgender and Gender-Diverse Individuals□	Single presentation
	Brigham Board Review in Endocrinology	Boston, MA
2020	□Care of the transgender patient□	Single presentation
	Intensive Review of Internal Medicine	Boston, MA
2020□2022	□Training to Teach - Egypt□	Small group facilitator
	Office of External Education, HMS	Egypt
2021	□Oncoendocrinology in cancer patients and survivors□	Single presentation
	Dana-Farber Cancer Institute Survivorship Course	Boston, MA
2022	□Training to Teach - China□	Small group facilitator
	Office of External Education, HMS	China

2022, 2023, 2024	□Building an Academic Trans Health Program□	Panel member
	Fenway Health□s Advancing Excellence in Transgender Health course	Boston, MA
2023	□Primary care for transgender and gender diverse individuals□	Single presentation
	Advancing Women□s Health: A 2023 Update	Boston, MA
2023	□Update in Thyroid Disease□	Single presentation
	Innovations and New Practices in Internal Medicine 2023	Boston, MA
2023	□Overview of Transgender Care□	Single presentation
	Intensive Review of Internal Medicine	Boston, MA
2023	□Primary Care for Transgender and Gender Diverse People□	Single presentation
	Intensive Review of Internal Medicine	Boston, MA
2023	□Primary Care for Transgender and Gender Diverse People□	Single presentation
	Fish Center Women□s Health Clinical CME Seminar	Boston, MA
2023	□Complicated Case Studies in Hormone Replacement□	Single presentation
	WPATH Global Education Institute, Advanced Medical Health Course	Westminster, CO
2024	□Clinical care for transgender and gender diverse patients□	Single presentation
	Office Practice of Primary Care Medicine	Boston, MA
2024	□Cancer risk, screening, and prevention for transgender and gender diverse people□	Single presentation
	Dana-Farber Annual Collaborative Symposium	Boston, MA
2025	□Gender-affirming hormone therapy initiation and antiretroviral therapy considerations□	Single presentation
	The Scott M. Hammer Annual Update on HIV Management	New York City, NY
2025	□Foundations in Gender-Affirming Hormone Therapy for Adults□	Single presentation
	WPATH Global Education Institute, Advanced Medical Health Course	Santa Ana Pueblo, NM
2025	□Complicated Case Studies in Hormone Replacement□	Single presentation
	WPATH Global Education Institute, Advanced Medical Health Course	Santa Ana Pueblo, NM

2025	□Transgender Health Matters: From Terminology to Treatment□	Single presentation
	Lawrence General Hospital Risk Management Grand Rounds	Lawrence, MA
2025	□Gender-Affirming Hormone Care in 2025□	Single presentation
	Fish Center Women□s Health Clinical CME Seminar	Boston, MA
2025	□Clinical Challenges, Educational Solutions: Building Competence in Transgender Health□	Single presentation
	Duke Endocrinology Grand Rounds	Durham, NC
2026	□Evolving Diabetes Care in People With HIV: Screening, Treatment, and the Rise of GLP-1 Therapies□	Single presentation
	The Scott M. Hammer Annual Update on HIV Management	New York City, NY

Local Invited Presentations:

No presentations below were sponsored by outside entities

2010	□A 66-year-old man with hypothyroidism - Novel antineoplastic agents and their effects on thyroid function□
	Longwood area Endocrinology Grand Rounds, Division of Endocrinology, Diabetes and Hypertension, Department of Medicine, BWH
2011	□Osteomalacia□
	Internal Medicine Grand Rounds, BWH
2012	□Lipodystrophy□
	Obesity Medicine Interhospital Rounds, Joslin Diabetes Center, Boston, MA
2013	□Phosphate homeostasis□
	Internal Medicine Grand Rounds, BWH
2015, 2017, 2021	□The endocrine management of transgender individuals□
	Brigham Human Immunodeficiency Virus Conference, BWH
2016	□Lecturing: Turning passive snoozing into active engagement□
	Fundamentals in Medical Education, CFDD, BWH
2016	Transgender health panel
	Lesbian, gay, bisexual, transgender and allies resource group, BWH
2016	□Endocrine effects of novel checkpoint inhibitors□
	Internal Medicine Grand Rounds, BWH
2016	□A 48-year-old woman with chest pain□
	Internal Medicine Grand Rounds, BWH
2016	□MasterClass: Treatment of symptoms of the menopause□

	Endocrinology Division MasterClass conference, BWH
2018	□Create educational videos that boost learning□ Workshop, Department of Medicine Education Retreat, BWH
2018	□Embracing NEJM Education Tools□ Maximizing Learning & Teaching□ Lecture, Brigham Education Institute, BWH
2018	□Taking Care of the Gender Non-Conforming Patient: Key considerations□ Lecture, Faculty Development Bedside Series, BWH
2019	□Preserving bone health in the patient with breast cancer□ Lecture, Breast Oncology Seminar Series, DFCI
2020	□Adrenal insufficiency and other endocrinopathies from immune checkpoint inhibitors□ Lecture, Oncology Hospital Medicine Seminar, BWH and DFCI
2020	□Care of the transgender patient: Hormonal therapy and its consequences□ Lecture, Department of Medicine Grand Rounds, BWFH
2020	□Trans Health: Changing Paradigms in a Changing Society□ Lecture, Southern Jamaica Plain Health Center Educational Conference, BWH
2020	□Hypocalcemia□, □Hypercalcemia□, □Transgender Health□, and □Careers in endocrinology□ Podcasts, □Run the List□ podcast, BWH
2020	□Connecting the NEJM Learning Platform to Your Continuing Education□ Invited speaker, Brigham Education Institute, BWH
2020	□Becoming visible: Considerations for coming out in healthcare□ Panel member, Lesbian, Gay, Bisexual, Transgender and Queer Employee Resource Group, BWH
2021	□Lead the Change: Transgender Advocacy and Gender Concordant Care□ Panel member, Public Policy Series, BWH
2022	□Immune checkpoint inhibitor-induced endocrinopathies in the perioperative setting□ Invited speaker, Weiner Center for Preoperative Evaluation Education Series, BWH
2022	□Eliminating disparities in the care of the LGBTQ+ community□ Moderator, panel discussion for □Addressing Health Disparities: Clinical Insights on Race and Social Justice□ webinar, HMS
2022	□Providing gender-affirming medical care during the Covid-19 pandemic: A case from the endocrine clinic□ Plenary speaker, Brigham Center for Transgender Health Grand Rounds, BWH
2022	□Care of the transgender patient□ Invited speaker, Brookside Community Health Center Provider Meeting, BWH
2022, 2024	□Management of menopausal symptoms□ Lecture, Indian Health Service Remote CME Program, BWH
2022	□LGBTQ+ health in cancer care□

Lecture, Department of Marketing and Communications, DFCI

2022 □Providing cardiovascular care to transgender patients□

Lecture, Corrigan's Women's Heart Health Program, Massachusetts General Hospital

2023 □Incorporating technology in your lectures - Engage your learners and enhance retention!□

Lecture, Annual Program Director Retreat, Mass General Brigham Graduate Medical Education Office, Mass General Brigham

2023 □Primary Care for Transgender and Gender Diverse Individuals□

Lecture, Department of Medicine Grand Rounds, BWFH

2023 □LGBTQ+ health in cancer care□

Lecture, DFCI Open Forum

2023 □Caring for Transgender and Gender Diverse People□

Lecture, Southern Jamaica Plain Health Center Educational Conference, BWH

2023 □Breast health in transgender and gender diverse individuals□

Lecture, Breast Oncology Seminar Series, DFCI

2023 □MasterClass: Standards of Care for the Health of Transgender and Gender Diverse People, Version 8□

Lecture, Division of Endocrinology, Diabetes and Hypertension Noon Conference, BWH

2024 □An overview of gender-affirming hormone therapy□

Lecture, Department of Medicine Grand Rounds, BWFH

Report of Regional, National and International Invited Teaching and Presentations

Invited Presentations and Courses

No presentations below were sponsored by outside entities

Regional

2017, 2018 Gender Dysphoria and Medical Management of the Transgender Patient / Obstetrics and Gynecology Resident Teaching Session

Tufts Medical Center, Department of Obstetrics and Gynecology

2021 Gender-affirming hormone therapy / Gender and sexual minority health workshop

Cambridge Health Alliance-Malden, MA

2021 □Clinical diagnosis and management of hyperparathyroidism□

Podcast, □Curbside consult□ podcast, NEJM

2022 □Implementing a Regularly Scheduled Series for Continuing Medical Education Credit□

Lecture, Annual Accreditation Conference, Massachusetts Medical Society

2023 □Immune checkpoint inhibitor-induced endocrinopathies□

Lecture, Fellows Didactic Series, New England Endocrine Alliance

Regional Abstract Oral Presentations

2019 □Increasing metacognitive awareness during medical residency training: Pilot results from a study involving internal medicine residents□. Abstract selected for oral presentation.

Eastern Sociological Society. 2019 Mini Conference on the Sociology of Health Professions Education

National

2014 □Pitfalls and promise of endocrine anti-aging strategies□

Presenter, Plenary Keynote Address, American Academy of Cosmetic Surgery 30th Annual Scientific Meeting, Fort Lauderdale, FL

2014 □Hypertension with VEGF signaling pathway inhibitors□

Presenter, Cardiovascular Endocrinology Research Conference, Morehouse School of Medicine, Atlanta, GA

2016 □Guidelines for letters of recommendations for the Match□

Presenter, American Medical Student Association webinar

2019 □Trans Health: Changing Paradigms in a Changing Society□

Presenter, Internal Medicine Grand Rounds, Rutgers Robert Wood Johnson Medical School, New Brunswick, NJ

2019 □From Priscilla to Northern Lights: Advancing transgender health through education□

Presenter, Babs Siperstein Humanities and Medicine Seminar, Rutgers University, New Brunswick, NJ

2020 □Choose Your Own Healthcare Adventure: Online Clinical Simulation Games for Primary Care Providers of Trans Clients□

Moderator, mini-symposium, WPATH 26th Scientific Symposium, virtual conference

2020□ □WPATH Global Education Institute - Advanced Medical Course□

Live-panel facilitator 3 hours twice yearly, virtual conference, WPATH, East Dundee, IL

2021 □A case-based approach to gender-affirming care□

Presenter, Northwestern Memorial Hospital Gender Pathways Program, Chicago, IL

2021 □USPATH 2021 Scientific Symposium □ Oral Abstracts □ Surgery□

Moderator, oral abstract session, USPATH 2021 Scientific Symposium, virtual conference, USPATH, East Dundee, IL

2021 □Diabetes and other endocrine complications of immune checkpoint inhibitors□

Expert, □Checkpoint NOW□ podcast, Duke Health Center, Durham, NC

2022 □Trans Health: Changing Paradigms in a Changing Society□

Presenter, Endocrinology Grand Rounds, Cedars-Sinai Medical Center, Los Angeles, CA

2022 □Transgender medicine across the spectrum□
Moderator, symposium, AACE Annual Meeting 2022, San Diego, CA

2022 □Faculty Development: Education and Leadership in Endocrinology. Fellowship Interviews and ABIM Pass Rate□

Presenter, AACE Annual Meeting 2022, San Diego, CA

2022 □Alternative agents for androgen blockade in transfeminine individuals□

Presenter, Transgender Health: Comprehensive approaches in primary care ECHO (Extension for Community Health Outcomes), Denver, CO

2022 □Board Review Day 2: Reproductive Disorders and Lipids, Obesity, and Nutrition□

Presenter, AACE Annual Meeting 2022, San Diego, CA

2022 □Cancer Screening in Gender Minorities□

Presenter, Endocrine Society Transgender Research and Medicine Special Interest Group Webinar, Washington, DC

2022 □What is oncoendocrinology?□

Presenter, Endocrine Society Oncoendocrinology Special Interest Group Webinar, Washington, DC

2023 □Primary Care for Transgender and Gender Diverse Individuals□

Lecture, Department of Medicine Grand Rounds, Los Angeles County + University of Southern California Medical Center, Los Angeles, CA

2023 □Diagnosis and management of male hypogonadism□

Presenter, Internal Medicine Grand Rounds, HCA Healthcare, Nashville, TN

2023□ □WPATH Global Education Institute - Foundations Course□

Live-panel member, 3 hours twice yearly, virtual conference, WPATH, East Dundee, IL

2023 □Care of the transgender patient in a hospital setting□

Lecture, American College of Osteopathic Internists Clinical Challenges in Hospital Medicine, Arlington, VA

2023 □Updates in Standards of Care for Transgender and Gender Diverse People Affecting Endocrinologists□

Symposium chair, Endo 2023, Chicago, IL

2023 □Teaching and Assessing Internal Medicine Residents: Innovative Educational Products□

Lecture, Academic Internal Medicine Week 2023, Austin, TX

2023 □Care of the transgender patient in a hospital setting□

Lecture, American College of Osteopathic Internists Clinical Challenges in Hospital Medicine, Arlington, VA

2023 □Primary care for transgender and gender diverse people□

Presenter, Internal Medicine Grand Rounds, HCA Healthcare, Nashville, TN

2024 □An overview of gender-affirming hormone therapy□

Presenter, Endocrinology Grand Rounds, Cedars-Sinai Medical Center, Los Angeles, CA

2024 □Hormone Therapy in Non-Binary and Genderqueer Individuals - Town Hall□

Presenter, Transgender Research & Medicine Special Interest Group Virtual Town Hall, Washington, DC

2025 □Optimizing Program Leadership: Collaborative Workflows Between Program Directors and Associate Program Directors□

Presenter, Association of Program Directors in Endocrinology and Metabolism Faculty Development Series, Washington, DC

National Abstract Oral Presentations

2019 □Implementing the Flipped Classroom into Graduate Medical Education: Feasibility and Effectiveness□. Abstract selected for oral presentation.

Innovations in Medical Education Conference. Transforming Health Professions Education Through Innovation, San Diego, CA.

2019 □The Who, Why, and How of Video-Based Education on a Shoestring Budget□. Abstract selected for workshop.

Presenter, Society of General Internal Medicine Annual Meeting, Washington, DC.

International

2012 □Thyroid dysfunction from antineoplastic agents.□ Online webinar.

European School of Oncology e-Grand Rounds, Milan, Italy

2014 □Preventing and managing neuropathy in type 2 diabetes.□ Diabetes Management Academy, lecture.

ACINDES, Boston, MA

2014 □Preventing and managing nephropathy in type 2 diabetes.□ Diabetes Management Academy, lecture.

ACINDES, Boston, MA

2014 Visiting Educational Scholar

Tokyo Medical and Dental University, Tokyo, Japan

2015 □Thyroid complications of antineoplastic therapies.□ Lecture.

National Thyroid Symposium, Norwegian Thyroid Group, Gardermoen, Norway

2015 □Tre behandlingsinduserte hormonforstyrrelser □ et kamprop for onkoendokrinologi□ [Three treatment-induced hormonal disturbances □ a battle cry for oncoendocrinology]. Grand Rounds

Norwegian Radium Hospital, Oslo, Norway

2018 □Endocrine complications of immune checkpoint inhibitors.□ Lecture.

Hospital de Clínicas □José de San Martin□, Buenos Aires, Argentina

2021	□HRT101: A conversation on hormonal therapy for trans and intersex activists□. Online lecture. Gays and Lesbians of Zimbabwe (GALZ), Kushinga, and Trans and Intersex Rising Zimbabwe (TIRZ)
2021	□Kjønnsbekreftende endokrinologisk behandling□ [Gender-affirming endocrine treatment]. Lecture, □Kjønnsmangfold og seksuelt mangfold□ [Gender and sexual diversity] continuing education course, SEX901. University of Agder, Kristiansand, Norway
2021	□Gender-affirming care in adults□. Lecture, □Demystifying Gender: Fostering gender friendly healthcare□. World Health Organization Collaborating Centre for Adolescent Health, Querencia, and Association for Transgender Health in India, New Dehli, India
2021	□Complex cases in transgender health□. Panel discussion, 25th Congress of the World Association for Sexual Health World Association for Sexual Health and Southern African Sexual Health Association, South Africa.
2022	□Overview of gender-affirming hormone therapy□. Lecture Oslo Municipal Health Center for Gender and Sexuality, Norway.
2023	□The new specialty of oncoendocrinology and its relevance to the practicing endocrinologist□. Plenary speaker The Philippine College of Endocrinology, Diabetes and Metabolism Annual Convention, Manila, Philippines
2023	□Transgender Care□. Plenary speaker The Philippine College of Endocrinology, Diabetes and Metabolism Annual Convention , Manila, Philippines
2023	□Endocrine concerns in patients with cancer□. Online lecture. First Affiliated Hospital of Sun Yat Sen Medical Center Survivorship Education Series, Guangzhou, China
2023, 2024	□Nursing care for transgender and gender diverse persons□. Online lecture. Oncoclínicas, Rio de Janeiro, Brazil
2024	□Endocrine management of transgender youth□. Lecture. Conference on gender incongruence in children and adolescents. Patient Organization for Gender Incongruence, Oslo, Norway.
2024	□Gender-affirming medical interventions in youth□. Lecture. Ayur Initiative, New Delhi, India
2025	□Guideline congruence in gender incongruence - providing high-quality gender-affirming hormone therapy to adults□ The Oslo Trans Health Conference 2025, Oslo, Norway

International Abstract Oral Presentations

2012	□Effect of short term / chronic energy deprivation and leptin administration on circulating undercarboxylated osteocalcin levels in humans□ Panhellenic Medical Congress on Obesity, Athens, Greece
2012	□Fibroblast growth factor 21 levels in young females display day/night variation and are increased in response to short-term energy deprivation□ Panhellenic Medical Congress on Obesity, Athens, Greece
2012	□Changes in GI-secreted hormones after bariatric surgery□ Panhellenic Medical Congress on Obesity, Athens, Greece

Report of Clinical Activities and Innovations

Current Licensure and Certification:

2009□	Full License, Massachusetts
2010□	Board Certification, Internal Medicine
2012□	Board Certification, Endocrinology
2021□2023	Certification, WPATH Global Education Institute Standards of Care 7
2021□2023	Full License, Connecticut
2021□2024	Full License, Maine
2022□2024	Full License, New Hampshire
2022□2024	Full License, Rhode Island
2023□	Certification, WPATH Global Education Institute Standards of Care 8

Practice Activities:

2009□ 2014	Moonlighter, Internal Medicine	Department of Medicine, BWFH	2 shifts per month
2012□ 2015	Moonlighter, Internal Medicine	Spaulding Hospital for Continuing Medical Care, Cambridge, MA	2 shifts per month
2012□ 2017	Attending, General Medicine Service	Department of Medicine, BWH	50 hours per week for 2-10 weeks per year
2013□	Attending, Endocrinology Clinic	Division of Endocrinology, BWH	Three half-day sessions per week yearly
2014□	Endocrinology Consult Service	Division of Endocrinology, BWH	40 hours per week for two weeks per year

2015□ 2024	Attending, Oncoendocrinology Clinic	DFCI	One half-day session per week yearly

Clinical Innovations:

2014□2024 Creation of the field of oncoendocrinology and establishment of an endocrinology clinic focused on care of the cancer patient at DFCI.	Endocrine disorders in patients with cancer require a specific skillset including knowledge of both endocrinology and oncology which I acquired, thus creating the field of oncoendocrinology at BWH. I also led the division□s efforts in creating an innovative oncoendocrinology clinic at DFCI. My experiences with creating this clinic have been shared with individuals interested in creating similar programs in Norway and Argentina, and have been published in *Endocrine Practice*. I am currently spearheading the creation of a collaborative of interested oncoendocrinologists to share clinical experiences, as well as educational and research resources, which lead to the creation of a Special Interest Group at the Endocrine Society which I am leading.
2017□ Establishment of the program in transgender health at BWH and creation of a BWH Center in Transgender Health	As a provider of gender-affirming hormones to transgender and gender diverse patients since 2010, I identified the gaps in the care provided at BWH to this group and worked with a diverse group of stakeholders to address these. These efforts contributed to the creation of a variety of policies addressing relevant topics of (rooming, gender information in the electronic health record), to the creation of a multidisciplinary group of providers of clinical services, and finally to the creation of the BWH Center for Transgender Health.
2019 Advocacy for access to gender-affirming care in Norway	As a native of Norway, I have followed the discussion around provision of clinical care to transgender and gender diverse individuals in that country. This had relied on an outdated □gate-keeper□ model; in January 2019, based on my background including prominence in the area of transgender health, I was invited to work with the Norwegian Directorate for Health and Social Affairs to rethink how this care should be organized. As an expert external to the very small community of clinicians providing this care in Norway, I was able to advocate for changes that would provide greater access to a wider variety of healthcare services for this population, changes which are currently in the process of being incorporated into the national health service.
2019 Creation of formal guidelines on interpretation of bone mineral density testing in transgender patients	Bone mineral density testing is used to diagnosed bone fragility (osteopenia and osteoporosis), ideally before fractures occur. However, guidelines on when to obtain such testing as well as the interpretation of some of the bone mineral density measurements differ based on gender, and the best approach to this testing in transgender / gender non-confirming patients had not been established. I served on a guideline panel convened by the International Society for Clinical Densitometry (ISCD) to review the current research and make clinical recommendations; this led to the publication of the official position on this topic by the ISCD which serves as the authoritative guidelines.

