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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

LINDSAY HECOX, et al.,

Plaintiffs,

v.

BRADLEY LITTLE, et al.,

Defendants.

No. 1:20-CV-184-CWD

EXPERT DECLARATION OF SARA SWOBODA, MD, IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Sara Swoboda, MD, have been retained by counsel for Plaintiffs Lindsay Hecox and Jane Doe, with her next friends, Jean Doe and John Doe, as an expert in connection with the above-captioned litigation.

1. The purpose of this declaration is to offer my expert opinion on: (1) typical sports physicals for high school athletes in Idaho; (2) the impact of H.B. 500 on the sports physical process; and (3) the potential harms of H.B. 500 to student-athletes through the imposition of a "biological sex" verification procedure.

2. In preparing this report, I reviewed the legislative findings for H.B. 500, as enacted, and the sources cited therein.

3. I have knowledge of the matters stated in this declaration and have collected and cite to relevant literature concerning the issues that arise in this litigation in the body of this declaration and in the attached bibliography.

4. In preparing this report, I relied on my education and training, my clinical experience and my knowledge of the scientific literature in the pertinent fields. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

PROFESSIONAL BACKGROUND

5. I am a general practice pediatrician in the St. Luke's Health System, Treasure Valley Pediatrics, in Boise, ID. A true and correct copy of my CV is attached

hereto as Exhibit A.

6. I am licensed to practice medicine in the state of Idaho. I am an American Board of Pediatrics certified pediatrician and a Fellow with the American Academy of Pediatrics.

7. I graduated from the Washington State University in Pullman, WA with a Bachelor of Art degree in Political Science in 2005. I earned my Doctor of Medicine degree from the University of Washington School of Medicine in 2010. I completed intern and resident training in Pediatrics at University of Washington School of Medicine/Seattle Children's Hospital in 2013. From 2013-2016, I was a general pediatrician with the Indian Health Services, Navajo Nation, in Chinle, Arizona. Since 2017, I have been a general practice pediatrician with the St. Luke's Health System, Treasure Valley Pediatrics, in Boise, ID.

8. Between 2014 and 2016, I served as a medical consultant to the Chinle area Suspected Child Abuse and Neglect (SCAN) Team during which time I worked closely with tribal child protective services, law enforcement, and medical providers to provide medical consultation and follow-up for children suspected to be victims of abuse and neglect.

9. Since 2018 I have served as a Board Member for Idaho Voices for Children, a policy organization that focuses on expanding healthcare access for families, foster care advocacy and early childhood advocacy, and literacy.

10. In my current practice, I have approximately 1,500 patients between the ages of 0 and 18 across Idaho.

11. I have not previously testified as an expert witness in either deposition or at trial. I am being compensated at an hourly rate of $250 per hour for preparation of expert declarations and reports, and $400 per hour for time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

GENERAL PEDIATRIC PRACTICE

12. As a pediatrician, my job is focused on caring for the health and well-being of infants, children, adolescents, and young adults. Working with children and their families, I provide well child care and health surveillance, preventative care, management and treatment of complex chronic medical conditions, and urgent treatment of acute illness in children and adolescents.

13. General principals of pediatric medicine instruct that we do no harm and focus on the best interests of the child. As a general practice, we also conduct patient history taking and examinations of adolescents and young adults outside of the presence of their parents to ensure appropriate privacy and confidentiality and to increase accuracy of assessments.

SPORTS PHYSICAL PROCESS

14. As part of my regular pediatric practice, I conduct sports physicals for Idaho student-athletes. I conduct approximately 100 sports physicals per year.

During July and August, my practice regularly includes these sports physicals to ensure that my patients are ready to participate in athletics in the fall.

15. The American Academy of Pediatrics (AAP) has clear guidelines on the purpose and testing that makes up a sports physical.

16. Under AAP guidelines, the sole purposes of the physical are to check for health conditions that could result in serious injury or death while a young person is participating in athletics, look for conditions that predispose to injury, provide an opportunity to discuss health, determine general health, and create an entry point into the health care system. These include obscure heart conditions, severe asthma, seizure disorders, a single kidney, and other serious medical conditions. The AAP instructs that the physical is intended to encourage participation not exclusion from athletics. American Academy of Pediatrics, Preparticipation Physical Evaluation 3 (5th ed. 2019) ("The purpose of the [Preparticipation Physical Evaluation] PPE is to facilitate and encourage safe participation, not to exclude athletes from participation").