2020□ Creation of a model of expanding gender-affirming care to clinical practices nationally and internationally	With increasing demand for gender-affirming care, a variety of clinicians and institutions have identified this as a gap in their skillset and have sought to fill this. Lectures can address some of the knowledge gaps but are insufficient on their own. Using my knowledge of medical education principles, I developed a program of lectures, small group sessions, and mentored practice in gender-affirming medicine. Implementing this program allowed the creation and continuation of programs providing gender-affirming care both locally, nationally, and internationally. Since developing these programs, I have been asked to replicate the mentorship as part of WPATH□s Global Education Institute mentorship program.
2025□ Creation of a student-led, faculty-supervised, clinic in gender-affirming care	Worked with student leaders to create the Medical Outreach for Supportive, Affirming, Inclusive Care (MOSAIC) Access Clinic. This clinic allows medical students to take the lead in assessing patients for gender-affirming care, and following them up longitudinally. The clinic has been very popular among medical students at HMS, leading to the addition of another faculty member to increase capacity. In addition to providing a learning opportunity for medical students, this clinic has also meaningfully improved access to care for an underserved community at a time of significant uncertainty for transgender and gender-diverse patients.

Report of Teaching and Education Innovations

2014□ Implementation of additional processes for evaluation, mentorship and coaching of endocrinology fellows	As part of the leadership team of the endocrinology fellowship at BWH, I was in charge of the implementation of several formal structures to help our fellows on their path to becoming leaders in academic endocrinology. I created the structure and processes involved in the Clinical Competency Committee, which reviews trainee performance to identify strengths to build on and areas of weakness to mitigate. As an academically focused program, it was also clear that our fellows needed additional mentoring and coaching; I therefore created the Scholarship Oversight Committee which is a formal committee created for each fellow to help oversee and guide their career development. I have created a variety of policies with the input of multiple stakeholders, including a progressive Parental Leave policy, and policies addressing back-up/coverage and pathways for fellows to safely raise concerns.
2016□ Implementation of case-based collaborative learning methodology at HMS	I was one of the original core faculty members that developed the endocrinology portion of Homeostasis 2, and I remain heavily involved in the updating and teaching of the course. This course was part of the curricular reform at HMS, thus it involved the implementation of case-based collaborative learning (CBCL) as the method of instruction. The endocrinology portion of this course has been getting the highest ratings from students since its inception, and has evolved as further understanding of the CBCL methodology has become available.
2017□2019 Revision of the current system of	Continuing certification □ the process of maintaining all the attributes expected of physicians who maintain a board certification in a medicine specialty □ is expected of the public, but the process did not meet the need of diplomates. As an active member of the □Continuing Board Certification: Vision for the Future Commission□ that was convened by the American Board

continuing board certification	of Medical Specialties (ABMS), I was part of the team that developed the final report from the commission. I was later asked to serve on their task force providing recommendations on remediation pathways for individuals who fail to meet the continuing certification requirements. Based on the Vision Commission report and the work of the task force, ABMS issued new standards for continuing certification in November 2021, with substantial changes to bring increased value both to the public and to diplomates.
2019□ Funding of, and creation of, an online program for training in pain management and opioid prescribing	Most states have added training requirements in opioid prescribing and pain management as one approach to address the opioid crisis in the United States. However, such training has often not relied on sound educational principles. I was part of a team that secured an unrestricted educational grant from the Food and Drug Administration□s mandated Risk Evaluation and Mitigation Strategy program (grant awarded to the Massachusetts Medical Society). This provided the opportunity to create an engaging online module featuring more than 60 case-based questions on pain management, safer prescribing of opioid analgesics, and the recognition and treatment of opioid use disorder. I oversaw the development of this module from inception to launch and beyond, including creation of learning objectives, recruitment of editorial team, creation of learning elements, and continuous updates. The impact of this program on opioid prescribing was studied and we found a greater decrease in various opioid prescribing parameters in users of this product compared with a matched group of non-users in Massachusetts. As of Sept 1, 2024, almost 250,000 individual learners have used this module, which is available free of cost at https://knowledgeplus.nejm.org/cme-moc/pain-management-and-opioids-cme/.
2020 Creation of a Covid-19 vaccine course for clinicians	When Covid-19 vaccines became available, there was an acute need for training of frontline clinicians who would be counseling patients and administering these vaccines. I led a team of content matter experts and educators to create an innovative online training program that used adaptive learning technology to efficiently and effectively teach the key points to understanding the vaccine landscape. The course was made available for six months and had over 8000 users during that period.
2020□2024 Implementing virtual technology into all aspects of the endocrinology fellowship program	With the advent of the Covid-19 pandemic, the endocrinology fellowship program was majorly impacted. In the space of two days, I converted the endocrinology inpatient and outpatient fellow services to become fully virtual. I also led the development of a virtual lecture series for the fellows, and the creation of a virtual elective for medical students at HMS. The latter was one of the few clinical elective opportunities available to HMS students and received very strong feedback. I also advocated nationally for APDEM to recommend a fully virtual recruitment season which they did; I then implemented a virtual recruitment process at BWH. Despite the change in format, the fellowship was able to recruit top candidate and the number of applicants has increased by 30%.
2025□ Creation of student-run access clinic for gender-affirming hormone therapy	Worked with student advocates from Harvard Medical School to create the □Medical Outreach for Supportive, Affirming, Inclusive Care (MOSAIC) Access Clinic□, a clinic that achieved its goals of reducing wait times, improving patient experience, and enhancing trainee education in gender-affirming care.

Report of Education of Patients and Service to the Community

No presentations below were sponsored by outside entities

Activities

2012	VA Boston Healthcare System, Type 2 diabetes support group
	□New treatments for type 2 diabetes mellitus.□ Invited speaker for 1-hour presentation.
2022	WWLP-TV 22, Mass Appeal, Springfield, MA
	□Endocrine issues in cancer patients□. Invited guest for interview for a local news and lifestyle program. Available at https://www.wwlp.com/massappeal/treating-endocrine-side-effects-of-cancer-medications/.
2022	USA Softball, Oklahoma City, OK
	Member, Medical Commission for Transgender and Non-Binary Athlete Participation
2023	Aftenposten, Oslo, Norway
	□En «frisk diskusjon»? Eller et forsøk på å bevare et utdatert statlig monopol?□ [□A □lively discussion□? Or an attempt at preserving an outdated governmental monopoly?□] Co-author on opinion piece on gender-affirming care for a national newspaper in Norway. Available at https://www.aftenposten.no/meninger/debatt/i/zEbqzK/en-frisk-diskusjon-eller-et-forsoek-paa-aa-bevare-et-utdatert-statlig-monopol.Available at https://www.aftenposten.no/meninger/debatt/i/zEbqzK/en-frisk-diskusjon-eller-et-forsoek-paa-aa-bevare-et-utdatert-statlig-monopol.
2023	Aftenposten, Oslo, Norway
	□Helsestasjon for kjønn og seksualitet haret kompetent fagmiljø□ [□The Health Center for Gender and Sexuality has competent professional staff□] Co-author on opinion piece on gender-affirming care for a national newspaper in Norway. Available at https://www.aftenposten.no/meninger/debatt/i/y6y4Bg/helsestasjon-for-kjoenn-og-seksualitet-har-et-kompetent-fagmiljoe.
2023	yahoo!life.
	□What is hormone therapy for transgender people? Experts explain this decades-old treatment□. Quoted expert in an artice about gender-affirming hormone treatment. Available at https://www.yahoo.com/lifestyle/hormone-replacement-therapy-nonbinary-trans-queer-lgbtq-155115597.html.
2023	STAT
	□Primary care physicians are learning how to fill the gaps in gender-affirming medicine□. Interviewed as part of article describing work to expand gender-affirming care to primary care practices. Available at https://www.statnews.com/2023/08/01/gender-affirming-care-pcp/.
2023	Reuters
	□The bills that ban gender transitions□. Interviewed as part of article describing legislative efforts to limit access to gender-affirming care. Available at https://www.reuters.com/graphics/USA-HEALTHCARE/TRANS-BILLS/zgvorreyapd/.
2023	Dana-Farber Cancer Institute
	□Reducing Barriers to Cancer Care for LGBTQ+ People□. Interviewed as part of article describing impact of cancer on LGBTQ+ populations and efforts at Dana-Farber to

mitigate this. Available at https://dfcionline.org/uploadedFiles/Site_Content/news/publications/ITI%2009-12-23(1).pdf

2024 Klassekampen, Oslo, Norway

"Går hardt ut mot Rikshospitalet" [The National Hospital is being condemned]. Quoted expert in an article on the delivery of healthcare to transgender people in Norway. Available at https://klassekampen.no/artikkel/2024-10-25/gar-hardt-ut-mot-rikshospita/G9DR

2024 Klassekampen, Oslo, Norway

"Faglig uforsvarlighet i pen innpakning" [Indefensible professional practice wrapped up nicely]. Co-author on opinion piece on gender-affirming care for a national newspaper in Norway. Available at https://klassekampen.no/utgave/2024-11-09/debatt-faglig-uforsvarlighet-i-pen-innpakning

2024 Aftenposten, Oslo, Norway

"God menneskerettsjournalistikk – en mangelvare" [Quality human rights journalism – in short supply]. Co-author on opinion piece on press coverage of gender-affirming care for a national newspaper in Norway. Available at https://www.aftenposten.no/meninger/debatt/i/B06AqG/god-menneskerettsjournalistikk-en-mangelvare

2025 Filter Nyheter, Oslo, Norway

"Leder for nasjonalt transtilbud stilte opp hos arrangør utpekt som LHBTQ-hatgruppe: – Uproblematisk, mener OUS" [Leader for the national transgender service participated in a conference organized by a designated LGBTQ hate group. – Not a problem, states Oslo University Hospital]. Quoted expert on the landscape of organizations offering opinions on transgender health care. Available at https://filternyheter.no/leder-for-nasjonalt-transtilbud-stilte-opp-hos-arrangor-utpekt-som-lhbtq-hatgruppe-uproblematisk-mener-ous/

2025 TheBodyPro

"What To Know About Prescribing Gender-Affirming Hormone Therapy With HIV Treatment". Quoted expert in an article about gender-affirming hormone treatment in people living with HIV. Available at https://www.thebodypro.com/hiv/gender-affirming-hormone-therapy-hiv-care.

Educational Material for Patients and the Lay Community

Books, monographs, articles and presentations in media

2021 DFCI Blum Resource Center Survivorship Series

"Common Endocrinology Issues among Cancer Survivors." Invited speaker for 1-hour webinar.

2021 Flame Bearers Podcast: The Women Athletes Carrying Tokyo's Torch.

"Caster Semenya". Expert guest discussing variations in sex/gender.

2022 Survivor Journeys Cancer Survivorship 101

	□Endocrinology in cancer survivorship□. Invited speaker for 1-hour recorded presentation.
2022	DFCI Blum Resource Center Survivorship Series □Cancer screening in sexual and gender minorities.□ Invited speaker for 1-hour webinar.

Recognition:

2022□2026	Top Doctor	Castle Connolly / Boston Magazine
2023□2025	Top LGBTQ+ Doctor	Castle Connolly

Report of Scholarship

ORCID ID: 0000-0002-3600-2628

Peer-Reviewed Scholarship in print or other media:

Research Investigations

1. Crowley RK, **Hamnvik OPR**, O□Sullivan EP, Behan LA, Smith D, Agha A, Thompson CJ. Morbidity and mortality in craniopharyngioma patients after surgery. Clin Endocrinol (Oxf). 2010 Oct; 73(4):516-21.

2. **Hamnvik OPR**, Liu X, Petrou M, Gong H, Chamberland JP, Kim EH, Christophi CA, Kales SN, Christiani DC, Mantzoros CS. Soluble leptin receptor and leptin are associated with baseline adiposity and metabolic risk factors, and predict adiposity, metabolic syndrome, and glucose levels at 2-year follow-up: the Cyprus Metabolism Prospective Cohort Study. Metabolism. 2011 Jul;60(7):987-93.

3. Baur DM, Klotsche J, **Hamnvik OPR**, Sievers C, Pieper L, Wittchen HU, Stalla GK, Schmid RM, Kales SN, Mantzoros CS. Type 2 diabetes mellitus and medications for type 2 diabetes mellitus are associated with risk for and mortality from cancer in a German primary care cohort. Metabolism. 2011 Oct;60(10):1363-71.

4. Liu X, **Hamnvik OPR**, Petrou M, Gong H, Chamberland JP, Christophi CA, Kales SN, Christiani DC, Mantzoros CS. Circulating lipocalin 2 is associated with body fat distribution at baseline but is not an independent predictor of insulin resistance: the prospective Cyprus Metabolism Study. Eur J Endocrinol. 2011 Nov;165(5):805-12.

5. Foo JP, Aronis KN, Chamberland JP, Thakkar B, **Hamnvik OPR**, Brinkoetter M, Zaichenko L, Mantzoros CS. Gender dimorphism and lack of day/night variation or effects of energy deprivation on undercarboxylated osteocalcin levels in humans. Obesity (Silver Spring). 2013 Dec;21(12):E527-32.

6. Liu X, **Hamnvik OPR**, Chamberland JP, Petrou M, Gong H, Christophi CA, Christiani DC, Kales SN, Mantzoros CS. Circulating alanine transaminase (ALT) and γ-glutamyl transferase (GGT), but not fetuin-A, are associated with metabolic risk factors, at baseline and at two-year follow-up: The prospective Cyprus Metabolism Study. Metabolism. 2014 Jun;63(6):773-82.

7. **Hamnvik OPR**, Choueiri TK, Turchin A, McKay RR, Goyal L, Davis M, Kaymakcalan MD, Williams JS. Clinical risk factors for the development of hypertension in patients treated with inhibitors of the VEGF signaling pathway. Cancer. 2015 Jan;121(2):311-9.

8. **Hamnvik OPR**, Thakkar B, Chamberland J, Aronis K, Schneider B, Mantzoros CS. Omentin-1 levels are reduced by pharmacologic doses of leptin, but remain unaffected by energy deprivation and display no day-night variation. Int J Obes (Lond). 2015 Feb;39(2):260-4.

9. McKay RR, Rodriguez GE, Lin X, Kaymakcalan MD, **Hamnvik OPR**, Sabbisetti VS, Bhatt RS, Simantov R, Choueiri TK. Angiotensin system inhibitors and survival outcomes in patients with metastatic renal cell carcinoma. Clin Cancer Res. 2015 Jun;21(11):2471-9.

10. Liu X, Huh JY, Gong H, Chamberland J, Brinkoetter M, **Hamnvik OPR**, Mantzoros CS. Lack of mature lymphocytes results in obese but metabolically healthy mice when fed a high-fat diet. Int J Obes (Lond). 2015 Oct;39(10):1548-57.

11. Sun M, Choueiri TK, **Hamnvik OPR**, Preston MA, De Velasco G, Jiang W, Loeb S, Nguyen PL, Trinh QD. Comparison of gonadotropin-releasing hormone agonists and orchiectomy: Effects of androgen-deprivation therapy. JAMA Oncol. 2016 Apr 1;2(4):500-7.

12. Vamvini MT, **Hamnvik OPR**, Sahin-Efe A, Gavrieli A, Dincer F, Farr OM, Mantzoros CS. Differential effects of oral and intravenous lipid administration on key molecules related to energy homeostasis. J Clin Endocrinol Metab. 2016 May;101(5):1989-97.

13. Liu X, Perakakis N, Gong H, Chamberland JP, Brinkoetter MT, **Hamnvik OPR**, Mantzoros CS. Adiponectin administration prevents weight gain and glycemic profile changes in diet-induced obese immune deficient Rag1-/- mice lacking mature lymphocytes. Metabolism. 2016 Dec;65(12):1720-30.

14. Lechner MG, Vyas CM, **Hamnvik OPR**, Alexander EK, Larsen PR, Choueiri TK, Angell TE. Risk factors for new hypothyroidism during tyrosine kinase inhibitor therapy in advanced nonthyroidal cancer patients. Thyroid. 2018 Apr;28(4):437-44.

15. Lechner MG, Vyas CM, **Hamnvik OPR**, Alexander EK, Larsen PR, Choueiri TK, Angell TE. Hypothyroidism during tyrosine kinase inhibitor therapy is associated with longer survival in patients with advanced nonthyroidal cancers. Thyroid. 2018 Apr;28(4):445-53.

16. Healy M, Petrusa E, Axelsson C, Wongsirimeteekul P, **Hamnvik OPR**, O□Rourke M, Feinstein R, Steeves R, Phitayakorn R. An exploratory study of a novel adaptive e-Learning Board Review product helping candidates prepare for certification examinations. MedEdPublish. 2018;7(3):24. DOI: https://doi.org/10.15694/mep.2018.0000162.1

17. Healy MG, Traeger LN, Axelson CGS, Wongsirimeteekul P, **Hamnvik OPR**, Ryan CT, Akresh-Gonzales J, O□Rourke M, Phitayakorn R. NEJM Knowledge+Question of the Week: A novel virtual learning community effectively utilizing an online discussion forum. Med Teach. 2019 Nov;41(11):1270-6.

18. Blair RA*, Caton JB*, **Hamnvik OPR**. A flipped classroom in graduate medical education. Clin Teach. 2020 Mar;17(2):195-9.

19. Foer D, Rubins DM, Almazan A, Chan K, Bates DW, **Hamnvik OPR.** Challenges with accuracy of gender fields in identifying transgender patients in electronic health records. J Gen Intern Med. 2020 Dec;35(12):3724-5.

20. Foer D, Rubins DM, Almazan A, Wickner PG, Bates DW, **Hamnvik OPR.** Gender reference use in spirometry for transgender patients. Ann Am Thorac Soc. 2021 Mar;18(3):537-40. [research letter]

21. Cheung YMM, **Hamnvik OPR**. Teriparatide in individuals with a prior history of radiation therapy a case series. Arch Osteoporos. 2021 Oct 4;16(1):149.

22. Cheung YMM, Wang W, MacGregor B, **Hamnvik OPR**. Associations between immune-related thyroid dysfunction and efficacy of immune checkpoint inhibitors: A systematic review and meta-analysis. Cancer Immunol Immunother. 2022 Aug;71(8):1795-812.

23. Nassar AH, El Zarif T, Khalid AB, Rahme S, Zhong C, Kwak L, Salame M, Farhat EB, Freeman D, El-Am E, Ravishankar A, Ahmad B, Nana FA, Kaldas D, Naqash AR, Sharon E, LeBoeuf NR, Cortellini A, Malgeri A, Gupta S, Al-Hader A, Sparks JA, Linnoila J, **Hamnvik OPR**, Mouhieddine TH, Marron T, Parikh K, McKay RR, Dilling T, Choueiri TK, Adib E, Najem E, Kim SY, Sonpavde G. Clinical outcomes and safety of immune checkpoint inhibitors in patients with solid tumors and paraneoplastic syndromes. J Immunother Cancer. 2024 Mar 5;12(3):e008724.

24. Rothman MS, Ariel D, Kelley C, **Hamnvik OPR**, Abramowitz J, Irwig MS, Soe K, Davidge-Pitts C, Misakian AL, Safer JD, Iwamoto SJ. The Use of Injectable Estradiol in Transgender and Gender Diverse Adults: A Scoping Review of Dose and Serum Estradiol Levels. Endocr Pract. 2024 Sep;30(9):870-878.

25. Misakian AL, Kelley CE, Sullivan EA, Chang JJ, Singh G, Kokosa S, Avila J, Cooper H, Liang JW, Botzheim B, Quint M, Jeevananthan A, Chi E, Harmer M, Hiatt L, Kowalewski M, Steinberg B, Tausinga T, Tanner H, Ho TF, Mark B, Zenger B, Hu S, Gebregzabheir A, Penny JM, Loeb DF, Strickland T, Iwamoto SJ, Rothman MS, **Hamnvik OPR**, Ariel D. Injectable Estradiol Use in Transgender and Gender-Diverse Individuals in the U.S.: A Multicenter Retrospective Study. J Clin Endocrinol Metab. 2025 Aug 7;110(9):e2898-e2907.

26. Misakian AL, Ariel D, Sullivan EA, Singh G, Loeb D, Strickland T, Iwamoto SJ, Rothman MS, Botzheim B, Liang JW, Kelley C*, **Hamnvik OPR***. Injectable estradiol monotherapy effectively suppresses testosterone in gender-affirming hormone therapy. Endocr Pract. 2025 Nov;31(11):1462-1469.

27. Chopra RR, Patel K, Rosner BA, Rocha TC, Duran-Mendicuti AM, Loftus JC, Savage-Borne J, Kourabas L, **Hamnvik OPR**, Khurana B. Comparing radiologically evident injuries among cisgender and transgender women. Inj Prev. 2025 Sep 9:ip-2025-045731. doi: 10.1136/ip-2025-045731. Epub ahead of print. PMID: 40930587.

Other peer-reviewed publications

1. Ní Áinle F, **Hamnvik OPR**, Gulmann C, Bermingham C, Kelly J, McEvoy P, Murphy P. Diffuse large B-cell lymphoma with isolated bone marrow involvement presenting with secondary cold agglutinin disease. Int J Lab Hematol. 2008 Oct; 30(5):444-5.

2. **Hamnvik OPR**, McMahon GT. Balancing risk and benefit with oral hypoglycemic drugs. Mt Sinai J Med. 2009 Jun; 76(3):234-43.

3. **Hamnvik OPR**, McMahon GT. Glycemic targets for patients with type 2 diabetes mellitus. Mt Sinai J Med. 2009 Jun; 76(3):227-33.

4. Mohammad AF, Ambrose N, **Hamnvik OPR**, Kearns G. Meticillin-sensitive Staphylococcus aureus costochondritis in a healthy man. Nat Rev Rheumatol. 2009 Dec;5(12):708-10.

5. **Hamnvik OPR**, Laury AR, Laws ER Jr, Kaiser UB. Lymphocytic hypophysitis with diabetes insipidus in a young man. Nat Rev Endocrinol. 2010 Aug;6(8):464-70.

6. Mantzoros CS, Magkos F, Brinkoetter M, Sienkiewicz E, Dardeno TA, Kim SY, **Hamnvik OPR**, Koniaris A. Leptin in human physiology and pathophysiology. Am J Physiol Endocrinol Metab. 2011 Oct;301(4):E567-84.

7. **Hamnvik OPR**, Larsen PR, Marqusee E. Thyroid dysfunction from antineoplastic agents. J Natl Cancer Inst. 2011 Nov;103(21):1572-87.

> **Hamnvik OPR,** Larsen PR, Marqusee E. Response: Re: Thyroid Dysfunction from Antineoplastic Agents. J Natl Cancer Inst. 2012 Mar 7;104(5):423.

8. Foo JP, **Hamnvik OPR**, Mantzoros CS. Optimizing bone health in anorexia nervosa and hypothalamic amenorrhea: new trials and tribulations. Metabolism. 2012 Jul;61(7):899-905.

9. Khan SM, **Hamnvik OPR**, Brinkoetter M, Mantzoros CS. Leptin as a modulator of neuroendocrine function in humans. Yonsei Med J. 2012 Jul;53(4):671-9.

10. Moon HS, Dalamaga M, Kim SY, Polyzos SA, **Hamnvik OPR**, Magkos F, Paruthi J, Mantzoros CS. Leptin's role in lipodystrophic and nonlipodystrophic insulin-resistant and diabetic individuals. Endocr Rev. 2013 Jun;34(3):377-412.

11. **Hamnvik OPR**, Becker CB, Levy B, Loscalzo J. Clinical problem solving: Wasting away. N Engl J Med. 2014 Mar 6;370(10):959-66.

12. **Hamnvik OPR**, Vaidya A, Becker CB. Interactive medical case: Wasting away. N Engl J Med. 2014 Feb 13;370(7):e12.

13. **Hamnvik OPR**, Saldana F, Levy B, Loscalzo J. Clinical problem solving: Against the grain. N Engl J Med. 2014 Oct 2;371(14):1333-8.

14. Rabin AR, **Hamnvik OPR**, Robinson ES, Miller AL, Loscalzo J. Clinical problem solving: Springing a leak. N Engl J Med. 2015 Oct;373(14):1362-7.

15. Aherne J, **Hamnvik OPR**, Barrow J, Nunn J. Incorporating oral health as part of routine diabetes care in Ireland. Ir Med J. 2017 Dec 18;110(10):660.

16. Park ESY, Rabinowits G, **Hamnvik OPR**, Dagi LR. A case of Graves' ophthalmopathy associated with pembrolizumab (Keytruda) therapy. J AAPOS. 2018 Aug;22(4):310-12.

17. Rosen HN, **Hamnvik OPR,** Jaisamrarn U, Malabanan AO, Safer JD, Tangpricha V, Wattanachanya L, Yeap SS. Bone densitometry in transgender and gender non-conforming individuals (TGNC): 2019 ISCD official position. J Clin Densitom. 2019;22(4):544-53.

18. Cetlin M, Fulda ES, Chu SM, **Hamnvik OPR**, Poteat T, Zanni MV, Toribio M. Cardiovascular Disease Risk Among Transgender People with HIV. Curr HIV/AIDS Rep. 2021 Oct;18(5):407-23.

19. **Hamnvik OPR,** Agarwal S, AhnAllen CG, Goldman AL, Reisner SL. Telemedicine and inequities in health care access: The example of transgender health. Transgend Health. 2022 Apr 11;7(2):113-16.

20. Cheung YM, McDonnell M, **Hamnvik OPR**. A targeted approach to phosphoinositide-3-kinase/Akt/mammalian target of rapamycin-induced hyperglycemia. Curr Probl Cancer. 2022 Feb;46(1):100776.

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23. Cheung YM, **Hamnvik OPR**, Shariff A, Gallagher E. Dearth of ICD Codes for Complications of Immune Checkpoint Inhibitors Impedes Clinical Care and Research. J Endocr Soc. 2023;7(4):bvad019. Chosen for the Endocrine Society Thematic Issue on Immuno-endocrinology 2023.

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27. **Hamnvik OPR**, Vaidya A, Siegel J, Irwig MS. A Smooth Transition. N Engl J Med. 2025 Mar 13;392(11):e30. doi: 10.1056/NEJMimc2404250. PMID: 40073313.

28. Berner AM, MacKenzie TM, Kulkarni S, Chong C, Schechter L, Michie C, **Hamnvik OPR**. Breast cancer in a transgender man. CA Cancer J Clin. 2025 Sep-Oct;75(5):376-386.

29. Zhu L, Cheung YM, Chiang C, Gallagher EJ, **Hamnvik OPR**, Mammen J, Quandt Z, Jones R, McDunn J, Al-Bahadili H, Angell T, Bancos I, Betof Warner A, Blackwell S, Calabrese C, Cho TA, Dougan M, Ferreira M, Funchain P, Herndon J, Johnson DB, Kennedy R, Kheterpal M, Khouri M, Lechner MG, Lim AM, Markova A, Meara A, Overton L, Perdigoto AL, Sachithanandan N, Sharon E, Spain L, Tsai K, Yarchoan M, Reynolds KL, Shariff A. Consensus-based disease definitions for endocrine immune-related adverse events of immune checkpoint inhibitors. J Immunother Cancer. 2025 Oct 15;13(10):e011865.

Non-peer reviewed scientific or medical publications in print or other media:

Reviews, chapters, monographs and editorials

1. **Hamnvik OPR**. Thyroid complications of cancer therapy an increasing challenge. AACE Clin Case Rep. 2016 Summer;2(3):e272-3.

2. **Hamnvik OPR**, Alford DP, Ryan CT, Hardesty IT, Drazen JM. NEJM Knowledge+ Pain Management and Opioids A new adaptive learning module. N Engl J Med. 2019 Apr 18;380(16):1576-7

3. **Hamnvik OPR**. Adrenalectomy for non-secreting adenoma or adenocarcinoma. In: Garg RK, Garber JR, Hennessey JV, Malabanan AO, editors. Handbook of Inpatient Endocrinology. Cham, Switzerland: Springer; 2020. p. 230-237.

4. Goldman AL, **Hamnvik OPR**. Integrated Care of the Transgender and Gender Non-Binary Person. In: Bhasin S, O□Leary M, Basaria S, editors. Essentials of Men□s Health. New York: McGraw-Hill; 2021. p. 309-324.

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Letters to the Editor

1. **Hamnvik OPR**, Dizon DS, Leone AG. Methodology Concerns Regarding Claims Data Studies in Transgender Health. JAMA Oncol. 2025 Mar 6. doi: 10.1001/jamaoncol.2025.0020. Online ahead of print.

Other non-peer reviewed scholarship

1. **Hamnvik OPR**, Løvdal L. (2024). Helsehjelp til mindreårige pasienter med kjønnsinkongruens: Juridiske og medisinske perspektiver [Healthcare for minors with gender incongruence: Legal and medical perspectives]. Available at https://egalia.org/wp-content/uploads/2024/10/Rapport_kjonnsinkongruens.pdf .

Professional educational materials or reports, in print or other media:

1. **Hamnvik OPR**. (2006). The endocrine intern. In The new intern□s guide to Beaumont Hospital. Information book for new interns starting at Beaumont Hospital

2. **Hamnvik OPR**. (2010). Faulkner Hospital. In Kostas T, Brim N (Eds.), Internal Medicine Resident Handbook 2010-2011. Boston, MA: BWH. Information book for new interns starting at BWH

3. **Hamnvik OPR**. (2011). Prolonged suppression of the renin-angiotensin-aldosterone system after treatment of hyperaldosteronism. New England chapter of American Academy of Clinical Endocrinologists Clinical case of the month for March 2011.

Educational case for endocrine fellows and attendings in the New England region

4. **Hamnvik OPR**, Alexander EK. (2013). Thyroid nodule evaluation. In Gopalakrishnan G, Laufgraben MJ (Eds.), Tarascon Endocrinology Pocketbook. Burlington, MA: Tarascon Publishing.

Chapter in pocket textbook aimed at endocrine fellows nationally.

5. Becker C, Tirosh A, **Hamnvik OPR**, Min L, Rosenquist K, Vaidya A, Woodmansee WW, Chamarthi B, Kim M. Endocrinology. In: Singh A, Loscalzo J, editors. Brigham Intensive Review of Internal Medicine Q&A Companion, 1st ed. New York: Oxford University Press; 2014. p.101-124. Question

contributor to the endocrine section of this book aimed at Internal Medicine physicians sitting their initial or recertification board exam.

6. **Hamnvik OPR**. (2014). NEJM Knowledge+. Authored 34 questions in Endocrinology and 1 question in Gastroenterology for comprehensive lifelong learning product from NEJM Group aimed at trainees at all levels; used nationally and internationally.

Available at http://knowledgeplus.nejm.org/

7. **Hamnvik OPR**. (2015). Genetic and genomic influence on disease. In Alexander EK (Ed.), Scientific American Medicine: Internal Medicine Clerkship Guide. Hamilton, ON: Decker Publishing.

Chapter in online textbook aimed at medical students nationwide.

8. **Hamnvik OPR**. (2015). Inappropriate or ineffective immune response. In Alexander EK (Ed.), Scientific American Medicine: Internal Medicine Clerkship Guide. Hamilton, ON: Decker Publishing. Chapter in online textbook aimed at medical students nationwide.

9. **Hamnvik OPR**. (2015). Hyperglycemic emergencies simulation cases. Developed two teaching cases that are used annually for BWH endocrinology fellows in the BWH Center for Medical Simulation.

10. **Hamnvik OPR**, Cohen D, Vaidya A. (2016). Clinical Problems 3. Developed a problem set used in HMS course IN757.ER, Endocrine and Reproductive Pathophysiology (2nd year medical students)

11. **Hamnvik OPR**. (2016). Concepts in pituitary physiology and pathophysiology. Developed 4 concept videos used in Homeostasis II, a required course for 1st year HMS students and by medical students at the University of Global Health Equity in Rwanda.

12. **Hamnvik OPR**. (2016). Concepts in glucose physiology and diabetes pathophysiology. Developed 6 concept videos used in Homeostasis II, a required course for 1st year HMS students and by medical students at the University of Global Health Equity in Rwanda.

13. **Hamnvik OPR**, Wassner AJ, Cohen DA, Wolfsdorf J, Kaiser UB, Vaidya A. (2016). Student guide: Introduction to endocrinology. Wrote the introductory endocrinology syllabus on used in Homeostasis II, a required course for 1st year HMS students.

14. **Hamnvik OPR**, Wassner AJ, Cohen DA, Wolfsdorf J, Kaiser UB, Vaidya A. (2016). Student guide: The pituitary gland. Wrote the syllabus on the topic of the pituitary gland used in Homeostasis II, a required course for 1st year HMS students.

15. Wassner AJ, Huang S, Cohen DA, **Hamnvik OPR**, Vaidya A. (2016). Student guide: The thyroid gland. Co-wrote the syllabus on the topic of the thyroid gland used in Homeostasis II, a required course for 1st year HMS students.

16. Vaidya A, Wassner AJ, Cohen DA, **Hamnvik OPR**. (2016). Student guide: Adrenal physiology and pathophysiology. Co-wrote the syllabus on the topic of the adrenal gland used in Homeostasis II, a required course for 1st year HMS students.

17. **Hamnvik OPR**, Cohen DA, Wassner AJ, Vaidya A. (2016). Student guide: The endocrine pancreas. Wrote the syllabus on the topic of the pancreatic hormones and diabetes used in Homeostasis II, a required course for 1st year HMS students.

18. Cohen DA, **Hamnvik OPR**, Wassner AJ, Vaidya A. (2016). Student guide: Complications of diabetes. Co-wrote the syllabus on the topic of complications of diabetes used in Homeostasis II, a required course for 1st year HMS students.

19. Cohen DA, **Hamnvik OPR**, Wassner AJ, Vaidya A. (2016). Student guide: Calcium and phosphate metabolism; PTH and vitamin D. Co-wrote the syllabus on the topic of calcium and phosphate metabolism used in Homeostasis II, a required course for 1st year HMS students.

20. Wassner AJ, Huang S, Cohen DA, **Hamnvik OPR**, Vaidya A. (2016). Student guide: Growth and sexual development. Co-wrote the syllabus on the topic of growth and sexual development used in Homeostasis II, a required course for 1st year HMS students.

21. Vaidya A, Cohen DA, Wassner AJ, **Hamnvik OPR**. (2016). Problem set: Principles of endocrinology. Developed cases used to teach basic concepts in endocrinology in Homeostasis II, a required course for 1st year HMS students.

22. **Hamnvik OPR**, Wassner AJ, Cohen DA, Vaidya A. (2016). Problem set: Pituitary pathophysiology. Developed cases used to teach pituitary pathophysiology in Homeostasis II, a required course for 1st year HMS students.

23. Wassner AJ, **Hamnvik OPR**, Cohen DA, Vaidya A. (2016). Problem set: Thyroid physiology and pathophysiology. Co-developed cases used to teach thyroid physiology and pathophysiology in Homeostasis II, a required course for 1st year HMS students.

24. Vaidya A, **Hamnvik OPR**, Cohen DA, Wassner AJ. (2016). Problem set: Adrenal physiology and pathophysiology. Co-developed cases used to teach adrenal physiology and pathophysiology in Homeostasis II, a required course for 1st year HMS students.

25. **Hamnvik OPR**, Cohen DA, Wassner AJ, Vaidya A. (2016). Problem set: Diabetes mellitus. Developed cases used to teach the pathophysiology of diabetes in Homeostasis II, a required course for 1st year HMS students.

26. Cohen DA, **Hamnvik OPR**, Wassner AJ, Vaidya A. (2016). Problem set: Diabetes complications. Co-developed cases used to teach about diabetes complications in Homeostasis II, a required course for 1st year HMS students.

27. Cohen DA, **Hamnvik OPR**, Wassner AJ, Vaidya A. (2016). Problem set: Calcium and bone. Co-developed cases used to teach about calcium and bone physiology and pathophysiology in Homeostasis II, a required course for 1st year HMS students.

28. Wassner AJ, **Hamnvik OPR**, Cohen DA, Vaidya A. (2016). Problem set: Reproductive physiology and pathophysiology. Co-developed cases used to teach reproductive physiology and pathophysiology in Homeostasis II, a required course for 1st year HMS students.

29. Cohen DA, **Hamnvik OPR**, Wassner AJ, Vaidya A. (2016). Critical thinking lab: Osteoporosis. Co-developed cases used to teach osteoporosis evaluation and management in Homeostasis II, a required course for 1st year HMS students.

30. **Hamnvik OPR**, Cohen DA, Wassner AJ, Vaidya A. (2016). Applied diabetes management lab. Developed practical teaching session on diabetes management and technologies used in Homeostasis II, a required course for 1st year HMS students.

31. **Hamnvik OPR**. Endocrinology. In: Singh A, Hammond SP, Loscalzo J, editors. Brigham Intensive Review of Internal Medicine Q&A Companion, 2nd ed. Philadelphia: Elsevier; 2017. p. 104-128. Wrote the questions for the endocrine section of this book aimed at Internal Medicine physicians sitting their initial or recertification board exam.

32. Ramaswami R, **Hamnvik OPR**, Elmer-DeWitt M, Margolin S, Simmons L. Patient Communication Rotation Prep. NEJM Resident360. Available at https://resident360.nejm.org/pages/home?resource_collection_id=19&subtopic=introduction (accessed 11/4/2021)

33**. Hamnvik OPR**. Why Endocrinology. The Logical Choice. Endocrine News April 2017. Available at http://endocrinenews.endocrine.org/endocrinology-logical-choice/ (accessed 11/4/2021).