17. A typical sports physical lasts 30 minutes, during which time I do the following: review a patient's personal and family medical history, verbally screen for history or symptoms that could indicate a life-threatening medical condition, complete a physical exam looking for signs of medical conditions that could cause morbidity and mortality, and discuss and encourage general principals of wellness. This exam would be conducted with the patient clothed and would involve very little

contact directly with the patient's body beyond listening to the person's heart and lungs and palpating the abdomen.

18. Sports physicals do not include blood tests for hormone levels or any other purpose. Sports physicals do not include genetic tests for chromosomes or any other purpose. It is also not part of a sports physical to conduct a genital or pelvic examination.

19. A sports physical does include a general question about whether a person has only one testicle, but that information can be collected through asking the patient. As part of an annual exam, testicular exams are more often conducted, but can also be done by history. Pediatricians are moving in this direction as we become more thoughtful as a profession about the necessity/utility of genital exams. Under the AAP guidelines for sports physicals, the purpose of the inquiry is to protect youth from the possibility of losing a remaining functional testicle for the purpose of sperm production where relevant. *Preparticipation Physical Evaluation* at 119.

IMPACT OF H.B. 500 ON SPORTS PHYSICALS

20. The language of Idaho's newly passed law requires that student-athletes who have their sex disputed obtain verification of their sex from a physician. As a pediatrician who regularly conducts sports physicals and who has a large number of student-athlete patients, I would likely be called upon under the terms of the law to write sex verification statements for my patients.

21. The law instructs physicians to verify a student's "biological sex as part of a routine sports physical examination relying only on one (1) or more of the

following: the student's reproductive anatomy, genetic makeup, or normal endogenously produced testosterone levels." None of these physiological characteristics would be tested for in any routine sports physical examination. There is also no procedure in medicine to verify an individual's "biological sex" by looking at a single physiological characteristic. I could not, as the law instructs, "verify biological sex" by examining a patient's genetic makeup, normal endogenously produced testosterone levels, or reproductive anatomy, either alone or in any combination. This would not be consistent with medical science.

22. Even if I were to certify a patient's sex characteristics related to their genes, hormones or reproductive anatomy, none of that testing is straightforward or ethical without a clear medical indication.

23. Genetic testing is complicated and personal as it reveals a significant amount of information. It is done by a specialist.

24. If a patient were to come to me and ask for genetic testing or endogenous testosterone testing, I would have to refer them to a pediatric endocrinologist. For patients in rural areas, it might be difficult to find and travel to a pediatric endocrinologist.

25. Where a patient presents with a constellation of medical concerns that indicate a need for genetic testing, I would refer to a pediatric endocrinologist and order a chromosomal microarray. This type of testing reveals a significant amount of very sensitive and private medical information. A chromosomal microarray looks at all 23 pairs of chromosomes that an individual has and would reveal things beyond

just whether a person has 46-XX, 46-XY, or some other combination of sex chromosomes. In ordering genetic testing of this kind, a range of genetic conditions could be revealed to a patient and patient's family. I do not do genetic testing as a routine part of any medical evaluation and am not aware of any pediatric practice that would (absent specific medical indications). Even in cases where a patient presents with possible medical or genetic conditions based off of medical or family history that would warrant genetic testing, such testing is complex and often requires insurance pre-authorization.

26. Likewise, if a patient were presenting with certain medical concerns I might refer that person to a pediatric endocrinologist for hormone testing. I do not test a patient's hormone levels as a routine part of any medical evaluation and am not aware of any pediatric practice where hormone testing would be done (outside of specific medical concerns).

27. I do not as a general practice conduct internal pelvic examinations on patients. Pelvic examinations in pediatric patients are limited to patients with specific concerns such as acute trauma or infection. In young patients, such an exam would often be done with sedation and appropriate comfort measures to limit psychological trauma. Routine pap smears are currently not indicated in pediatric populations, including adolescents. Pediatric consensus recognizes that genitalia exams are always invasive and carry the risk of traumatizing patients if not done with careful consideration of medical utility, discussion about the purpose and

subsequent findings of any exam with the patient and their family, and explicit consent of the patient.