34. Expert faculty, NEJM Resident360 discussion forums "Prepping for PGY1: What You Need to Know Before Starting Residency" (91,758 views as of 11/8/2021), "Ask the Experts: Your Endocrinology Questions Answered!" (22,436 views as of 11/8/2021), and "Applying to Fellowship"What Do I Need to Know?" (30,388 views as of 11/8/2021). Available at https://resident360.nejm.org/discussions?list=past (accessed 11/4/2021)

35. Akresh-Gonzalez J, **Hamnvik OPR**. APDIM Conference Q&A with Education Editor Dr. Ole-Petter Riksfjord Hamnvik. Available at https://knowledgeplus.nejm.org/blog/apdim-conference-qa-with-education-editor-dr-ole-petter-riksfjord-hamnvik/ (235 views as of 11/8/2021, accessed 11/4/2021).

36. **Hamnvik OPR**. Should Patients with Type 2 Diabetes Take Aspirin to Prevent Stroke and Coronary Events? NEJM Knowledge+ Blog. Available at https://knowledgeplus.nejm.org/blog/patients-type-2-diabetes-take-aspirin-prevent-stroke-coronary-events/ (23,188 views as of 11/8/2021, accessed 11/4/2021).

37**. Hamnvik OPR**. Fellows" Training Series at Endo 2017. Available at https://youtu.be/zbKuTNmzPrg (accessed 11/4/2021).

38. **Hamnvik OPR**. Applying for Fellowship: What you Need to Know. Resident 360 Expert Consult. Available at https://resident360.nejm.org/content_items/applying-for-fellowship-what-you-need-to-know/ (24,536 views as of 11/8/2021, accessed 11/4/2021).

39. Chang LS, Cohen DA, Vaidya A, **Hamnvik OPR**, Wassner A. (2018). Student guide: Obesity. Co-wrote the syllabus on the topic of obesity used in Homeostasis II, a required course for 1st year HMS students.

40. Chang LS, Cohen DA, Vaidya A, **Hamnvik OPR**, Wassner A. (2018). Problem set: Obesity. Developed cases used to teach the pathophysiology of obesity in Homeostasis II, a required course for 1st year HMS students.

41. NEJM Knowledge+ (2019). Pain Management and Opioids. Available at https://knowledgeplus.nejm.org/cme-moc/pain-management-and-opioids-cme/. Online module featuring more than 60 case-based questions on pain management, safer prescribing of opioid analgesics, and the recognition and treatment of opioid use disorder. I oversaw the development of this module from inception to launch and beyond, including creation of learning objectives, recruitment of editorial team, creation of learning elements, and continuous updates. As of Sept 1, 2024, almost 250,000 individual learners have used this module.

42. **Hamnvik OPR**. (2018). How Do You Approach a Patient with Suspected Bacterial Meningitis? NEJM Knowledge+ Blog. Available at https://knowledgeplus.nejm.org/blog/suspected-bacterial-meningitis/ (4,786 views as of 11/8/2021, accessed 11/4/2021).

43. Gender-Affirming Hormone Therapy for Transgender Individuals (2018). Endocrine Society Fellows Training Series. Available at education.endocrine.org (accessed 11/4/2021).

44. **Hamnvik OPR**. (2019). Applying for Residency as an International Medical Graduate. NEJM Knowledge+ Blog. Available at https://resident360.nejm.org/content_items/applying-for-residency-as-an-international-medical-graduate/ (63,524 views as of 11/8/2021, accessed 11/4/2021).

45. **Hamnvik OPR**. (2019). Scoring the USMLE Where to next? NEJM Knowledge+ Blog. Available at https://knowledgeplus.nejm.org/blog/scoring-the-usmle-where-to-next/ (2,176 views as of 11/8/2021, accessed 11/4/2021).

46. Continuing Board Certification: Vision for the Future Commission. Final Report (2019). Available at https://www.abms.org/wp-content/uploads/2020/11/commission_final_report_20190212.pdf.

47. NEJM Knowledge+ (2021). Covid-19 Vaccine Training: What Every Clinician Needs to Know. Online adaptive learning module teaching over 50 learning objectives around Covid-19 vaccines. I oversaw the development of this module from inception to launch and beyond, including creation of learning objectives, recruitment of editorial team, creation of learning elements, and continuous updates. The program had greater than 8000 active users between January and June 2021.

48. **Hamnvik OPR**. (2021). American Academy of Clinical Endocrinology Self-Assessment Program (ASAP). Authored 4 questions in the Female and Male Reproduction section of this product, aimed at helping to prepare trainees and endocrinologists for board certification, recertification, or ongoing assessment.
Available at https://pro.aace.com/educational-opportunities/aace-self-assessment-program-asap-2021 (accessed 11/4/2021).

49. Bikas A, **Hamnvik OPR** (2024). Endocrinology. In: Singh A, Hammond SP, Loscalzo J, editors. Brigham Intensive Review of Internal Medicine Q&A Companion, 4th ed. Philadelphia: Elsevier; 2024. Wrote the questions for the endocrine section of this book aimed at Internal Medicine physicians sitting their initial or recertification board exam.

50. **Hamnvik OPR** (2024). Management and Treatment of Obesity in Primary Care: An Evolving Landscape CME Series. Directed 3-module series with NEJM on management of obesity in primary care, accessed by nearly 10,000 learners during the 12 months that it was active.

Local/Unpublished Clinical Guidelines and Reports:

1. [Unnamed authorship] Feminiserende hormoner til personer med kjønnsinkongruens. [Feminizing hormones to individuals with gender incongruence]. Guideline issued by Oslo Municipal Health Center for Gender and Sexuality.

2. [Unnamed authorship] Maskuliniserende hormoner til personer med kjønnsinkongruens. [Masculinizing hormones to individuals with gender incongruence]. Guideline issued by Oslo Municipal Health Center for Gender and Sexuality.

3. **Hamnvik OPR**, Min L. Approach to the Evaluation and Management of Checkpoint Inhibitor Endocrine Toxicity (2018). Guideline created for the DFCI Immunotherapy Toxicity Management Program.

4. [Unnamed authorship] World Professional Association for Transgender Health Standards of Care version 8, Norwegian adaptation (2023). Led the efforts to translate and adapt the standards of care for implementation in the Norwegian setting. Available at https://www.wpath.org/media/cms/Documents/SOC%20v8/Translations/SOC8%20Norwegian%20May%2016%202023_clean.pdf

Thesis:

Hamnvik OPR. Novel regulators of blood pressure. The role of omentin-1 and VEGF-A. Harvard Medical School, May 2014.

Abstracts, Presentations and Exhibits Presented at Professional Meetings:

1. Blair RA, Caton JB, **Hamnvik OPR**. Implementing the Flipped Classroom into Graduate Medical Education: Feasibility and Effectiveness. Oral presentation, 2019 Innovations in Medical Education Conference, Los Angeles, CA, March 2019.

2. Healy M, Petrusa E, Noronha C, Axelsson CGS, **Hamnvik OPR**, Elmore M, Marchwinski L, ORourke M, Phitayakorn R. Measuring metacognitive skills: Pilot results from a study involving internal medicine residents. Poster, AMEE 2019, Vienna, Austria, August 2019.

3. Foer D, Rubins DM, Bates DW, Almazan AN, Wickner PG, **Hamnvik OPR**. Spirometry use for transgender patients. Oral presentation, American College of Allergy, Asthma & Immunology Annual Meeting, Houston, TX, November 2019.

4. McGregor BA, Wang XV, **Hamnvik OPR**, Cheung YM, Wei XX, Ravi P, Fichorova RN, Sweeney C. Changes in bone turnover markers (BTM) and association with outcomes in patients with metastatic hormone-sensitive prostate cancer (mHSPC) treated with androgen deprivation therapy (ADT) +/- docetaxel (D) in CHAARTED (ECOG-ACRIN E3805). Poster, 2022 American Society of Clinical Oncology (ASCO) Genitourinary Cancers Symposium

5. Misakian AL, Kelley CE, Sullivan EA, Chang JS, Singh G, Jelinek SK, Kokosa S, Avila J, Cooper H, Liang JW, Botzheim B, Quint M, Jeevananthan A, Chi E, Harmer M, Hiatt L, Kowalweski M, Steinberg B, Tausinga T, Tanner H, Ho TH, Mark B, Zenger B, Hu S, Gebregzabheir A, Penny JM, Loeb DF, Strickland T, Iwamoto SJ, Rothman MS, **Hamnvik OPR**, Ariel D. Injectable Estradiol Use In Adult Transgender And Gender Diverse Individuals Throughout The U.S.: A Multisite Retrospective Study. Poster, Endocrine Society Annual Meeting 2024, Boston, MA, June 2024.

6. Misakian AL, Kelley CE, Sullivan EA, Chang JS, Singh G, Jelinek SK, Kokosa S, Avila J, Cooper H, Liang JW, Botzheim B, Quint M, Jeevananthan A, Chi E, Harmer M, Hiatt L, Kowalweski M, Steinberg B, Tausinga T, Tanner H, Ho TH, Mark B, Zenger B, Hu S, Gebregzabheir A, Penny JM, Loeb DF, Strickland T, Iwamoto SJ, Rothman MS, **Hamnvik OPR**, Ariel D. Injectable Estradiol Use In Adult Transgender And Gender Diverse Individuals Throughout The U.S.: A Multisite Retrospective Study. Oral presentation, WPATH 28th Scientific Symposium, Lisbon, Portugal, September 2024.

7. **Hamnvik OPR**, Dizon D, Schechter L. Clinical considerations in the assessment and management of sex-hormone responsive cancers in transgender and gender diverse people. Mini-symposium, WPATH 28th Scientific Symposium, Lisbon, Portugal, September 2024.

8. **Hamnvik OPR**, Irwig MS, Radix A, Siegel J, Streed Jr C. Assessing and addressing cardiovascular health in transgender and gender diverse people & communities. Mini-symposium, WPATH 28th Scientific Symposium, Lisbon, Portugal, September 2024.

9. Misakian AL, Ariel D, Sullivan EA, Singh G, Loeb DF, Strickland T, Iwamoto SJ, Rothman MS, Botzheim B, Liang JW, Kelley CE*, **Hamnvik OPR***. Injectable Estradiol for Gender-Affirming Hormone Therapy Effectively Suppresses Testosterone Concentrations. Poster, Endocrine Society Annual Meeting 2025, San Francisco, CA, July 2025. Winner of Poster Highlight Tour and Competition, Reproductive Endocrinology category.

10. Misakian AL, Ariel D, Sullivan EA, Singh G, Loeb DF, Strickland T, Iwamoto SJ, Rothman MS, Botzheim B, Liang JW, Kelley CE*, **Hamnvik OPR***. Injectable Estradiol for Gender-Affirming Hormone Therapy Effectively Suppresses Testosterone Concentrations. Oral presentation, USPATH 2025 Scientific Symposium, Santa Ana Pueblo, NM, September 2025.

11. Dontu S, Tselovalnikova T, Morais NS, Garber J, Bikas A, **Hamnvik OPR**. A Case of Cushing□s Syndrome in the setting of Ectopic Adrenocorticotropic Hormone Production from Metastasized Small Cell Lung Cancer. Poster, New England Endocrine Alliance Annual Meeting 2025, Westborough, MA, September 2025.

SUPPLEMENTAL APPENDIX G

Expert Declaration of Dr. Cathy Thompson in Support of Plaintiffs' Motion for an Updated Preliminary Injunction,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. Apr. 29, 2026)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiff, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691

EXPERT DECLARATION OF DR. CATHY THOMPSON IN SUPPORT OF PLAINTIFFS' MOTION FOR AN UPDATED PRELIMINARY INJUNCTION

I, Cathy Thompson, hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify.

2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

4. I submitted an expert declaration in this case on March 14, 2024 (my "Initial Declaration"). I incorporate that declaration by reference.

5. My background and qualifications are discussed in my Initial Declaration.

6. In the last four years I have not given expert testimony by deposition or trial any cases.

7. Since my Initial Declaration, I have reviewed the following documents related to this case: the Bureau of Prisons' ("BOP") Program Statement 5260.01, Management of Inmates with Gender Dysphoria (the "Program Statement"); the Memorandum on Program Statement

5260.01, Management of Inmates with Gender Dysphoria (Feb. 19, 2026) (the "Memorandum").

8. I submit this declaration in support of Plaintiffs' Motion for an Updated Preliminary Injunction.

EXPERT OPINIONS

A. BOP's experience providing hormone therapy and social transition accommodations is at odds with the stated rationales for the Program Statement.

9. I have reviewed the Memorandum on Program Statement 5260.01, which prohibits gender affirming care, including hormone therapy (precluding the initiation of treatment and providing for the withdrawal of those currently receiving such treatment), and accommodations for social transition. The Memorandum asserts that there is a lack of evidence that hormone therapy and social transition help alleviate gender dysphoria, especially in prisons, and that providing these interventions can present security and prison-administration concerns. I was struck by the absence of any discussion of BOP's years of experience providing this care to individuals with gender dysphoria. If it had been included, it would have refuted their asserted rationales for the policy.

10. I was a psychologist at BOP for more than two decades until I left in September 2023. Starting in 2017, I was the Chief of Drug Treatment Programs for BOP. As a section chief, I frequently served as Acting Psychology Services Branch Administrator. In that role, I served as the senior agency psychologist on the Transgender Executive Council, which was BOP's "official decision-making body on all issues affecting the transgender population." (Transgender Offender Manual, Exh. B to my initial declaration, at 4). I also had regular interaction with the Transgender Executive Council in my role as the Chief of Drug Treatment Programs when there were drug treatment planning issues for transgender patients.

11. During my time at BOP, particularly since 2017, when BOP issued a national policy providing for gender-affirming care for individuals with gender dysphoria, including hormone therapy and accommodations for social transition, I have seen or reviewed the medical files of many patients who have received such treatment. These interventions were effective at treating gender dysphoria in our patient population. Many patients experienced relief of their gender dysphoria and improvement in mental health and functioning including a reduction in symptoms of depression and anxiety, a reduction in self-harm, and greater engagement in programs like education and reentry preparation.

12. During my years at BOP when hormone therapy and social transition accommodations were available to individuals with gender dysphoria, I did not hear of it creating any security or prison-administration problems, including the security issues referenced in the Memorandum. I did not hear of any incidents of social transition accommodations facilitating escape. I did not hear that these accommodations created an issue regarding the concealment of contraband. I did not hear that other inmates threatened or became violent with these individuals due to resentment of their access to social transition accommodations. Nor did I hear that victimization of transgender people increased as a result of hormone therapy and accommodations for social transition being provided. As the Acting Psychology Services Branch Administrator, I would have expected to be informed if any mental health treatments we provided were creating security concerns. The Psychology Services Branch is responsible for oversight and consultation to the field regarding mental health care for individuals in BOP custody, and such issues would fall within that scope. Additionally, the Psychology Services Branch Administrator is responsible for collaborating with the Correctional Services Administrator to address concerns arising at the intersection of institutional security and mental

health treatment.

13. Rather than creating security or administrative challenges, providing this care improved institutional safety. As I discussed in my prior declaration, these interventions reduced psychological distress and helped prevent mental health crises, including aggression, self-castration attempts, and suicide. This, in turn, enhanced safety for the individuals receiving care, as well as for staff and others in custody. It also benefitted prison administration, as I was aware of fewer acute mental health crises and suicide watches, which require clinical and correctional management.

B. During my long career at BOP, medically necessary care was not denied to patients based on security concerns.

14. The Memorandum says that even if the prohibited treatments are medically necessary to address gender dysphoria, gender-affirming care should not be made available because providing it in the prison environment raises security and prison administration concerns. As I discussed above, I was not aware of any such issues arising during the years that BOP provided hormone therapy and social transition accommodations to individuals with gender dysphoria. But if such issues were to arise, in my more than two decades at BOP, it was not the policy of BOP to deny medically necessary care due to security concerns and I am not aware of any case in which medically necessary treatment was denied on that basis. Rather, BOP would put in place procedures to ensure that treatment was provided without compromising safety.

15. For example, medications such as Suboxone and methadone are routinely provided to patients to treat opioid use disorder. While the potential for diversion of these medications presents a legitimate security concern, and patients prescribed them may be at risk of being targeted by other individuals, these concerns did not result in the denial of medically

necessary treatment. Instead, the BOP has developed and implemented protocols to administer these medications in a controlled manner, reducing the risk of diversion and enhancing patient safety. Similarly, medically necessary assistive devices such as canes and crutches are provided to individuals with mobility impairments, notwithstanding the potential for misuse as weapons or for concealing contraband. The security risks (e.g., escape, staff assault) associated with transporting incarcerated individuals to outside medical facilities are well-known; however, patients requiring emergency or inpatient care are not denied treatment. Rather, the BOP employes established safeguards, including the use of restraints and armed escorts, to mitigate these risks while ensuring access to necessary care.

C. Additional responses to the specific security concerns cited in the Memorandum

16. In addition to the facts that, during my time at BOP (until 2023), i) the potential security risks of gender affirming care cited in the Memorandum were not an issue, and ii) security concerns were never deemed a basis to deny medically-necessary care, I have some additional reactions to the specific security issues mentioned in the Memorandum.

The claim that gender-affirming care will make patients targets for violence

17. The Memorandum asserts that providing hormone therapy or accommodations for social transition will make individuals a target for attacks and increase the risk of harm to prison officials tasked with protecting them. I have several reactions to this based on my experience at BOP.

18. First, transgender people are vulnerable to being targeted whether or not they are receiving gender-affirming care. Earlier in my career at BOP before such care was consistently available, transgender people were considered a vulnerable population at risk of being targeted. I am aware of transgender people in BOP custody being subjected to assault whether or not they

were receiving hormone therapy or social transition accommodations.

19. In my experience, providing gender-affirming care did not exacerbate the targeting of transgender individuals; if anything it made them less vulnerable by improving their mental health. People with gender dysphoria experience profound distress when assigned social roles that are inconsistent with their gender identity. The feelings of anxiety and depression associated with gender dysphoria can impair social functioning in ways that are likely to increase their chances of being targeted. For example, people experiencing these conditions may have difficulty accurately interpreting social cues, may withdraw or self-isolate, and may exhibit irritability or heightened reactivity, increasing the likelihood of interpersonal conflict. As mental health improves, individuals are better able to engage in healthy, prosocial interactions; interpret social dynamics more accurately; and regulate their emotions and behavior. These factors contribute to greater personal safety.

20. Second, if medically necessary care makes someone vulnerable to being targeted by others in custody, BOP protects them; it doesn't deny medically necessary care. As noted above, medications such as Suboxone and methadone are routinely provided to patients to treat opioid use disorder. Patients prescribed them may be at risk of being targeted by other individuals; however, these concerns did not result in the denial of medically necessary treatment. Instead, the BOP has established procedures to protect individuals who are at risk for coercion, threats, and violence from others, including changing housing assignments, placing someone into protective custody, and transferring them to another facility. Nor is the burden or cost of protecting people a reason BOP would deny medically necessary care.

21. There are many reasons people in prison may be targeted by others and at greater risk of violence, including their sexual orientation, cognitive limitations, being physically

weaker, or having a serious mental illness. People may also be targeted because they have access to certain areas of the institution like kitchen workers, who can be targeted to obtain contraband. When there are concerns about individual safety, BOP takes steps to protect them, whether placing them in protective custody, changing their housing assignment, or transferring them to another facility.

The claim that social transition accommodations raise fairness concerns

22. The Memorandum states that providing social transition accommodations that allow people to change their appearance "raises fairness concerns and can breed resentment among other inmates, which can lead to violence." Memorandum at 14.

23. The idea that cisgender men in prison would resent that they aren't getting bras or women's grooming items is hard to take seriously. But even if others were envious of these items, all sorts of accommodations are provided to people in custody for medical or religious reasons that give them access to something others don't have. For example, BOP would provide lower bunk passes for those with physical limitations. It would provide special shoes to people who have orthopedic conditions. Special diets would be provided for medical or religious reasons. It would provide educational accommodations to people with diagnosed learning disabilities. And in some cases, work assignments would be changed as a religious accommodation. Concern about resentment and resulting violence was never a basis to deny these accommodations that were medically necessary or provided for religious reasons.