28. If a patient came to my office and asked me to examine their "reproductive anatomy," from a medical perspective, it would not be clear what such an examination would entail. "Reproductive anatomy" is not a medical term. That could include internal reproductive organs, external genitalia, or other body systems.

29. A medically unnecessary pelvic examination would be incredibly intrusive and traumatic for a patient. I would not conduct such an examination.

30. Determining whether an individual has ovaries may, in some circumstances, require more intrusive testing including transvaginal ultrasounds and may require referral to pediatric gynecologists, endocrinologists, and geneticists. None of this testing would be a necessary part of a sports physical or any standard medical examination absent medical concerns and indications of underlying health conditions necessitating treatment.

31. Subjecting a pediatric patient to any unnecessary testing is against medical guidelines. Specific testing of genetics, internal or external reproductive anatomy, and hormones could reveal information that an individual was not looking to find out about themselves and then could result in having to disclose information to a school and community that could be deeply upsetting to pediatric patients.

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

Executed on April 29, 2020

Sara Swoboda, MD

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 30th day of April, 2020, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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Sherri Ybarra,
Individual members of the State Board of Education,
Boise State University,
Marlene Tromp,
Individual members of the Idaho Code Commission

DATED this 30th day of April, 2020.

/s/ Richard Eppink

EXHIBIT A

Sara Swoboda, MD

Education

2010 – 2013 Pediatrics Residency
University of Washington School of Medicine/Seattle Children's Hospital, Seattle, WA

2006 – 2010 M.D.
University of Washington School of Medicine, Seattle, WA

2001 – 2005 B.A., Political Science (with emphasis on global politics); *Summa Cum Laude*
Washington State University, Pullman, WA

Clinical Experience

2017-current
General Pediatrician
St. Luke's Health System, Treasure Valley Pediatrics
Boise, ID

2013-2016
General Pediatrician, inpatient and outpatient services
Indian Health Services, Navajo Nation
Chinle, AZ

2010–2013
Pediatric resident
University of Washington
Seattle, WA

Community and Advocacy

2018-current
Board member, Idaho Voices for Children
Idaho Voices for Children serves as the voice for children and families to ensure their needs are met in lawmaker's decisions and state policy. Advocacy and legislative lobbying focus areas include expanding healthcare access for families, foster care advocacy and early childhood advocacy, and literacy.

2014-2016
Medical consultant, Chinle area Suspected Child Abuse and Neglect (SCAN) Team
Worked closely with tribal child protective services, law enforcement and medical providers to provide medical consultation and follow-up for children suspected to be victims of abuse and neglect.

Sara Swoboda, MD

2015-2016
R.I.S.E.: Respond, Intervene, Support, Educate
Co-author and pediatric program advisor for IHS Domestic Violence Prevention Initiative grant award to increase sexual assault response resources to pediatric populations in Chine, AZ.
Funding for $220,000/year for clinical programs

2015-2016
Hooghan Be' Adhií noo glí: A Home with Dignity
Co-author of IHS Domestic Violence Prevention Initiative grant award to implement ACEs screening and trauma-informed care into healthcare services in Chinle, AZ.
Funding for $170,700/year for community and clinical programs

Publications

Cantey, P., Weeks, J., Edwards, M., Rao, S., Ostovar, A., Dehority, W., Alzona, M., **Swoboda, S.**, et al. The Emergence of Zoonotic Onchocerca Lupi Infection in the United States--A Case Series. Clinical Infectious Diseases. Nov 2015, 62(6):778-83.

Cantey, P., Eberhard, M., Weeks, J., **Swoboda, S.** and Ostovar, A. Letter to the Editor: Onchocerca lupi infection. Journal of Neurosurgery: Pediatrics. Published online Oct 2015.

Swoboda, S. and Feldman, K. Skeletal Trauma in Child Abuse. Pediatric Annals. Nov 2013, 42(11):458.

Awards

Chinle Medical Staff "Above and Beyond" Award, 2016.

Navajo Area IHS Director's Award for Outstanding Health Care Provider, 2015.

Licensure/Certifications

- State of Idaho Medical License
- American Board of Pediatrics certified pediatrician
- Fellow, American Academy of Pediatrics

References available upon request