The claim that social transition accommodations create the risk of concealing contraband or escaping and hindering investigation of in-prison crimes

24. The Memorandum asserts that a reason for prohibiting accommodations for social transition is that "providing accommodations heightens the risk of inmates concealing dangerous

contraband or escaping and may hinder the prison's ability to investigate intra-prison crimes." Memorandum at 14.

25. People in BOP custody hide contraband in all sorts of places, including socks, shoes, bags, underwear, and in their hair. BOP has established procedures for thorough pat searches of individuals to include all areas of clothing that might conceal contraband, in addition to an individual's hair and personal property. Nothing about social transition accommodations would create a special risk of concealment of contraband, including binders. Other similar garments such as back support braces and belts are permitted when medically necessary and officers are able to search them.

26. The asserted concern about concealment of contraband has no conceivable connection to many of the social transition accommodations that are available, e.g. hygiene items and makeup.

27. Suggesting that access to social transition accommodations would enable someone to change their appearance enough to conceal their identity and possible escape from secure custody or avoid being investigated for intra-prison crimes is based on extreme speculation rather than any documented instance of this happening in federal custody, and does not explain why all accommodations are removed, including undergarments and hygiene products. BOP has established procedures to minimize risks of escape by incarcerated individuals who alter their appearance, including procedures for staff to be identified by presenting photo ID anytime they exit the institution, and staff escorts for all visitors.

The claim that providing gender-affirming care conflicts with the practice of refusing to reward threats of self-harm and may even increase self-harm

28. The Memorandum states that providing gender-affirming care "conflicts with reasonable practice of refusing to reward threats of self-harm and may even increase self harm."

Memorandum at 14.

29. This makes no sense at all. When people are feeling hopeless and desperate in prison, threatening self-harm does sometimes happen. The suggestion that *permitting* gender-affirming care for patients who have a need for it would incentivize self-harm to get access to such treatment is illogical. If the treatment is available, there would be no reason to take such drastic measures to get care.

30. To the contrary, having a policy that *prohibits* gender-affirming care regardless of medical need would create that sense of hopelessness and desperation among people with gender dysphoria that could prompt self-harm. Before BOP consistently provided gender-affirming care to people with gender dysphoria, I was aware of some people who attempted self-castration.

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

Executed this 28 day of April, 2025

C. Thompson PhD

Cathy L. Thompson, Ph.D.

SUPPLEMENTAL APPENDIX H

Third Expert Declaration of Dr. Cathy Thompson,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. May 21, 2026)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiff, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691

THIRD EXPERT DECLARATION OF DR. CATHY THOMPSON

I, Cathy Thompson, hereby declare and state as follows:

1. I am over the age of 18, of sound mind, and in all respects competent to testify.
2. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
3. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.
4. I submit this declaration to respond to some of the statements made in the Declaration of Elizabete M. Stahl, Medical Director of the Federal Bureau of Prisons.
5. In my declaration submitted in this case on April 27, 2026, I discussed the positive impact of hormone therapy and social transition accommodations on patients with gender dysphoria in BOP custody. Specifically, I said that many patients experienced relief of their gender dysphoria and improvement in mental health and functioning. *See* Thompson April 27, 2026 Declaration, ¶ 11.
6. Dr. Stahl's declaration appears to try to discredit this testimony by calling into question my experience with this patient population, stating that I only served as

Acting National Administrator for Psychological Services ("Acting") for seven months. As I stated in my prior declaration, I "frequently served" as Acting during the time that I served as National Chief of Drug Treatment Programs. Second Thompson Decl., ¶ 10. The longest period in which I served in this role was 7 months but over the course of my time as Chief of Drug Treatment Programs, I was often in that role for shorter periods of time when the National Administrator for Psychological Services was unavailable. When in the role of Acting, I sometimes attended meetings of the Transgender Executive Council (TEC) and was the senior agency psychologist present.

7. Additionally, my experience with this patient population and its treatment needs was not limited to the time I was in the role of Acting. I also interacted with the TEC and attended its meetings on other occasions in my capacity as National Chief of Drug Treatment Programs when issues arose with transgender patients receiving drug treatment. And I saw patients with gender dysphoria and reviewed medical files of additional patients with this condition. Moreover, I was involved in developing BOP's Transgender Offender Manual.

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

Executed this 17th day of May, 2026

C. Thompson, PhD
Cathy L. Thompson, Ph.D.

SUPPLEMENTAL APPENDIX I

Declaration of Alishea Sophia Kingdom,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. Mar. 17, 2025)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiffs, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691-RCL **DECLARATION OF ALISHEA SOPHIA KINGDOM**

My name is Alishea Sophia Kingdom. [1] I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 26 U.S.C. § 1746, I declare:

1. I am a 34-year-old transgender woman in the custody of the Bureau of Corrections ("BOP"). I am currently incarcerated at Fairton Federal Correctional Institution ("FCI Fairton").

2. I have been aware that my gender identity is female since childhood. Growing up in Wisconsin, around age 7, I remember being sad and upset when I learned that my body was not like my girl cousins' bodies, because I knew I was a girl, too. When my uncles bought me G.I. Joes, I would dress them up in my sister's Barbies' clothes. My mom would buy "boy's" bedspreads for me and "girl's" bedspreads for my sister. I would sometimes borrow a princesses blanket from my sister and sleep with it underneath my Ninja Turtles blanket.

[1] My legal name is Joshua Mueller. My Federal Bureau of Prisons Register Number is 13131-089.

3. Because she thought I was either gay or too feminine, my mom started sending me to various mental health centers and boys' residential programs, starting when I was around age 10. While it hurt to know that she thought there was something wrong with me, I also found a certain sense of freedom in some of this time away from home. While my mom would always tell me to speak in a deeper voice or walk like a boy, I was free to express myself in some of the group homes.

4. When I started going through male puberty, I really knew something was wrong—that I should be growing into a woman. I started to feel intense anxiety. I had regular panic attacks, especially when I started to grow facial hair. I couldn't sleep, and I would break out into cold sweats as I lay awake worrying about my body and how uncomfortable I was with my body masculinizing.

5. I came out as a transgender woman when I was a teenager, and began wearing typically-female clothing, hairstyles and cosmetics.

6. Because I did not have access to doctors who could treat my gender dysphoria, starting around age 17, I would get estrogen pills from a friend. I did this because I was desperate to alleviate my dysphoria.

7. I was arrested when I was 19 years old, served a sentence in state prison, and I have been in BOP custody since I was 23 years old.

8. BOP providers diagnosed me with gender dysphoria in 2016. Later in 2016, I saw an endocrinologist who prescribed me hormone therapy.

9. I was also approved to get commissary items like women's undergarments and cosmetics to alleviate my gender dysphoria in 2016.

10. It was a huge relief to be able to be on hormones again and access items to help me present as the woman I know myself to be.

11. Last year I went before the Transgender Executive Council (TEC) so they could review me for surgery to further alleviate my gender dysphoria.

12. On January 26, 2025, I was supposed to receive my regular hormone shot but was denied care. BOP staff told me that, because of President Trump's Executive Order, they would no longer provide care to transgender people at FCI Fairton.

13. On or about January 26, 2025, FCI Fairton removed all commissary items that transgender women previously had access to in alignment with our gender identity.

14. On or about January 26, 2025, FCI Fairton changed its regulations for searches to allow male guards to do visual and pat down searches of trans women. BOP staff also stopped using correct pronouns or avoiding using pronouns (such as by calling someone inmate and their last name) and began to misgender people, saying that under the EO they are not allowed to use female pronouns for transgender women.

15. All books with LGBTQ+ themes have been removed from the FCI Fairton library. When I asked Administrative Supervisor Bergensen why the books were removed, he told me that the prison couldn't "promote" anything dealing with LGBTQ+ identity.

16. On February 6, 2025, I was supposed to receive another shot, but again was told that I could not receive care because of the Executive Order.

17. I submitted a BP-08 grievance on February 4, 2025, grieving that I was no longer able to access treatment for gender dysphoria because of the Executive Order.

18. I received a response to my BP-08 grievance on February 6, 2025, containing language from the Executive Order with no additional response to my grievance. The response

read, “Executive Order ‘Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,’ signed by President Donald Trump on January 20, 2025, states in Section 4(c) that the Attorney General shall ensure that the Bureau of Prisons revises its policies concerning medical care to be consistent with this order and shall ensure that no federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.”

19. I had been scheduled to receive another shot on February 12, 2025, but again was denied care with BOP staff saying that the Executive Order did not allow me to access health care for my gender dysphoria.

20. On February 27, 2025, I spoke with Clinical Director Martin and asked when I would be receiving my hormone therapy. Director Martin informed me that I would not be receiving my shots, and that BOP was receiving new policies confirming the denial of hormone therapy.

21. After approximately a decade of receiving hormone therapy while in BOP custody, I have now been cut off from access to this medication. After more than a month without care, my gender dysphoria has become incapacitating. The distress of losing my care has caused me to experience anxiety, panic attacks, and mood swings, and I have been unable to sleep. Losing my care has caused me to feel hopeless, and I have begun having suicidal thoughts as a result. I frequently find myself thinking, I would rather not live than be forced to live as a man.

22. I was due to be further evaluated for surgical treatment for my gender dysphoria this March 2025, but with the shutdown of the TEC, there is now no avenue for me to continue

to seek surgery. This causes me extreme distress. I regularly think about taking a pair of scissors and removing my own genitals to end the pain of my dysphoria.

I, Alicia Sophia Kingdom, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 03/04/2025

/s/ Alishea Sophia Kingdom
Alishea Sophia Kingdom

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Alishea Kingdom, and that she affirmed that the foregoing is true and correct on 03/04/2025.

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

Dated: 03/13/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

SUPPLEMENTAL APPENDIX J

Third Declaration of Alishea Sophia Kingdom,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. Apr. 29, 2026)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

THIRD DECLARATION OF ALISHEA SOPHIA KINGDOM

My name is Alishea Sophia Kingdom.[1] I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 26 U.S.C. § 1746, I declare:

1. I am a 35-year-old transgender woman in the custody of the Bureau of Corrections ("BOP"). I am currently incarcerated at Fairton Federal Correctional Institution ("FCI Fairton").

2. In my previous declarations, I described how President Trump's Executive Order caused BOP staff at FCI Fairton to cut off my hormone therapy for nearly two months from January to March of 2025 and to revoke access to feminine undergarments and feminine commissary items.

3. My hormone therapy was restored in March of 2025. My access to feminine undergarments and feminine commissary items has been restored since the time of my last

[1] My previous declarations mentioned a prior legal name of mine. Since that time, a Cumberland County, New Jersey court legally changed my name to Alishea Sophia Kingdom. BOP has recognized that name change and updated my name in its system. My Federal Bureau of Prisons Register Number is 13131-089.

declaration as well. Since then, my medications and access to gender-appropriate items has been consistent.

4. Because, and only because, my hormone therapy has been consistent, I am able to focus on my future. In the first half of 2027, I expect to be released to a halfway house back home in Wisconsin.

5. Upon my release, I envision becoming a successful woman. I look forward to reintegrating into my community, and I will not be coming back to prison. I plan to be an active citizen: to continue to be an advocate for my transgender community, to get involved with government and politics, and eventually to start my own business. I cannot wait to take walks in the park and to taste fresh seafood again. I am the most excited to reestablish my relationship with my thirteen-year-old son.

6. When I was cut off my hormone therapy last year, I could not think about my future. My need to restart my medical care was all-consuming, and I could barely muster the will to live.

7. If I were subjected to Program Statement 5260.01, I would be robbed of my focus on the future once again. If BOP started tapering my hormone dosage or required me to be constantly reevaluated to end my hormone therapy, then survival mode would be my constant frame of mind. My hormone therapy is what enables me to function.

8. If I were deprived of social accommodations for my gender dysphoria under Program Statement 5260.01, I similarly would not be able to focus on my future. I would not feel safe walking a men's prison without a bra, and my constant focus would be on how I could look more feminine.

I, Alishea Sophia Kingdom, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 04/17/2026

/s/ Alishea Sophia Kingdom
Alishea Sophia Kingdom

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Alishea Kingdom, and that she affirmed that the foregoing is true and correct on 04/17/2026.

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

Dated: 04/17/2026

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

SUPPLEMENTAL APPENDIX K

Declaration of Solo Nichols,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. Mar. 17, 2025)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

DECLARATION OF SOLO NICHOLS

My name is Solo Nichols.[1] I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. I am a 40-year-old transgender man in the custody of the Federal Bureau of Prisons ("BOP"). I am currently incarcerated at Federal Correctional Institution ("FCI") Tallahassee.

2. Growing up in Michigan, even at a young age I knew I was a boy. I would tell people, "Don't call me a girl. I'm a boy." I was in fifth grade the first time I confidently told a friend that I was a boy.

3. As I grew, my gender dysphoria started causing depression and anxiety. I felt invisible, small, inadequate, mentally and physically weak. It was the worst when I would get my period. I felt exposed, and I felt like a fraud. Walking to the bathroom with a tampon, I would sweat and my heart would race. It felt like being naked in public.

[1] My legal name is Latasha Ann Nichols. My Federal Bureau of Prisons Register Number is 16212-040.

4. Starting around age 15, I began what I now understand to be called "social transition." I wore exclusively men's clothes and used men's hygiene products. I also started wearing a chest binder to give my chest a more masculine appearance.

5. I have been in federal prison since 2013. My current release date is August 28, 2029.

6. Though I had known myself to be a man for a long time, it was in federal prison that I first heard the word "transgender." Around 2016, I learned that if BOP recognized me as transgender, I could access boxers, chest binders, and men's hygiene products—just as I had before coming to prison. It took BOP about two years to recognize me as transgender, and I was allowed access to these items in 2018.

7. A BOP healthcare provider diagnosed me with gender dysphoria in 2021, and I started testosterone hormone therapy around June 2021.

8. Being on testosterone has made me feel "normal" for the first time in my life. From ages 14 to 36 I was prescribed approximately 13 different psychiatric medications. Since starting testosterone, I have not had a need for any psychiatric medications. Other medications never controlled my anxiety or agitation. Before starting testosterone, I experienced constant racing thoughts, and I could not control my temper. Since starting testosterone, I feel "grounded" and in control of myself in a way I never did before. Testosterone has enabled me, for the first time in my life, to handle difficult situations in a measured way, and to take constructive criticisms not as attacks, but as opportunities to learn and grow. Testosterone has also stopped my period.

9. In 2022, BOP medical providers approved me for "top surgery"—a double mastectomy to further treat my gender dysphoria. That approval was the result of a long process

that included a chest x-ray, a mammogram, answering about 200 questions for a clinical director, a video conference with the Transgender Utilization Review Advisory Group. The TURAG and the BOP medical director approved me for surgery. I have been waiting for a consultation with a surgeon ever since.

10. Ever since President Trump issued the Executive Order, I have been living in fear that BOP will take away the medication that allows me to live as my true self.

11. The week of January 27, BOP psychologist Dr. Proulx informed me that she was aware of an email from officials at a BOP central office in Grand Prairie, TX directing BOP medical staff to discontinue hormone therapy at FCI Tallahassee. She apologized and said that this was not the decision she would make. However, I later spoke with Warden Pistro, and she told me that nothing was changing yet.

12. That same week, Dr. Proulx posted a message on an inmate bulletin board that included information about the effects of discontinuing testosterone hormone therapy. That message read, in part, "apart from endocrine problems, discontinuation of high-dose, long-term TRT can also lead to testosterone withdrawal symptoms, such as depression, uncontrollable desire to get back on T, sleep problems and insomnia, lack of energy and fatigue, lack of appetite, anorexia, decreased libido, muscle and joint pain, and headaches."

13. Prior to February 12, 2025, I received a 100mg testosterone injection every other week. It is my understanding that 100mg is a lower dose than other transgender men require. It is my understanding that 100mg is effective for me because I previously underwent a partial hysterectomy. My injections are ordinarily administered by Nurse Practitioner Nelson.

14. On February 12, 2025, when I arrived to receive my regularly scheduled injection a new staff person, Mr. Goodman, was there to administer testosterone injections for me and

three other transgender men. We were all surprised to learn that our doses were reduced that day. Instead of 100mg, I received only 50mg. Mr. Goodman told me that on February 26, 2025, I would receive a 25mg injection and that that would be my last testosterone injection. Mr. Goodman said that this was happening because of President Trump's Executive Order.

15. I received no prior notice that my testosterone dosage would be reduced or discontinued. I have not had any recent lab work done, and no medical or mental health provider spoke to me about my course of treatment and what a reduction or discontinuation of my testosterone hormone therapy would mean for me individually.

16. After receiving my reduced dose on February 12, I experienced fatigue and mood swings. It feels like the other transgender men and I were walking around like zombies.

17. On Friday, February 21, 2025, the other transgender men and I were informed that our testosterone treatments would be restored to our full dosages. The staff said this would only last until "the restraining order is up."

18. I am very scared to live without testosterone hormone therapy. It feels like who I am and all of the progress I've made is being taken from me, and I feel extremely anxious. I fear losing muscle mass, I am scared to get my period again, and I worry what other detrimental physical and mental health effects I will experience.

19. The last week of February, BOP staff informed me that they would no longer provide, and I would no longer be able to purchase, boxers or chest binders.

20. I have filed BP-8, BP-9, and BP-10 grievances about the changes to our access to care for gender dysphoria.

I, Solo Nichols, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 03/05/2025

/s/ Solo Nichols
Solo Nichols

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Solo Nichols, and that he affirmed that the foregoing is true and correct on 03/05/2025.

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

Dated: 03/13/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

SUPPLEMENTAL APPENDIX L

Third Declaration of Solo Nichols,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. Apr. 29, 2026)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al., Plaintiffs, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:25-cv-00691-RCL **THIRD DECLARATION OF SOLO NICHOLS**

My name is Solo Nichols.[1] I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. I am a 41-year-old transgender man in the custody of the Federal Bureau of Prisons ("BOP"). I am currently incarcerated at Federal Correctional Institution ("FCI") Tallahassee.

2. As I mentioned in my previous declarations, I have been on testosterone hormone therapy since around June 2021.

3. In my previous declarations, I described how FCI Tallahassee briefly reduced my testosterone dosage—as it did with all other transgender men here—in February 2025. In addition to that incident, I was cut off my hormones from mid-November 2025 to Mid-February 2026. I experienced extreme hot flashes, from the top of my head to the tips of my toes. I could not sleep and had rapid mood swings. Everyday challenges made me unreasonably sad and

[1] My legal name is Latasha Ann Nichols. My Federal Bureau of Prisons Register Number is 16212-040.

tearful. I was extremely irritated by small inconveniences, and living with my roommate felt much more difficult than it should.

4. I therefore know how it would feel to be tapered off or removed from hormone therapy, as would be required by BOP's new Program Statement 5260.01. Even if I were allowed to remain on my hormones at first, if I was "reevaluated regularly with respect to cessation of hormones," I would feel constant dread. I would dread waking up each morning.

5. Program Statement 5260.01 says that BOP plans to treat us with psychotherapy and psychotropic medications instead of hormone therapy. But, as I explained in my first declaration, from ages 14 to 36 I was prescribed approximately 13 different psychiatric medications, and I have not had a need for any psychiatric medications since starting testosterone hormone therapy. I have also been treated with psychotherapy for at least seven years of my life. Having tried so many different mental health treatments, I know unequivocally that testosterone is what works for me. Testosterone has fixed what so many other medications failed to. That's because I am a man who has gender dysphoria. Testosterone is the treatment I need.

6. Program Statement 5260.01 would also deprive me of men's body wash, deodorant, boxers, and chest binders and force me to wear panties and bras. I am a man. Like a lot of men, being forced to wear panties or bras would be an incredibly degrading experience. I know that being subjected to this treatment would make me suicidal.

I, Solo Nichols, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 04/16/2026

/s/ Solo Nichols
Solo Nichols

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Solo Nichols, and that he affirmed that the foregoing is true and correct on 04/16/2026.

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

Dated: 04/16/2026

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

SUPPLEMENTAL APPENDIX M

Declaration of Jas Kapule,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. Mar. 17, 2025)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

DECLARATION OF JAS KAPULE

My name is Jas Kapule.[1] I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. I am a 35-year-old transgender man in the custody of the Federal Bureau of Prisons ("BOP"). I am currently incarcerated at Federal Correctional Institution ("FCI") Waseca.

2. When people ask me why I'm trans, I just say I've always been like this. I knew I was a boy when I was five years old. When I was growing up, I tried to make my family happy and tried to be feminine, but it never felt right when people saw me as a girl. I was never comfortable with femininity and always wanted to present as a boy. People would mistake me for a boy sometimes, and I would be happy when they did.

3. After high school, when I was around 18 years old, I realized I wanted to be myself and try to be happy. I was deeply depressed trying to be someone I am not, and not accepting myself, so I started living as who I am, a man. I still struggled with dysphoria and

[1] My legal name is Jasmine Lalani Kapule. My Federal Bureau of Prisons Register Number is 97856-298.

started using drugs as a coping mechanism. If I had known about hormones to treat gender dysphoria, I would have started them then.

4. I have been in federal prison since 2020. My current release date is in 2028.

5. Shortly after I entered BOP custody in 2020, I began to seek hormone therapy for my gender dysphoria. In 2022, I was diagnosed with gender dysphoria and began receiving hormone replacement therapy. I have continued taking testosterone as a treatment for gender dysphoria since then.

6. Being on hormone therapy has dramatically changed my life for the better. My lifelong depression finally began to lift. When my period ended due to the hormone therapy, I felt like I had turned over a whole new leaf and finally began feeling comfortable in my body.

7. Since approximately 2022, I have also been able to access commissary items that matched my gender identity, such as men's underwear and chest binders. This has helped decrease discomfort with how I dress and present myself.

8. Last year, in 2024, I began pursuing "top surgery"—a double mastectomy to further treat my gender dysphoria. I met with Assistant Warden Davis, who evaluated me. Assistant Warden Davis referred me to Dr. Reyna, the facility's chief psychologist, who confirmed my gender dysphoria diagnosis and referred me to the Transgender Executive Council (TEC). On December 19, 2024, Assistant Warden Davis sent me a message saying that the TEC had reviewed my case and made the following recommendations: "Hormone levels are on target and have been consistent. Clear conduct since July 2023. *WASPB [Women and Special Populations Branch] to initiate a surgical referral to HSD [Health Services Department] for further review." I was waiting for a final response when the Executive Order was issued.

9. When I went to get my hormone shot on January 23, 2025, I asked if I would still be allowed to access care for gender dysphoria. BOP staff told me that I would get my shot that day, and that would continue until they heard how to implement the Executive Order from central office. BOP staff have since told me that my hormone therapy will be discontinued when my current prescription runs out. On March 12, 2025, I asked the staff person who gave me my injection when my prescription runs out, and she could not or would not tell me.

10. On January 31, 2025, BOP staff posted a bulletin about President Trump issuing an Executive Order. The bulletin said that inmates could no longer contact the Transgender Executive Council and that it is being ended.

11. The prison has also stopped offering a class led by a BOP staff member called Emerging Identities, where we discussed and learned about identity, including gender identity. The FCI Waseca staff member who used to lead the class later gathered us together told us the class was on hold due to the Executive Order.

12. On February 24, 2025, BOP staff told us that we could no longer receive or purchase chest binders to address dysphoria related to our chests. The next day, February 25, 2025, BOP staff told us that we had to turn in our boxers as we were now forbidden from wearing them. They gave us panties to wear. I did not even know what size to ask for, as I haven't worn them in years. It felt degrading to have even our underwear taken away from us.

13. Ever since President Trump issued the Executive Order, I have been afraid that that BOP will take away the medication that allows me to live as my true self. Now that I am finally in a place where I feel ok, I am scared that I will be forcibly detransitioned and taken back to a very bad place, mentally. I am particularly afraid of my period returning and the depression and dysphoria it will cause.

14. Because the TEC has been abolished, I will not be able to access surgery to alleviate my gender dysphoria, as I was awaiting a decision from them. When I asked Assistant Warden Davis about my surgery on February 25, 2025, I was told that everything is stopped and that I will not have surgery as it was still in process when the Executive Order was issued.

15. I submitted a BP-10 grievance form on February 12, 2025, by certified mail. I used a BP-10 regional grievance form because I knew that FCI-Waseca cannot remedy my situation because of the Federal policy change. I grieved the loss of access to surgical care and the impending loss of other care for my gender dysphoria. I received a response advising me to resubmit my grievance as a BP-08 grievance. I filed my BP-08 as instructed on March 3, 2025, and the unit manager received it on March 7, 2025. On March 12, 2025, I received a response to that BP-08 which stated, "Pursuant to President Trump's January 20, 2025 Executive Order, 'Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government,' the Transgender Offender Manual was rescinded. Until further notice, the Bureau of Prisons will follow any updated policies published by the Department of Justice.' I also appealed the response to my BP-10 by filing a BP-11 on March 6, again grieving the loss of access to surgical care and the impending loss of other care for my gender dysphoria.

I, Jas Kapule declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 03/12/2025

/s/ Jas Kapule
Jas Kapule

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Jas Kapule, and that he affirmed that the foregoing is true and correct on 03/12/2025.

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

Dated: 03/13/2025

/s/ Shawn Thomas Meerkamper
Shawn Thomas Meerkamper

SUPPLEMENTAL APPENDIX N

Declaration of Jas Kapule,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. Apr. 29, 2026)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

Case No. 1:25-cv-00691-RCL

DECLARATION OF JAS KAPULE

My name is Jas Kapule.[1] I am over the age of 18 and fully competent to make this declaration. Under penalty of perjury, pursuant to 28 U.S.C. § 1746, I declare:

1. I am one of the named Plaintiffs in this action. I am a transgender man currently incarcerated at Federal Correctional Institution (FCI) Waseca.
2. In late 2025, the medical staff at FCI Waseca lowered my testosterone dose without informing or consulting me. I only found out after the fact, after I had begun experiencing the effects of the lowered dose. It was a horrible experience.
3. In November of 2025, I started noticing emotional changes. I felt angry and impatient more often than was normal for me, and my depression and anxiety were worse. I felt really emotional all the time. In December, I started getting extremely bad uterine cramps.
4. Around December 2025, when I was getting my biweekly testosterone shot, the nurse mentioned that my dose had been lowered to 150 milligrams. The last I had been told, my dose had been 200 milligrams. It had been constant at 200 milligrams for about two years.
5. I spoke to Ms. Peterson, the Health Services Administrator, about my testosterone dose being lowered at mainline in December. She told me that the pharmacy had lowered my dose because my bloodwork showed that my testosterone levels were too high. I asked her a few times at mainline what my levels were, but she wouldn't tell me or show me.
6. I then got my menstrual period in early 2026 for the first time in two years. I was also getting cramps outside of my menstrual period. Getting my period makes my gender dysphoria much worse. I was devastated. I felt humiliated and emasculated. I had to borrow panties from someone else because I needed to use a pad, which I couldn't use when wearing boxers. I even got my period twice in the month of March, with only one week off of it.

[1] My legal name is Jasmine Kapule. My Federal Bureau of Prisons register number is 97856-298.

7. In early March of 2026, my testosterone dose was raised back up to 175 milligrams. I told Dr. Moore about the negative effects that I had been experiencing, such as the mood swings and my period returning, and she agreed that I needed a higher dose in order to effectively treat my gender dysphoria.
8. I am still feeling the effects of my testosterone dose being lowered. I isolated myself, withdrawing from supportive relationships with friends and loved ones. Being on hormones made me feel like I was able to climb out of a hole I had been in for a long time; being tapered made me feel like I had been dragged back down into that hole. Although I have been back on a higher dose for a bit over a month, I still feel like I am climbing back out. Since my dose was increased, I have felt more hopeful and upbeat. My emotions are still unstable, and my anxiety and depression are still worse than usual, but they have started to improve a bit since my dose was increased. It will likely be a couple of months before my menstrual period stops again, and it feels frustrating, like I have to go through the whole process that I went through just to get back to the point I was before my dose was lowered.
9. I am so scared about the new gender dysphoria treatment policy that the BOP announced. When the policy was posted on the bulletin boards at Waseca, all of the trans people were really afraid that our hormones were going to be tapered. My old partner from the PAWS service dog training program, a transgender woman, woke me up and showed me the new policy. My heart dropped. I felt extremely anxious, and I started to feel depressed and lost. A bunch of other transgender guys at Waseca came to me because they knew I was a part of this case, asking what was going to happen because they were scared. I had already had my dose lowered, and the effects of that were horrible for me. The mood swings and mental health effects were really bad, and getting my period for the first time after two years was horrible, and it made my dysphoria so much worse.
10. I know how being subjected to this new policy would feel because of how BOP very recently tapered my hormone dose. When my testosterone dose was lowered, I was a mess. I am usually a very “together” person, but when BOP tapered my hormones, my close friends told me that they were worried about me because I was much more emotional, breaking down from the distress and anxiety that came with my dose being lowered. My transition has been a crucial piece of my sobriety. Before I could fully accept myself and begin my transition, I numbed the pain with substance abuse -- which is how I wound up in prison in the first place. I would feel hopeless, and I would worry about my ability to maintain my sobriety if I were under constant threat of losing my hormones.

I, Jas Kapule, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and recollection.

Dated: 04/14/2026

/s/ *Jas Kapule*
Jas Kapule

I, Shawn Thomas Meerkamper, certify that I have read the foregoing to Jas Kapule, and that he affirmed that the foregoing is true and correct on 04/14/2026.

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

Dated: 04/14/2026

/s/ *Shawn Thomas Meerkamper*
Shawn Thomas Meerkamper

SUPPLEMENTAL APPENDIX O

Declaration of Leslie Cooper in Support of Plaintiffs' Motion for an Updated Preliminary Injunction and to Stay Agency Action & Transcript Excerpts, *Alishea Kingdom, et al., v. Donald J. Trump, et al.*, No. 25-cv-691, (D.D.C. Apr. 29, 2026)

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, *et al.*, *individually and on behalf of all others similarly situated*, *Plaintiffs*, v. DONALD J. TRUMP, et al., *Defendants*.	Civil Action No. 1:25-cv-00691-RCL

DECLARATION OF LESLIE COOPER IN SUPPORT OF PLAINTIFFS' MOTION FOR AN UPDATED PRELIMINARY INJUNCTION AND TO STAY AGENCY ACTION

I, Leslie Cooper, declare pursuant to 28 U.S.C. § 1746 that:

1. I am an attorney with the American Civil Liberties Union, attorneys of record for Plaintiffs in this action.

2. I submit this declaration in support of Plaintiffs' Motion for an Updated Preliminary Injunction and to Stay Agency Action. I have personal knowledge of the facts set forth in this declaration, and if I were called as a witness, I could and would testify competently to them.

3. I am counsel for Plaintiffs in *Keohane v. Dixon*, in the Northern District Court of Florida, case no. 4:24-cv-00434. In *Keohane v. Dixon*, Dr. Kristopher Kaliebe was deposed in that case on December 15, 2025.

4. Attached hereto as Exhibit A to my declaration is a true and correct copy of excerpts from the Deposition of Kristopher Kaliebe taken in *Keohane v. Dixon*, Case No. 4:24-cv-00434.

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

Executed on April 29, 2026

/s/ Leslie Cooper
Leslie Cooper

Exhibit A

couple of things. There are some things that I would have added to my new C.V.

Q Okay. So, the date on this report, if we can scroll back to the date page with the signature on page 69 of the PDF, is October 6th. October 6th.

I'm going to focus in on the topic of gender dysphoria. Have you added any publications on gender dysphoria since October, 2020 -- oh, October 6th, 2025?

A Yes. I think the most relevant publication was the Department of Health and Human Services, gender dysphoria report, which I was a coauthor on.

Q Okay. Anything else?

A In terms of just publications?

Q Just publications relating to gender dysphoria or transgender people.

A I don't know if my Obstacles To Progress article is on that C.V., but I'm guessing that it is. So, I believe -- I believe that the HHS report would be the only other addition.

Q Okay. So, you mentioned you've been a psychiatrist since I think you said 1999; is that right?

A I graduated in medical school in '99.

Q Okay. And when did you say you became a

psychiatrist?

A Well, I think most people would consider you to be a psychiatrist when you finish your first residency. So, I would -- I went -- I did general psychiatry for three years, and then I went into child. So, I went from general to child in 2002.

Q Okay.

A And then by some people's measures you're only fully minted in your profession when you're done with your fellowships. So, I finished my child psychiatry fellowship in 2004, and my forensic psychiatry fellowship in 2005. So, that was when my training ended.

Q Okay. And can you give an estimate of the number of patients that you've seen in your career for anything?

A Well, that's a good question, and it's difficult to estimate because we usually don't, you know, keep track, but I can -- I know that in my clinic in -- at the St. Charles Community Health Center, we did a chart review just before I left, and I average seeing 14 patients a day, per clinic day when I worked there, and I was at that clinic for 11 years, and I was two days a week for about half a day, and one day a week for half. So, I

mean, I think those are all individual patients encounters. So, you know, some people -- obviously many of them were seen multiple times. Throughout all of my career I'd probably guess -- I mean, definitely over 10,000 patients.

Q Okay.

A It's probably closer to double that, I think would be a rough estimate in my head, but I -- you know, that's probably a rough estimate, 20,000.

Q Okay. Thank you.

And can you give a rough estimate of pediatric versus adult patients among the patients you've seen over your career?

A Yes. I would probably estimate an 80/20 --

Q Uh-huh.

A -- split. Maybe -- or a quarter, 25/75. I think maybe more recently I've seen a higher percentage of adults. So, it may be now 25/75.

Q Okay. And I saw from your C.V. you have worked in juvenile correction settings; is that correct?

A Yes.

Q Have you worked ever in adult correction settings?

A Yes.

Q Where was that?

A So, during my training I worked at the -- at a correctional center in Louisiana when I was doing my forensic psychiatry fellowship. As part of correct -- forensic fellowships there's a requirement to train in correctional settings.

Q Uh-huh.

A And then I also worked for the Orleans Parish Prison, and during that time I was -- on two -- and really sort of two sort of separate occasions. First when I was living in Louisiana I did some coverage for -- at some other correctional facilities that they were contracted with. I remember Hunt was one of them. I don't know, you know, how this was -- I don't even think this is reflected on my C.V. because I was -- it was just a period of months of, you know, coverage sort of, because they ran out of --

Q Uh-huh.

A -- psychiatrists I guess to cover the facility.

And then somewhere again around 2018 or '19 I was contacted -- I was also Orleans Parish -- I was contracted again with Orleans Parish Prison. So, I --

but it has been typically through the places that I was employed with, like LSU Health Science Center or the University of South Florida. I have had some work outside, but it's usually contract work. So, I don't have a regular individual private practice.

Q Uh-huh.

A And nor have I ever had an individual private practice.

Q When you say, contract work, what does that mean? What kind of -- who was contracted?

A Correction -- some of my correctional work has been contract work.

Q Okay.

A So, that is not sort of flowing through. Like when you work at a university, you sometimes are not fully employed with them or you do something outside of the university.

Q Uh-huh.

A So, that's what I mean by contract work, that it just was work that I was doing independent of the university that I was also employed with at the time.

Q Uh-huh. Okay. So, now I've been asking you general questions about your work as a psychiatrist. I want to focus in on the patients

with gender dysphoria at this point.

Okay. And I've seen some of your past testimony, where you were asked about estimates, and I think the last time you testified was I -- it appears to be the -- I think the Cano case about a year ago; is that right?

A Yeah. As far as I recall, that was the last time I've testified in these matters, yeah.

Q Okay. So, sitting here today, December 15th, 2025, what -- approximately how many patients with gender dysphoria have you seen in your career?

A Well, I think, you know, as I mentioned in the Cano case, the number was in the 20s, probably -- maybe it's more like 30 at this point --

Q Uh-huh.

A -- because I have -- currently have patients with gender dysphoria. So, that would -- that would probably be -- I mean, 30 I think would be a fair estimate.

Q Okay. And of the patients you've seen approximately 30 patients with gender dysphoria, how many were adults versus pediatric cases?

A Yeah. Well, I'd say the majority would be pediatric cases. I've had some that have aged into adulthood while being seen --

Q Uh-huh.

A -- so, you know, they would be -- they would be young adults, and legally they're adults. And then there are patients in my outpatient resident clinic with gender dysphoria. So, there's probably, you know, a half dozen in that -- in that clinic or that I've seen in the -- in that clinic. So, that's a -- so, maybe there's -- for 18 years and over I'm guessing somewhere it would be like six or eight patients.

Q Okay. And of the 30 or so patients you've seen with gender dysphoria, how many have been in carceral settings?

A I would guess that that's a dozen --

Q Okay.

A -- perhaps even -- perhaps more than that, but maybe 15. Once again, you know, I'm sorry, you don't track things over time. And, so --

Q Uh-huh. So, about -- you think a dozen to 15, nearly half of your 30 or so gender dysphoria patients have been in carceral settings?

A Yeah, that would be right.

Q Okay. And just to help clarify, and I can show you, if you need, at the time of your Cano deposition a year ago, I believe you said you had

five patients with gender dysphoria you treated in a carceral setting. So, does that -- does that still sound about right? Do you think you had about ten more or eight more in the past year?

A Yeah. I mean, perhaps -- perhaps it is a -- yeah. I mean, my guess right now was more like 12 or 15, I'm thinking, but I have had -- certainly have had at least five patients with gender dysphoria in the last year.

Q In the carceral settings?

A In those settings, yeah.

Q Okay. And of the dozen or 15 patients with gender dysphoria that you've seen in the carceral setting -- carceral setting, how many were adults versus minors?

A Well, the vast majority would have been under 18 because I -- since I'm working in juvenile correctional centers, people at those centers do age into -- you can be in a juvenile center up to age 21 really. So, I believe -- there's at least two that aged in or were 18 at the time of treatment.

Q Okay. Understanding that at least two were -- turned 18 while being treated, of the dozen to 15 patients with gender dysphoria that you've seen in carceral settings, were they all in juvenile

settings or were some of those dozen to 15 in adult settings?

A Right now I'm only working in juvenile correctional centers, so --

Q Okay.

A -- those are in juvenile settings.

Q So, all 12 to 15 were in juvenile settings?

A Correct. I don't remember -- as far as I remember, I don't remember seeing gender dysphoria in adult settings.

Q In adult carceral settings?

A Adult corrections, yes.

Q Okay. So, I want to now -- I was just focusing on the carceral settings. Now, I want to focus in on adult care that you've --

A Uh-huh.

Q I think you said -- well, actually I'm not sure I asked you this yet.

To save you time, I'm checking my notes.

Oh, I think you testified about six or eight of the -- about 30 patients with gender dysphoria were 18 or over; correct?

A Yes.

Q Okay. So, focusing in on that group of six or eight adults with gender dysphoria you've

treated, can you tell me what settings you saw them in?

A We just talked about some of them have -- are 18, yet in juvenile corrections. And then there's an adult general psychiatry clinic that I work at. And then I work at Tampa General Hospital covering the hospital on the -- on the weekends.

Q Uh-huh.

A Right now those are the settings that I'm working in.

Q So, we're talking about six to eight adults. Can we break it down, how many you saw at the adult clinic? And is that the USF Clinic?

A Yes.

Q How many do you see there of the six to eight?

A I'd say the vast majority, so it's probably six or so then.

Q Okay. And then how many did you see at Tampa General of the six to eight?

A I would say that there's been two patient encounters. That's coverage. So, this is on-call coverage.

Q And that's counted in your six to eight patients you've seen who are adults with gender

dysphoria?

A Yes.

Q Okay. And then -- so, that gets you -- if there's about six at the USF Clinic, and about two in your Tampa General on-call coverage, is that -- that's all of them?

A Yes.

Q Okay. And in the on-call coverage, that -- would that just be one visit when you're on-call, and somebody needs to see a psychiatrist, and you see them that one time?

A Yeah, that's coverage at a major hospital, so it's what's called a consultation liaison service.

Q Uh-huh.

A So, you would either be covering someone that's already been seen by the service or it would be a new admission to the emergency room or someone on the floors of the -- of the hospital.

Q I see. Would that be a one-time --

A Yes. It would be, yes.

Q Okay. And at USF -- at the USF Adult Clinic where you said you saw about six adult patients with gender dysphoria, what is the nature of that clinical relationship? Is that more ongoing

or can you tell me a little about that?

A Yes. So, that's a resident clinic where you cover any sort of -- any incoming patients from the community that have just sort of wound up at that clinic by whatever referral system that they got there. So, it's a general full-service psychiatry clinic run by residents with attending supervision.

Q And, I'm sorry, did you say resident clinic or residential clinic?

A It's a resident, resident --

Q So, run by residents?

A The trainee -- yes. The trainees, and I supervise, and the patients are seen by the trainees.

Q Uh-huh. So, the six adult patients with gender dysphoria who you've seen at that clinic were being seen by residents who you supervised; is that correct?

A So, depending -- yes. The -- correct.

Q Okay. And is that ongoing treatment where someone comes in for weekly treatment or how often would they be with the clinic?

A So, it typically is ongoing treatment. So, there -- they can be longstanding patients. Some

people stay in treatment for longer, some people are there for a shorter amount of time, but it could be years, it could be months --

Q Uh-huh.

A -- but it is typically not a one-time deal.

Q And of these six patients, adult patients with gender dysphoria that were at the USF Clinic, were all of them seen by residents or did you -- were some of them your patients?

A Yes, we -- those are all seen at that clinic, and are seen by residents with my supervision.

Q And as the supervisor of the residents at that clinic who are providing treatment, do you meet with the patient as well?

A Yes. If they're a new admit or they're on -- depending on their insurance, that I would have to have a meeting with them if they're Medicaid or Medicare. If they have private insurance, then it may be that they're only seen by me during their initial visit. So, depending on the type of insurance I may see them every single time or they may be just seen by me initially, and then the resident follows up with them --

Q Uh-huh.

A -- and presents the case to me, and then I --

Q Okay. So, of those six, were you involved in the initial evaluations of all of them or just some of them?

A It would just -- it would depend. Just some of them. It sort of depends, did they show up to the clinic or are they new to the resident at the time --

Q Uh-huh.

A -- the year starts or are they already -- have ongoing treatment, and it's just sort of being taken over, it could be either way.

Q I see. And of those six adult patients with gender dysphoria at the USF clinic that you referred to, how many did you provide therapy to yourself?

A Those patients I have not provided direct -- well, when you say, therapy to, I -- you know, at that psychiatry clinic it is sort of a general psychiatry clinic. So, I don't think therapy would be the ideal sort of description of what it is.

Q Okay.

A So, they're seen for, you know, holistic mental health care, and medication management, and

therapy, depending on what's needed. So, it's a -- it is not a, quote, unquote, therapy clinic, where therapy is the emphasis of what we provide. We provide it, if needed, and -- but maybe -- or maybe not providing therapy, if not needed, if that's -- if you understand.

Q So, would treatment be a better word than treatment --

A Yes.

Q -- if I asked that question again?

A Yes. Treatment would make more sense, yes.

Q Okay. And just to be clear, treatment could include medication; is that right?

A Yes.

Q Yes. And it could include therapy, if it was indicated?

A Yes.

Q What other treatments? I just want to make sure I understand the full range.

A You know, when you evaluate someone's mental health needs, there's many different possible things that you could provide to them. Psychotherapy is typically seen as an in-depth exploration of a set of challenges or problems that a person wants to come in and specifically work on,

fit into psychotherapy and medication management in my type of clinics, and how I train the residents.

So, I just want to be clear that, yes, sometimes the words psychotherapy or medication management don't really, you know, cover everything we do.

Q Got you. And, so, at the USF Adult Clinic, is there a particular population or a particular set of issues that the clinic draws?

A No, it's a general clinic. So, we would just get whatever range of individuals from the community get to -- get referred to us.

Q Uh-huh.

A So, we take all type -- different types of problems.

Q Okay. And, so, going back to the six adult patients with gender dysphoria you referenced at the clinic, at USF, did you directly provide treatment of any kind to any of those six adults?

A Yes, in that I directly assessed or have seen them in person, and with the resident and, you know, came up with the treatment plan, so --

Q How many of them?

A Probably -- say probably two-thirds were seen, at least seen individually by me at either the

first time that I saw them, and then they were followed up or were -- their -- depending on their insurance they may need to be followed every time.

Q Uh-huh. So, were any of these six people you provided therapy to, psychotherapy?

A No, I would not be the psychotherapy provider in that case.

Q Okay. Would that be a resident?

A Yes. If that -- if a patient requires psychotherapy in the clinic, it would come through the resident.

Q Did any of those six patients require psychotherapy in the clinic?

A None of those six patients were coming to the clinic for psychotherapy or following up officially for psychotherapy. So, we were providing psychosocial supports and other types of assistance, but not what I would say traditional psychotherapy.

Q Uh-huh. For any of the six?

A Correct.

Q Correct. Okay. Did you see any of the -- strike that.

You said you were involved in the assessment and treatment planning for about two-thirds of that group of six. Did you see any

one of the group of six more than once?

A Yes. So, many of them are ongoing patients that we're seeing month to month or -- or sometimes less often, it really depends on the acuity of the patient, what's going on, how often the resident or I feel they need to follow up with us, and how stable they are.

Q Uh-huh.

A So, yeah, they're ongoing -- that group is mostly ongoing treatment cases.

Q And -- but -- and maybe my question wasn't clear.

Were they seen more than once by you, Dr. Kaliebe, or as opposed to by residents and others?

A Yeah, I would say half of them would be ones that I see because of insurance reasons or, you know -- so, they have to follow up with me --

Q Okay.

A -- in addition to the resident.

Q Uh-huh. All right. Since this is a pretty small number of people, we can probably get a little more granular.

Of the six, were any of them coming to treatment for gender dysphoria?

A Well, how do you mean? How do you mean?

Q Well, so, maybe there's a different language you use in your field.

Do you talk about presenting conditions, is that an appropriate term?

A Yeah, I mean, I think if we're asking about what is -- what are their present -- I guess you could say presenting conditions or what are the, you know, problems or challenges that we're treating them for. If they're diagnosed with gender dysphoria, that's part of their overall picture, and would be part of our, you know, biopsychosocial assessment and treatment approach.

Q Uh-huh. And can you say what kind of presenting conditions these six adults came with?

A What other -- are you asking -- could you -- I'm not sure what you're asking.

Q Sure. So, of the six adults who have gender dysphoria that you referred to seeing at the USF Clinic, what kinds of presenting conditions did they come with?

MR. STEELY: Object.

A Presenting -- well, I mean, gender dysphoria would be a presenting condition.

BY MS. COOPER:

Q Uh-huh.

A Are you saying, what, in addition to gender dysphoria? I mean, I guess --

Q Yeah.

A -- we've already established that they have gender dysphoria.

Q Yes.

A So, that's one treatment.

You're saying what in addition to the gender dysphoria --

Q Yes.

A -- presenting treatment? Well, co-morbidities would include autism, psychosis, anxiety disorders, depressive disorders, personality disorders. I think within those that -- that range would be the ones that I have seen.

Q Uh-huh. But you mentioned none of those people are coming for psychotherapy at the clinic?

A They -- none of them were engaged in psychotherapy with us at the clinic. Some of them have therapists, but they may go to an individual therapist outside of the clinic.

Q Uh-huh. Okay. Of the six adult patients, you mentioned that about half because of their insurance you would see more often than just the one evaluation; correct?

A Correct.

Q Yeah. So, the other half you would just do the evaluation, and the treatment planning, but then the resident would be the one seeing them going forward?

A Yes.

Q Okay. So, for the half that you -- so, that would be about three that you saw more often. How long did you see those patients?

A Well, it would -- are you asking how many visits have you seen or are you asking how long have you spent per visit or -- I'm not sure what you're asking.

Q Sure. Well, let's start with how many visits.

A Uh-huh. Well, some patients would be ongoing. So, there may be a patient that -- you know, so some maybe I've seen three or four times, and they're in the process of continuing follow up. So, in terms of the ongoing -- and some have come to the clinic, and now, you know, I'm not sure -- you never really know in our business if they're coming back to the clinic. So, you've seen people, they're scheduled, you know, I haven't really scheduled. There's lots of residents. I don't know, you know,

are people really going to be seen again? Are they going to continue to follow up?

And then year to year if you are the supervisor for a case, they don't necessarily come back to your clinic. So, you may be someone's treatment provider for a year, and then they move on to a different, you know, attending supervisor because they get a new resident. You know, some residents keep patients for two years, that would probably be the -- be the maximum in our clinic.

So, some patients may have come and gone, and I saw them on -- you know, depending on how much they're following up, four occasions during the year. Some that would probably be the typical number, but maybe it would be more, six, if they're coming every two months. It would be 12 if they come every month, but I would say most of our patients are more like one to two months. So, I would say it's like six times a year would be a more -- depending on their acuity level, some are -- come more frequently than that. And then some are relatively stable, and are only seen every three months, so that would be four times.

Q So, understanding that every patient has a different routine based on their needs. For the --

I want to focus in on the patients with gender dysphoria.

So, you said there were about six, and half -- about half or three or so you've seen more than just at the evaluation time. Can you tell me how many times you've seen each of those three patients?

A I'm trying to -- you know. So, I would guess something about five times -- you know, three times for two of them, five times for one would be my -- would be my guess, something like that.

Q So, would -- so, just to put that together. For the three, somewhere between three and five times each?

A Yeah. And we're speaking only of the ones that need to follow up with me or that I've seen.

Q Yes.

A Okay. Yeah. Uh-huh.

Q Yes. Got you. And you anticipated my next question.

Of the other three or so who were seen by residents, how long are they being seen or how many visits have they had?

A I mean, there's -- there's some that have been -- had had more visits, and have been ongoing. So, some have been a higher number than that. I

would say maybe one that was more like eight or ten visits, and then two that were more like four, five visits.

Q Okay. And none of these six, though -- just I want to make sure I didn't get confused.

None of these six were receiving psychotherapy from you or the residents at the clinic at USF; right?

A No, I would say that's not right. I think that there were of the -- of the patients who are -- have been seen by the residents, that there are patients who did receive some psychotherapy from the residents. So, I do have some residents -- supervision of residents who were seeing patients for psychotherapy.

Q Okay. So, of the group of six adults with gender dysphoria seen by the clinic, of the three that were seen by residents, some of those folks were receiving psychotherapy by the residents?

A These two patients that I remember did -- were receiving psychotherapy from the resident.

Q Okay. And that would be -- do you recall -- well, you said of the three seen by residents, you estimated one of those patients was seen maybe eight to ten visits, and the other two about four to

five.

Do you recall whether the patients receiving psychotherapy were receiving it for four to five visits or eight to ten visits?

A Yes, sometimes the cases that you're -- you take over a resident, and they've already seen the patient, and, so, like at least one of the cases that I'm thinking of, the resident had a different supervisor the year before, and then I took over as a supervisor, and they continued with me, you know. So, they had already seen the patient a number of times --

Q Uh-huh.

A -- for psychotherapy, and medication management, and all of that, and then continued with me. So, I don't want to give the impression that the patient was only seen less times overall than they were seen, but in my supervisory capacity those were the numbers that I was giving you, if you -- if that makes sense.

Q It does.

Thank you for clarifying.

Okay. So, of these six adults with gender dysphoria that you referenced seen by the -- at the USF clinic, you have not provided psychotherapy to

any of those individuals; correct?

I didn't hear.

A I said, correct. You said to me directly provided psychotherapy --

Q Yes.

A -- yes, correct.

Q Okay. Got you. And then the other adult with gender dysphoria you mentioned were two people who you saw on-call at Tampa General; right?

A Correct.

Q But that was one visit --

A Correct.

Q -- for each?

A Yes.

Q Okay. So, switching gears from your adult patients, and focusing in on the pediatric patients or minors. By my math, you saw about 30 patients with gender dysphoria, and you said about six or eight were over 18, that would be 32 -- sorry, 22 or 24 were minors; does that sound about right?

A Yes. Yeah. I mean, I'm getting a little confused with these numbers, so --

Q Yeah.

A Sorry, you know, I'm having trouble.

Q Yeah. Let me ask again.

A I --
Q Let's make sure we're clear.
So, we have about -- you mentioned about 30 patients that you've seen with gender dysphoria, and I believe you said about six or eight were 18 or older, and the rest were pediatric; does that -- did I get that right?
A Yeah. I'm kind of -- so, we're -- well, we would add the ones that we saw that we just discussed who were seen in the adult clinic, and then we would add the ones who were 18 at the time in the child -- seen in juvenile corrections, but were over 18. So, there's at least a couple in that -- in that category.
Q All right. And I want to make sure I'm clear. So, the total number, whether you -- when you don't try to tease out ages, it's about 30 is what you said; right?
A Uh-huh.
Q And then I get that somebody might be in a pediatric setting, but could be 18 or 19; right?
A Yeah.
Q Okay. So, when you were giving me the number of six to eight were adults, the ones you saw at the USF -- the six or so you saw at the USF

on the record is, yeah, I had a colleague ask me about, you know, the ability to consent for a young person, you know, considering puberty blockers.

Q Uh-huh.

A So, that -- I think I previously have testified regarding that. So, I also had that. But it was not a psychotherapy question, it was just a different question about care of a youth who would potentially, you know, go on to some medical therapies.

Q Uh-huh. Okay. But those -- that was the -- those three would be the examples of formal consults you had?

A Correct. Yes.

Q Okay. So, of the patients with gender dysphoria you saw at the juvenile corrections facilities or the USF Pediatric Clinic, were you providing psychotherapy to any of those youths?

A Yes. So, in juvenile corrections, depending on the setting, sometimes I'm in places where I, you know, spend more hours, and I'm able to do psychotherapy with certain patients. So, there were a number of patients who I've worked on in psychotherapy with gender-related distress or gender dysphoria diagnosis.

Q Uh-huh. And of those I think we said roughly 22 to 24 youths who -- with gender dysphoria that you've seen, approximately how many did you provide psychotherapy to?

A Well, to broadly speak I would say at least -- I would say a half dozen of the -- of the youth in corrections that I would -- that I provided psychotherapy for.

Q Uh-huh. And at USF, at the gender -- yeah, at the -- sorry, the pediatric clinic there?

A No, this is -- yeah, that's all in juvenile corrections, what I just said. And then I have one, you know, juvenile patient at USF that I had ongoing psychotherapy with.

Q Okay. So, just to be clear. When I asked how many of the juvenile patients with gender dysphoria you provided psychotherapy to, it was about a half dozen of youth and corrections, and one patients at USF Pediatric Clinic?

A Yeah.

Q Okay.

A Yes.

Q Thank you.

And what's the longest that you've spent -- let me ask it differently.

What was sort of the longest psychotherapeutic relationship you've had with any of these seven or so youths with gender dysphoria?

A The facility, Tampa Residential, which was where I'm spending the most clinical hours up until about two years ago, maybe a year and a half ago, maybe it was a year or so, they changed from a -- they changed the level of facility. So, up until this change they were what in Florida would call a level eight facility, which was a minimum nine month stay. And then if things went not ideally, you could end up staying longer. So, you know, we were hoping to get the kids in and out by nine months, but if they don't do their work or get in trouble or whatever it could be longer.

So, I know in those patients in that facility, the nine months would be sort of your expected amount of time that they would be under my care, and that I'd be working with them. And, so, that would be the -- that would be some of them were in that facility.

Q So, the half dozen or so youths with gender dysphoria you provided psychotherapy to in juvenile corrections, it would be nine months?

A Nine months for some, six months for some.

you know, all sorts of other problems, trauma reactions. So, you know, like I said, it's difficult to disentangle what would be the primary treatment, so, the primary treatment target.

Q Okay. Let's take a break now. We've been going a little -- about an hour.

Is five minutes okay or do you need a little bit more?

A Five is fine with me.

Q All right. See you back at -- in five minutes.

Thank you.

(Thereupon, a recess was had at 10:38 a.m.; whereupon, we reconvened at 10:43 a.m.)

MS. COOPER: All right. We can go back on.

BY MS. COOPER:

Q One thing about your pediatric patients that I think I forgot to ask.

You had mentioned that of the 30 patients, I think we did the math, that about 22 to 24 were minors; correct?

A (No verbal response. The deponent nods his head up and down.)

Q Correct? Can you answer out loud?

A Yes.

Q You've been doing great. One nod there.

And then of those minors, you said about a dozen to 15 were in the juvenile corrections context; right?

A Yes.

Q Yes. Okay. And, so, that would mean about -- you know, the remainder eight, nine, somewhere in there would have been at Silver, the Silver Clinic at USF?

A Yes, although I'm not totally sure that that may not be a slight underestimate, I don't want to be -- so, if -- as we break down those numbers, the amounts seen at Silver, maybe that's a little -- but it's in the ballpark, yes.

Q Okay. Great.

MS. COOPER: Sarah, if we can put up tab three, please, at page -- well, let's start at the cover page.

I'm going to -- we will be marking this as Exhibit 2, which -- I will be identifying it I should say as Exhibit 2, not marking.

(Plaintiffs' Exhibit Number 2 was identified and will be marked after the deposition is completed and/or received.)

BY MS. COOPER:

Q This is going to be a transcript of your deposition in the Dekker case.

And I'll ask you a few questions as soon as we have that up.

Okay. Can you see that or do we need to make it a little bigger?

A I can see it.

Q Okay. Let's see the date.

Does this look like your --

MS. COOPER: Scroll down a little bit just to see it.

MS. COOPER:

Q -- the deposition that you gave in the Dekker case?

A Yes.

Q Okay.

MS. COOPER: And scrolling back up to the top page. This was -- scroll down a little bit.

BY MS. COOPER:

Q We see the date there, March 20th, 2023; correct?

A Yes.

Q Okay. And just for the purpose -- for the court reporter, I think when you say, yes, sometimes you're saying it very softly.

A It would depend on the context. I think there's some context where I'd feel it would be more appropriate to avoid just using -- I mean, you don't have to address someone by their, you know, name if they're in a -- but there -- there are times when I feel like it would be appropriate, and, yes, I would use the -- the name that they prefer, and the pronoun they prefer, but I think that's a clinical decision based on a patient in front of you.

Q Okay.

MS. COOPER: If we can put up what we've identified as Exhibit 1 again, the expert report of Dr. Kaliebe. And I'd like to look at page 6.

BY MS. COOPER:

Q Okay. There's -- paragraph 19 says, my recent publications related to gender dysphoria include.

MS. COOPER: And if you could scroll down slowly so Dr. Kaliebe can just -- oh, actually we can see them all; right? Almost.

BY MS. COOPER:

Q So, these are all publications you've written about gender dysphoria; correct?

A Correct.

Q And you say recent ones, you had previous

publications on gender dysphoria as well?
A No, those are the -- those are the -- in medical journals, those are the only ones.
Q Okay. And the only thing since is the HHS report -- and I understand that's not a medical journal, but that's a publication that came out since this report; correct?
A Correct. Yeah. The finalized peer review article -- version is published.
Q Okay. And looking at the first one, Adolescent Onset Gender Dysphoria, Our Perspective, AACAP News, that's the American Academy of Child and Adolescent Psychiatry News --
A Correct.
Q -- is that right?
A Yes.
Q And this -- this was an opinion piece that you provided?
A Correct.
Q Okay. The next one, A Reply to Legal, Mental Health, and Societal Considerations Related to Gender Identity and Transexualism, Letter to the Editor, Journal of the American Academy of Psychiatry and the Law. That is a letter to the editor that you wrote?

A Correct.
Q Okay. And the following one is also a letter to the editor?
A Correct.
Q Okay. The question about the last one, Kozlowska, et al., including you, Obstacles To Progress and Pediatric Gender Medicine, European Journal of Developmental Psychiatry, was that a peer reviewed article?
A Yes.
Q And the -- this was a reviewed article that you wrote?
A Correct. I was a co-author on it.
Q Uh-huh.
A But, yes, I believe -- the journals title articles under different things for different journals. So, I'm not sure exactly what the official type of -- or category that the journal put it in, but I think a reviewed article would be --
Q Uh-huh.
A -- that probably would, you know, fairly suffice to describe it.
Q Okay. So, is this your only peer reviewed publication on gender dysphoria that's published in a scientific journal?

A The letters to the editor of the Journal of the American Academy of Psychiatry and Law are peer reviewed, they don't just publish a letter to an editor. You have --

Q Okay.

A -- to be reviewed to get into those. So, those are also considered peer reviewed articles.

Q Okay. So, let me ask it differently then. The Kozlowska, et. al., is that the only peer reviewed study or review that you've published in a peer reviewed journal?

A Yes.

Q Yes. Okay. And Kozlowska is about pediatric general medicine, as the title indicates; is that correct?

A It does. It covers a lot of issues that are important with -- for adult gender medicine also, but it is focused on pediatric gender medicine.

Q Uh-huh. Okay. So, have you -- oh, strike that.

Have you conducted any original research on gender dysphoria or transgender people?

A No.

Q Okay.

MS. COOPER: We can take down that, the exhibit for now.

BY MS. COOPER:

Q When did you first begin reading the literature, the scientific literature on gender dysphoria?

A Well, I think that to describe my evolution of knowledge regarding what we're currently calling gender dysphoria, you have to go back to my education, you know, even in medical school, and in residency which, you know, included different names for similar or if not exactly the same presentations. So, there was gender identity disorder. And during residency and adult psychiatry, and then in child psychiatry, and in forensic psychiatry you cover disorders of sexuality or sexual-related disorders or -- you know. So, depending on what the different organization or, you know, ICD versus DMS --

Q We're breaking up a little bit.

Is that -- is that --

A Am I back? Can you hear me okay?

MR. STEELY: I can hear you just fine.

MS. COOPER: Oops.

A Okay. Well, I'll keep talking if people

patients most of the time.

Q Okay. Let me -- let me -- thank you for that breakdown.

So, are you aware of any studies or evidence showing that adults with gender dysphoria are likely to overcome their gender dysphoria, more likely to overcome it if they are not able to socially transition?

A I didn't think that the matter has been studied. So, yeah, I don't think we have data one way or another on that.

Q Okay. And when you say that providing accommodations for social transition may enhance a patient's reluctance to receive psychotherapy, do you have -- is there evidence showing that people are unlikely to receive psychotherapy if they're able to socially transition?

MR. STEELY: Objection.

A Well, I think that all of this -- that question comes down to this really interesting dilemma that we have. If you have institutional support for the idea that mostly we should be going along with, and accommodating your, you know, cross sex ideas, then that will be helpful to you versus if an institution says, well, I think it's better

environments people are in, the -- you know, it becomes then sort of frowned upon, and perhaps going against how people feel they should be treated to then, you know, engage in psychotherapy, right. So, there is a lot of stigmatization of psychotherapy within the professional community that -- like those -- like WPATH, and within those who follow that type of approach.

And, so, I think it happens, and I think it can make -- that it does make a difference with regard to engagement, what sort of stance, you know, institutions and mental health providers take regarding these things.

So, no, we don't have a lot of data on it, but I think it is reasonable to think that the -- the willingness of an engagement for those with gender dysphoria, which is often difficult to get this special population to engage in substantial, you know, psychotherapy treatment can be underlined.

Q We don't have any data; right? It's not just that we don't have a lot of data --

A Uh-huh.

Q -- we don't have any data showing that --

A Uh-huh.

Q -- social transition makes people less

likely to pursue psychotherapy; is that correct?
A Yes, it hasn't -- it hasn't been adequately studied, but I would say in my -- in my experience --
Q Okay.
A -- this -- this is a patient population that generally is reluctant to engage in psychotherapy.
Q And your understanding is that people who follow the WPATH standards are reluctant to provide therapy to their patients, and suggestions?
A Yeah, they're reluctant to provide what I would call, you know, high quality psychotherapy because there's a tension between saying that hormones and surgeries are the solution to your gender-related distress, and psychotherapy is the solution to your gender-related distress.
Q Uh-huh.
A So, those who are sort of more enthusiastically advocating for hormones and surgeries tend to be downplaying psychotherapy.
Q But you don't know how most providers are providing care, those who you would call affirming providers; right?
A I do know that I've been following the

dysphoria?

A Not that I -- not that I'm not aware of.

Q Okay. And I want to make sure I understand your view. Are you saying psychotherapy ought to be the exclusive treatment? I understand you -- well, let me -- let me rephrase.

I understand you say it should be the primary treatment. Is it your view it should be the exclusive treatment as well for gender dysphoria?

MR. STEELY: Object to form.

A Are you asking me about in correctional environments or --

BY MS. COOPER:

Q I'm asking in --

A -- in general?

Q Let me ask generally in the community.

A I do believe it should be the first line approach, and the primary approach. I don't --

Q Uh-huh.

A So, that's what I'm saying, it should be the first approach, and the primary approach.

Q But it should not necessarily be the exclusive approach in the community, psychotherapy?

A Correct.

Q Okay. But in the correctional environment

you believe psychotherapy should be the exclusive approach to gender dysphoria?

A Well, I believe as I've detailed in my report that I'm a -- I am -- I think that we can accept that certain exceptions are made to psychotherapy only, you know, especially under circumstances where someone has already presented in treatment.

Q Okay. And there are no studies, right, that demonstrate the effectiveness of psychotherapy alone to treat gender dysphoria; right?

A There are no studies demonstrating the -- basically no studies demonstrate the effectiveness or ineffectiveness. It's not been studied.

Q Okay. So, is it your view that psychotherapy is effective at treating other mental health conditions, you believe they can be effective to alleviate gender dysphoria?

A Yes, I mean, in part I think the proven track record of helping individuals with all sorts of distress would include a very high likelihood that it would help individuals with gender-related distress. I don't see any reason why gender-related distress should be exceptionalized.

Q Uh-huh. Uh-huh. But there -- at this

point there's not evidence looking at that; is that correct?

A Basically one way or another there's not evidence, yes.

Q Uh-huh. Okay. And you cite an article by Hakeem about psychotherapy; right?

A Correct.

Q Yeah. Now, Hakeem is not suggesting that psychotherapy should be the exclusive treatment for gender dysphoria; right?

A Well, I would think -- I guess you would have to ask Dr. Hakeem about that. I don't believe, but I'm not a hundred percent sure what he recommends.

Q Well, in the article they recognize that homotherapy and gender conforming surgeries can be helpful for gender dysphoria; right?

A The article -- yeah, I'm not sure if his viewpoint has evolved since that time, but --

Q Uh-huh.

A -- yeah.

Q But in that article that's what he said?

A Yes.

Q Okay. Of your -- I think we said -- you said six to eight adult patients who you've treated

or had residents treat who have gender dysphoria, did any of those patients of their gender dysphoria resolve through psychotherapy?

A Well, I'm not aware of the outcome of some of the patients if they're no longer in the clinic. So, I don't know. And some already have ongoing treatment, and I would -- some have been medically treated already. So, none -- none have exclusively used psychotherapy as an approach. So, I -- so, no, I don't think that that's the case.

Q You say none of the six to eight patient --- adult patients with gender dysphoria that you or your residents have seen use psychotherapy as the exclusive approach?

A You asked about the adult patients?

Q Yes. Yes.

A Oh.

Q Is that correct?

A Correct. Correct.

Q Okay. Now, in your reports you offer various assertions about WPATH and WPATH's Standards of Care 8 based on documents from a WPATH production in a lawsuit in Alabama called Boe V. Marshall; right?

A Yeah, I mean, there's many lines of

Q Uh-huh. And significant psychological distress for some inmates?

A Yes, I think especially in the short-term when they're -- when policies are changed, and someone is used to a certain policy. I think that's true with, you know, commentary policies much less something more, you know, impactful to inmates.

Q So, you don't disagree, I take it then that for someone with gender dysphoria the inability to socially transition and present to the world consistent with their gender identity, that that can help for some people improve their mental health?

MR. STEELY: Object to form.

A Well, I think it's a complex tradeoff that we're -- that we're contemplating individuals with gender dysphoria because the social transition I think for a large group of them would serve them to feel pleased and better, you know, in the short run, but may not help them in the long run, right. So, I mean, obviously this is an area that we need more study of how to get people to, you know, come to peace with their bodies that they have, but you can see that that would be a positive if someone was not upset about the body that they have, and exactly what institutional policies and other approaches

lead to someone, you know, having less distress is a -- you know, a question that obviously we've been talking about it's a plus.

BY MS. COOPER:

Q So, in your view the goal for treatment of gender dysphoria is -- still should be helping people come to peace with the body they have?

A Well, I think, as we mentioned, there's a number of potential psychotherapeutic or other goals that you could, you know, reach with a patient, but I do think that at least some component of treatment would be to reduce gender dysphoria, that's a psychiatric disorder.

Q Uh-huh.

A So, if we can reduce that, that would be good.

Q Yeah. But at the moment we don't know if there's -- there's no evidence indicating whether psychotherapy can help reduce that dysphoria; correct?

A Uh-huh. Yes. But there's also very limited evidence on social transition.

Q Uh-huh.

A So, yes, there's a number and -- and the potential that there's some tradeoff that's high

iatrogenic or, you know, induced harm from continuing with the -- you know, with the social transition rather than working to accept the body that they have.

Q Even though we don't have any evidence that psychotherapy can help people come to accept the body that they have?

A Well, we have --

MR. STEELY: Object to form.

A We do have good evidence that in other disorders that they can. So, the evidence for something like a body dysmorphic disorder, CPT protocols are very effective. So, we -- and sebopsoriasis actually help also in that case. So, there's a number of other disorders where we do work with people to help accept their body, and work with the body, and get over body-related distress.

So, I think there is a good amount of evidence. And when you're talking about evidence-based medicine, especially in situations where the -- there's a lack of study in the particular disorder or problem that you're facing, then you look at all evidence, right. So, there's uncertain evidence regarding gender dysphoria of how to approach it, I think it's perfectly reasonable to

SUPPLEMENTAL APPENDIX P

Defendants' Motion to Stay the June 17, 2026 Preliminary Injunction Pending Appeal,
Alishea Kingdom, et al., v. Donald J. Trump, et al., No. 25-cv-691,
(D.D.C. June 22, 2026)

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, *et al.*, Plaintiffs, v. DONALD J. TRUMP, *et al.*, Defendants.	Civ. A. No. 25-691 (RCL)

DEFENDANTS' MOTION TO STAY THE JUNE 17, 2026 PRELIMINARY INJUNCTION PENDING APPEAL

Defendants respectfully request that the Court stay the Preliminary Injunction it issued on June 17, 2026 (ECF No. 215) pending appeal. The Solicitor General has authorized the appeal of that preliminary injunction as well as any request for a stay of the injunction in the appellate court. Federal Rule of Appellate Procedure 8(a)(1), however, provides that "a party must ordinarily move first in the district court" for an order staying an injunction pending appeal. Defendants are accordingly seeking that relief in this Court.

Defendants respectfully request that the Court stay the preliminary injunction pending appeal, and if the Court is not inclined to grant the stay, then deny the Government's request by June 25, 2026. "The test for a stay or injunction pending appeal is essentially the same" as the test for a preliminary injunction, "although courts often recast the likelihood of success factor as requiring only that the movant demonstrate a serious legal question on appeal where the balance of harms strongly favors a stay[.]" *Dunlap v. Pres. Advisory Comm'n on Election Integrity*, 390 F. Supp. 3d 128, 131 (D.D.C. 2019) (quoting *Al Anazi v. Bush*, 370 F. Supp. 2d 188, 193 & n.5 (D.D.C. 2005)). Defendants believe that for the reasons discussed in their opposition to Plaintiffs' Motion for an Updated Preliminary

Injunction and to Stay Agency Action (ECF No. 186), they have met that standard. Defendants are likely to succeed on the merits of their appeal because they are likely to show that there is no Administrative Procedure Act violation and that the balance of equities decidedly tip against issuance of the injunction.

Defendants have conferred with counsel for Plaintiffs, who oppose the relief requested herein.

Dated: June 22, 2026

Respectfully submitted,

BRETT A. SHUMATE
Assistant Attorney General

JEAN LIN
Special Litigation Counsel

/s/ M. Jared Littman
M. JARED LITTMAN
ELIZABETH B. LAYENDECKER
Trial Attorneys
U.S. Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, NW
Washington D.C. 20005
Jared.littman2@usdoj.gov

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, *et al.*, Plaintiffs, v. DONALD J. TRUMP, *et al.*, Defendants.	Civ. A. No. 25-691 (RCL)

[PROPOSED] ORDER

Upon consideration of Defendants' Motion to Stay the June 17, 2026 Preliminary Injunction Pending Appeal, and any response thereto, it is hereby **ORDERED** that Defendants' motion is **GRANTED**.

DATED:_____

_____
Royce C. Lamberth
United States District Judge

SUPPLEMENTAL APPENDIX Q

Excerpt from Transcript of Bench Trial,
Reiyn Keohane, et al., v. Ricky D. Dixon, et al., No. 24-cv-434,
(N.D. Fla. July 8, 2026)

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION
Case No: 4:24-CV-00434-AW-MAF

REIYN KEOHANE, *et al*,

Plaintiffs,

v.

RICKY D. DIXON, in his official capacity as Secretary of the Florida Department of Corrections, *et al.*,

Defendants.

Tallahassee, Florida
July 8, 2026
8:31 a.m. - 5:45 p.m.
Pages 564-864

TRANSCRIPT OF BENCH TRIAL
VOLUME 4
BEFORE THE HONORABLE ALLEN C. WINSOR
CHIEF UNITED STATES DISTRICT JUDGE

APPEARANCES:

For the Plaintiff:

By: Li Nowlin-Sohl, Esq.
By: Leslie Cooper, Esq.
By: Sruti Swaminathan, Esq.
American Civil Liberties Union Foundation
125 Broad Street
New York, New York 10004
And
By: Daniel Tilley, Esq.
By: Samantha Past, Esq.
American Civil Liberties Union
4343 West Flagler Street
Suite 400
Miami, Florida 33134

By: Anthony Anscombe, Esq.
By: George Desh, Esq.
By: Sadaf Misbah, Esq.
Steptoe, LLP
227 West Monroe Street
Suite 4700
Chicago, Illinois 10004

PROCEEDINGS RECORDED BY FEDERAL OFFICIAL COURT STENOGRAPHER
TRANSCRIPT PRODUCED BY COMPUTER-AIDED TRANSCRIPTION

For the Defendants:	By: William R. Lunsford, Esq. By: Megan N. McNab, Esq. Butler Snow, LLP 200 West Side Square Suite 100 Huntsville, Alabama 35801 And By: George Wright, Esq. Butler Snow, LLP 445 North Boulevard Suite 300 Baton Rouge, Louisiana 70802
Reported by:	Dawn M. Savino, RPR, CRR Official United States Court Reporter 111 North Adams Street Tallahassee, Florida 32301 (850) 521-3674 Dawn_Savino@flnd.uscourts.gov

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Q. So orthopedic shoes, or a low bunk, or special diet, or noise-canceling headphones could be medically necessary.
A. Could be, yes.
Q. And care that doesn't cure, but treats symptoms, can be medically necessary.
A. Correct.
Q. Earlier you were talking a little bit about medical research, and just going to go over a little bit to make sure we're on the same page.
So high certainty evidence means that it is likely a randomized control trial, correct?
A. Well, a randomized control trial does provide a high certainty of evidence. However, there are other forms of evidence that could also have high certainty. For instance, especially these national registries followed over time could provide some high certainty evidence too. So there's other ways to get there.
Q. And when you say "high certainty," are you using that kind of within the grade specifications, or a little bit more colloquial?
A. Yes. I'm saying you can get higher levels of certainty with things other than with randomized control trials. Sometimes it's often said that you need a randomized control trial in order to get high certainty. That's not accurate.
Q. Okay. And you said higher. So, I mean, there's very low,

there's low, there's medium and there's high. And so the population study that you're talking about, are you saying that could receive a high level of certainty?

A. I think, yes. If designed well enough and with enough data, you could have high certainty, especially in very well-organized controlled systems like they have in Finland and in Scandinavia because so much is entered into the record, and they can follow so much over time. In a lot of ways you're going to get data from that that would be next to impossible to get in a randomized control trial almost on any topic.

Q. And observational studies are typically graded low certainty?

A. Correct.

Q. We're using high certainty and low certainty, but that's sometimes also called high quality, low quality?

A. Correct.

Q. And you'd agree that many medical treatments and mental health treatments are provided that are supported solely by low certainty or low quality evidence?

A. That's correct.

Q. And you'd also agree that much of the treatment for mental health is based on low certainty or low quality evidence?

A. That is correct.

Q. You provide medication to your patients for indications that are not supported by high quality evidence?

5:03 1 A. That is correct.
5:03 2 Q. And in your opinion, the fact that a treatment is not
5:03 3 supported by high quality evidence is not itself a reason to
5:03 4 not utilize that treatment.
5:03 5 A. That is correct.
5:03 6 Q. So in your report you cite the Dhejne study. I'll just say
5:03 7 that Dr. Karasic knows Ms. Dhejne and has said that's how it's
5:03 8 -- so I think the record is going to be very unclear, but it's
5:03 9 Dhejne or Dhejne or Dhejne. It's the Swedish study, correct?
5:03 10 A. Yes.
5:03 11 Q. Okay. And that study's titled Long-term Follow-up of
5:04 12 Transsexual Persons Undergoing Sex Reassignment Surgery, Cohort
5:04 13 Study in Sweden, correct?
5:04 14 A. Correct.
5:04 15 Q. And that study compared suicidality in a group of
5:04 16 transgender people who received sex reassignment surgery to the
5:04 17 general population, correct?
5:04 18 A. Yes.
5:04 19 Q. Now, it did not include a comparison group of people with
5:04 20 gender dysphoria who did not receive treatment?
5:04 21 A. Correct.
5:04 22 Q. And it did not look at the efficacy of social transition to
5:04 23 treat gender dysphoria?
5:04 24 A. Well, it presumes that those who undergo surgical
5:04 25 transition are also going to have social transition. So you do

5:45 1 Court's adjourned.

5:45 2 COURT SECURITY OFFICER: All rise. This Honorable

5:45 3 Court is adjourned.

5:45 4 (Proceedings concluded)

5:45 5 C E R T I F I C A T E

I certify that the foregoing is a correct transcript
5:45 6 from the record of the proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to
5:45 7 the Judicial Conference Policy on Privacy is noted within the transcript.

5:45 8

7-19-2026 /s/ Dawn M. Savino, R.P.R., C.R.R.

5:45 9 Date DAWN M. SAVINO, R.P.R., C.R.R.

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I N D E X

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